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, 10 September 2026 at 2.00 pm to 4:30 pm
in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

No.	Agenda Item	Format	Purpose	Time
1.	**CORE / STANDING BUSINESS ITEMS**			
1.1	**Welcome, Group Chair's Opening Remarks and Apologies for Absence** Alan Downey, Group Chair	Verbal	Information	**14:00**
1.2	**Staff Charter and Values** Alan Downey, Group Chair	Attached	Information	
1.3	**Questions from the Public and Governors** Alan Downey, Group Chair	Verbal	Discussion	**14:05**
1.4	**Declarations of Interest** Alan Downey, Group Chair	Verbal	Assurance	**14:10**
1.5	**Minutes of the Meeting held on Thursday, 9 July 2026** Alan Downey, Group Chair	BIC(26)188 Attached	Approval	
1.6	**Matters Arising** Alan Downey, Group Chair	Verbal	Assurance	
1.7	**Action Tracker** - **Public** Alan Downey, Group Chair	BIC(26)189 Attached	Assurance	
2.	**CHIEF EXECUTIVE & CHAIR REPORTS**			
2.1	**Group Chair's Briefing** Alan Downey, Group Chair	BIC(26)195 Attached	Assurance	**14:15**
2.2	**Group Chief Executive's Briefing** Lyn Simpson, Group Chief Executive	BIC(26)196 Attached	Assurance	**14:25**
2.3	**National Reports and Guidance** Lyn Simpson, Group Chief Executive	BIC(26)197 Attached	Assurance	**14:35**
2.4	**Carnall Farrar Report** Lyn Simpson, Group Chief Executive	BIC(26)230 Attached	Approval / Ratification	**14:40**
3.	**PATIENT SAFETY UPDATE**			
3.1	**Monthly Patient Safety Update (including Assurance Committee update)** Mr Peter Sedman, Deputy Medical Officer, Hilda Gwilliams, Group Chief Patient Safety Officer & Jo Ledger, Deputy Chief Nurse	BIC(26)190 Attached	Assurance	**14:45**
3.2	**Maternity Oversight:**			
3.2.1	**Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG and HUTH** Dr David Sulch, NED Maternity & Neonatal Safety Champion	BIC(26)192 Attached	Assurance	**14:55**

3.2.2	**Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH (including Maternity Incentive Scheme (MIS) Year 8 & Perinatal Mortality Review Tool (PMRT) Quarterly Report)** Jo Ledger, Deputy Chief Nurse & Yvonne McGrath, Group Midwifery Director	BIC(26)193 Attached	Assurance	**15:05**
3.2.3	**Ockenden Independent Review - Nottingham** Jo Ledger, Deputy Chief Nurse & Yvonne McGrath, Group Midwifery Director	BIC(26)194 Attached	Assurance	**15:15**
4.	**STRATEGIC PROGRESS**			
4.1	**Public Purse (including Assurance Committee update)** Emma Sayner, Group Chief Financial Officer & Murray Macdonald, NED Committee Chair	BIC(26)198 Attached	Assurance	**15:25**
4.2	**Patients – Performance (including Assurance Committee update)** • **Cancer** • **Urgent & Emergency Care** • **Referral to Treatment** • **Diagnostics** Sam Peate, Group Chief Delivery Officer Murray Macdonald, NED Committee Chair	BIC(26)199 Attached	Assurance	**15:35**
4.3	**People (only the Assurance Committee update)** Julie Beilby, NED Committee Chair	BIC(26)200 Attached	Assurance	**15:45**
5.	**OTHER ITEMS FOR ASSURANCE**			
5.1	**Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report** Jane Hawkard, NED Committee Chair	BIC(26)202 Attached	Assurance	**15:55**
6.	**OTHER ITEMS FOR APPROVAL**			
6.1	**Modern Slavery Statement – NLaG & HUTH** Helen Marks, Group Chief People Officer	BIC(26)203 Attached	Approval	**16:05**
6.2	**Group Charities – NLaG & HUTH** Alan Downey, Group Chair	BIC(26)204 Attached	Approval	
6.3	**Winter Plan** Sam Peate, Group Chief Delivery Officer	BIC(26)229 Attached	Approval	
6.4	**Medical Appraisal & Revalidation Annual Report – NLaG & HUTH** Mr Peter Sedman, Deputy Medical Officer	BIC(26)210 Attached	Approval	
7.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**			
7.1	**Items for Information / Supporting Papers (as per Appendix A)** Alan Downey, Group Chair	Verbal	Information / Assurance	
8.	**ANY OTHER URGENT BUSINESS**			
8.1	**Any Other Urgent Business** Alan Downey, Group Chair	Verbal		**16:25**

9.	MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON			
9.1	**To agree any matters requiring referral for consideration on behalf of the Trust Boards by any of the Board Committees-in-Common** Alan Downey, Group Chair / All	Verbal	Discussion	

10.	DATE OF THE NEXT MEETING
10.1	**The next meeting of the Boards-in-Common will be held on Thursday, 8 October 2026**

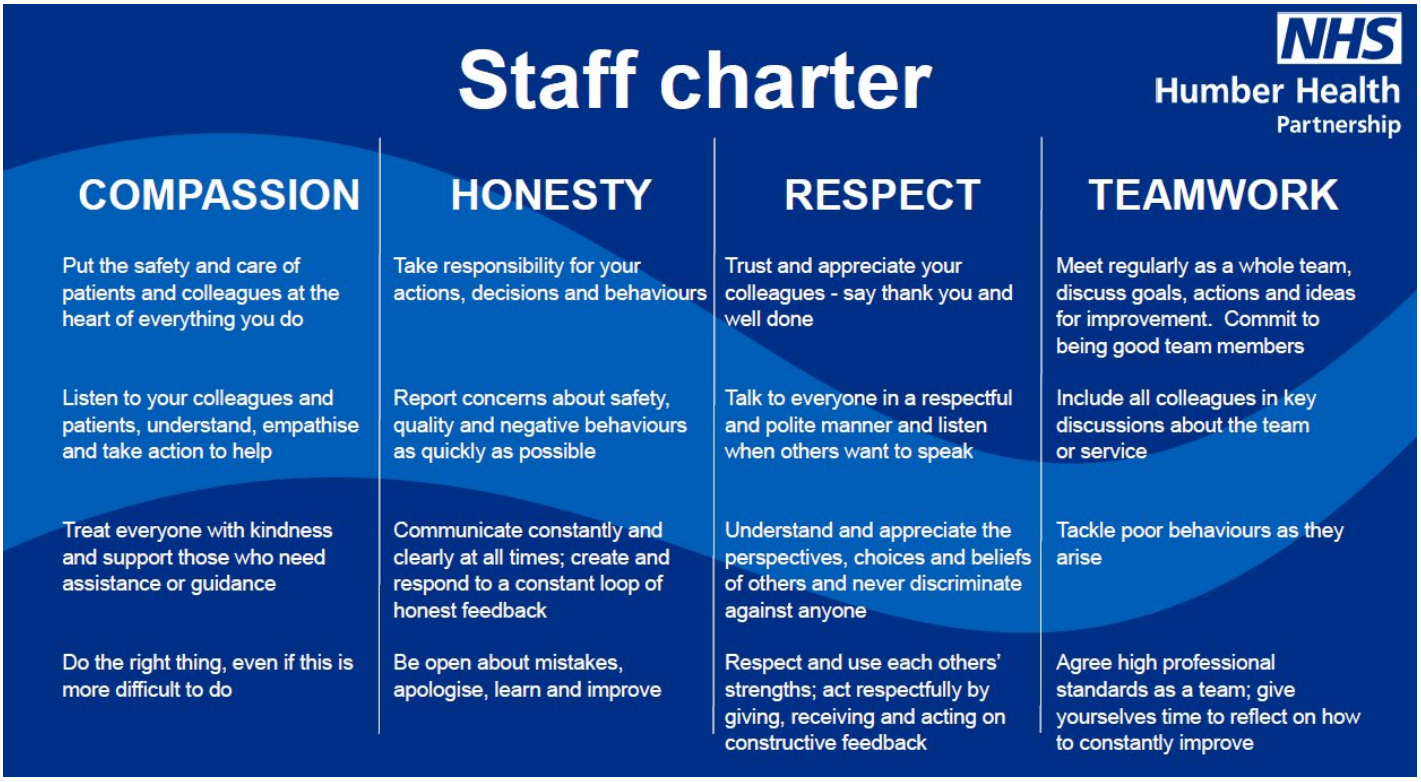
KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

7.	ITEMS FOR INFORMATION / SUPPORTING PAPERS	
7.1	**Quality & Safety Committees-in-Common**	
7.1.1	**Quality & Safety Committees-in-Common Minutes – June 2026** Dr David Sulch, Non-Executive Director Committee Chair	BIC(26)205 Attached
7.1.2	**Medicines Management Annual Report** Mr Peter Sedman, Deputy Medical Officer	BIC(26)206 Attached
7.1.3	**Organ Donation Annual Report** Mr Peter Sedman, Deputy Medical Officer	BIC(26)207 Attached
7.2	**Performance, Estates & Finance Committees-in-Common**	
7.2.1	**Performance, Estates & Finance Committees-in-Common Minutes – March, May, June, July 2026** Murray Macdonald, NED Committee Chair	BIC(26)222 Attached
7.2.2	**Finance Report – Month 4** Emma Sayner, Group Chief Financial Officer	BIC(26)208 Attached
7.3	**Workforce, Education & Culture Committees-in-Common**	
7.3.1	**Workforce, Education & Culture Committees-in-Common Minutes – May 2026** Julie Beilby, Non-Executive Director Committee Chair	BIC(26)209 Attached
7.4	**Audit, Risk & Governance Committees-in-Common**	
7.4.1	**Audit, Risk & Governance Committees-in-Common Minutes – June 2026** Jane Hawkard, Non-Executive Director Committee Chair	BIC(26)211 Attached
7.5	**Health Tree Foundation Trustees Committee Highlight Report**	
7.5.1	**Health Tree Foundation Trustees Committee Highlight Report** Neil Gammon, Independent Chair	BIC(26)228 Attached
7.6	**Other**	
7.6.1	**Group Performance Report – NLaG and HUTH** Chris Fry, Group Director of Performance	BIC(26)212 Attached
7.6.2	**Trust Boards & Committees Meeting Cycle – 2026** Keith Haynes, Interim Board Secretary	BIC(26)213 Attached
7.6.3	**Council of Governors (CoG) and Trust Board Engagement Policy** Keith Haynes, Interim Board Secretary	BIC(26)214 Attached

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

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



Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

DRAFT
TRUST BOARDS-IN-COMMON MEETING IN PUBLIC
Minutes of the meeting held on Thursday, 9 July 2026 at 10.00 am
in the Boardroom, Diana, Princess of Wales Hospital

For the purpose of transacting the business set out below:

Present:

Murray Macdonald	Group Vice Chair (Chair of Meeting)
Lyn Simpson	Group Chief Executive
Sam Peate	Group Chief Delivery Officer
Emma Sayner	Group Chief Financial Officer
Mr Peter Sedman	Deputy Chief Medical Officer
Julie Beilby	Group Non-Executive Director
Professor John Craig	Non-Executive Director (HUTH)
Jane Hawkard	Group Non-Executive Director
Dr David Sulch	Group Non-Executive Director

In Attendance:

Paul Bunyan	Deputy Chief People Officer (Covering Group Chief People Officer)
Jennifer Clarke	Trust Member
Nichelle Gromet	Matron, Acute and Emergency Medicine (for item 1.3)
Hilda Gwilliams	Group Chief Patient Safety Officer
Keith Haynes	Interim Board Secretary
Brent Huntington	Governor
Wendy Page	Care Group Nurse Director (representing Jo Ledger)
John Palmer	Trust Member
Dr Alastair Pickering	Interim Group Chief Digital Officer
Ian Reekie	Lead Governor (attended virtually)
Leslie Saunders	Trust Member
Kevin Woolas	Trust Member
Sarah Meggitt	Executive Assistant to the Group Chair (minute taker)

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

1. CORE BUSINESS ITEMS

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

Murray Macdonald welcomed Board members and observers to the meeting and declared it open at 10.00 am.

Murray Macdonald introduced Keith Haynes, Interim Board Secretary to members. He added that Professor John Craig would also join the meeting as the HUTH nominated University Non-Executive Director (NED).

Apologies for absence were received from:

Alan Downey	Group Chair
Jo Ledger	Deputy Chief Nurse (covering Group Chief Nurse)
David Sharif	Group Director of Assurance
Dr Kate Wood	Group Chief Medical Officer

1.2 **Staff Charter and Values**

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

1.3 **Patient Story**

Wendy Page introduced Nichelle Gromet, who shared a patient story regarding care received in the Emergency Department (ED) at Hull Royal Infirmary (HRI) and a subsequent admission to an elderly care ward.

Nichelle Gromet outlined concerns raised by the patient and family, including poor communication, delays in care, multiple ward transfers, and a lack of explanation regarding the challenges being experienced by the organisation at the time. These issues contributed to a poor patient experience and concerns that the care provided had not met expectations.

The family raised concerns that the patient's care had been adversely affected by multiple ward transfers and poor communication. They reported not feeling listened to, involved in care decisions, or assured that the patient's dignity had been maintained.

Nichelle Gromet highlighted the key learning from the case, emphasising the importance of visible compassion and effective communication in delivering safe, high-quality care. While maintaining clinical safety remained essential, compassionate care and meaningful engagement with patients and families were recognised as equally important in ensuring a positive care experience.

Learning to be taken from the story was shared with Board members highlighting that compassion during care should always remain visible and that communication was an important part of safe care. Although there was a responsibility to ensure care was clinically safe at all times compassion was also key in providing care to patients and families to ensure every family felt safe.

Murray Macdonald thanked Nichelle Gromet for sharing the patient story and asked that the Board's thanks be conveyed to the family for allowing their experience to be shared. He noted that it was fortunate the patient had family members who were able to advocate on their behalf and raise concerns. Board members acknowledged that the experience described was disappointing and regrettable.

Murray Macdonald queried how the learning from the patient story would be shared with staff and embedded across the organisation to help prevent similar incidents occurring in the future.

Wendy Page acknowledged the impact of the patient story and advised that learning from such cases was shared through relevant forums, including ward sister meetings. She emphasised that the learning reinforced the importance of the fundamentals of patient care, particularly kindness, compassion, and effective communication.

Dr David Sulch noted that such issues often arose during periods of significant operational pressure, although this was not acceptable. He observed that multiple patient moves could make continuity of care and communication more challenging. It was acknowledged that a different approach to managing capacity across the organisation was required to help mitigate these risks.

Sam Peate was keen that stories continued to be shared in relevant forums to ensure learning continued for staff. He added that the new teletracking system would also support improvements.

Hilda Gwilliams advised that the patient safety programme currently being piloted in ward areas included a focus on fundamental standards of care to help embed learning and reinforce their importance in delivering high-quality patient care.

Wendy Page advised that positive feedback had been received from areas piloting the new programme, which incorporated learning from the patient story. She noted that the programme used a supported self-assessment approach, enabling teams to reflect on practice and embed wider learning with input from specialist staff.

Lyn Simpson emphasised the importance of consistently delivering the fundamentals of good care, particularly listening to and communicating effectively with patients and their families. She noted that sharing patient stories of this nature was important in reinforcing key learning and embedding improvements in practice across the organisation.

Murray Macdonald referred to the action tracker in respect of item 1.3 from the 11 June 2026 meeting and requested an update in respect of this from Myles Howell as it related to patient stories. Myles Howell explained that the communications team had worked with the patient experience team to introduce and capture patient stories to support learning. These were now shared on Bridget to ensure stories were visible, those stories would also be shared more widely through the Learning Improvement Safety Academy (LISA).

Murray Macdonald thanked Nichelle Gromet for sharing the story which had resonated strongly with Board members.

1.4 **Questions from the Public and Governors**

Murray Macdonald advised two questions had been asked by members of the public prior to the meeting. Those questions and responses were provided in the meeting as follows.

Question1 from a member of the public/patient:
“I’m under vascular at HRI and was treated really well by the consultants and all the staff but where possible appointments what could be done nearer to home i.e. GDH MRI CT ultra sound, he was ok but others are not all I seem to do is go

to HRI/CHH the cost racks up and adds up and I'm having to get someone to take me on numerous occasions having to drive round to find parking. I asked about having an ultrasound at GDH but was told I would have to cancel and speak with the consultant, obviously I didn't bother."

Sam Peate advised that in terms of investigations, some vascular scans can only be performed by the organisation's Vascular Scientists, who were currently based at HRI. There were plans to train additional staff and expand this service to other sites in the future; however, this was currently limited by workforce capacity.

Other investigations, such as ultrasound scans and CT scans, would be arranged at local sites wherever possible.

Question 2 from a member of the public/patient:
"I've seen a post about Diabetic eye screening which is under HRI but the staff undertaking it use Bartholamew MG, when I asked why they was using that instead of GDH I was told because of space. Someone else from Goole has been sent to Hull for the same why not Goole where possible because people from York are being sent to Goole they have the equipment in GDH."

Sam Peate advised that historically the diabetic eye screening service had been provided from a number of medical centres in and around Goole. The Ophthalmology management team were currently looking at the opportunity to improve access to this service in line with existing services provided from GDH and further updates would be provided towards the end of this Summer.

1.5 **Declarations of Interest**

Murray Macdonald sought declarations of interest from Board members, none were received.

1.6 **Fit & Proper Persons Test: Annual Declaration – BIC(26)158**

Murray Macdonald referred to the paper and advised of the recommendations within the report noting that within the Register of Interests one return had been noted as to be confirmed. It was agreed that the individual would be reminded of the need to complete the return, either making a return or a nil return.

Julie Beilby referred to the report and advised that it stated the period was until the end of May 2026, however, this should be the end of March 2026. It was agreed this would be amended as part of the update required.

Action: Keith Haynes to confirm required details within the report and ensure this was updated

The Trust Boards-in-Common approved the Fit & Proper Persons Test: Annual Declaration once subsequent changes had been made.

1.7 **To approve the minutes of the Trust Boards-in-Common meeting held on Thursday, 11 June 2026 – BIC(26)159**

The minutes of the meeting held on the 11 June 2026 were accepted as a true and accurate record and would be duly signed by the Group Chair.

1.8 **Matters Arising**

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

1.9 **Action Tracker – Public – BIC(26)160**

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

- Item 3.1, 14 May 2026 meeting. Hilda Gwilliams advised that Jo Ledger had followed up on this action in respect of sharing a story. It was agreed Wendy Page would follow this up with Jo Ledger outside of the meeting.
- Item 1.3, 11 June 2026 meeting. Myles Howell had provided an update on this item as part of the patient story. It was agreed this action would be closed.
- Item 3.1, 11 June 2026 meeting. Mr Peter Sedman advised that the information had been circulated to Board members. It was agreed this action would be closed.
- Item 4.2.1, 11 June 2026 meeting. Wendy Page advised that Jo Ledger had shared the required information with the Freedom to Speak Up Guardians (FTSUG) and that a meeting had been arranged. It was agreed this action would be closed.

2. GROUP CHIEF EXECUTIVE & CHAIR REPORT

2.1 **Group Vice Chair's Report – BIC(26)161**

In addition to the contents of the Vice Chairs report, Murray Macdonald reflected on recent Care Group visits, noting the valuable opportunity they had provided to engage directly with staff and gain additional insight from staff.

He advised that the Non-Executive Director (NED) recruitment process had commenced, including the appointment of Professor John Craig.

Murray Macdonald also highlighted the Donna Ockenden Review of Maternity Services at Nottingham University Hospitals NHS Trust and the Baroness Amos Report. He noted that both reports contained significant findings and actions for organisations to consider and encouraged Board members to read them to support organisational learning. It was noted that work was underway to respond to requests from NHS England (NHSE) to review our maternity and mortuary services in light of the reports and which would be reported to the Board.

2.2 **Group Chief Executive's Briefing – BIC(26)162**

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

She reported that the organisation had commenced a programme of complex change informed by the NHSE external review and work being undertaken with Carnall Farrar. It was noted that this work was expected to conclude by mid-summer, with findings to be reported to the Boards.

She further advised that an internal operating model review was underway, involving three organisational workstreams to identify best operational practice. Chiefs of Service were supporting and were engaged in the work, including consideration of the current care group structure. It was acknowledged that a reduction in the number of care groups was likely to be required, and further updates would be provided to the Boards in due course.

Lyn Simpson provided an update on discharge and patient flow, highlighting ongoing improvement work in this area. She reported that two Multi-Agency Discharge Events (MADE) had been successfully delivered across the North and South Bank, with learning from these events being used to inform future improvements.

She also highlighted and was pleased to report the successful completion of the organisation's first robotic prostate surgery at Castle Hill Hospital (CHH). The procedure had been completed successfully, and the organisation was keen to further develop its robotic surgery programme for the benefit of patients.

Lyn Simpson referred to the Donna Ockenden Report and highlighted the importance of maintaining safe maternity triage services, with a continued focus on listening to patients and families. She noted that maternity safety had a higher profile at Board level, supported through increased assurance via the Quality & Safety Committees-in-Common and maternity service deep dives. While significant progress had been made, further improvements were still required.

Lyn Simpson reported that the planned resident doctors' industrial action had been stood down. She noted that work to improve working conditions would continue across the organisation and advised that future industrial action involving consultant staff remained a possibility, as reported nationally.

Lyn Simpson also referred to national communications regarding unlawful access to patient records. It was reiterated that records should only be accessed where required for professional purposes and that access driven by curiosity was inappropriate. The Board noted that further work would be undertaken with Information Governance and operational teams to review arrangements across the organisation.

Lyn Simpson advised that Sam Allen had commenced as Interim Regional Director. She noted that, she had already engaged with the organisation, particularly regarding the elective recovery position.

Lyn Simpson further reported that there was a national view that the organisation had ended the previous year in a positive position and should build on that progress to support delivery of its objectives during the year ahead.

Lyn Simpson advised that a National College of Leadership and Management had been established to provide a consistent approach to management development

and leadership and that a review would be undertaken of its offering and utility for the management and leadership staff of the Trust.

It was reported that the organisation had experienced a “never event” involving wrong-site surgery, the first “never event” for several months. An investigation was underway to identify learning and any necessary actions. The Board noted the importance of continuing to strengthen the organisation’s learning culture to minimise the risk of further “never events”.

Murray Macdonald welcomed the improvements in discharge performance and queried what had been learnt to ensure progress was sustained. Lyn Simpson acknowledged that focused attention had delivered improvements but emphasised that discharge planning needed to remain a priority throughout a patient’s care pathway, rather than solely at the point of discharge. She noted that strengthening this approach would support a more timely and seamless discharge process.

Sam Peate added that the MADE sessions held had been a structured way of working with local authorities with some opportunities for improved working in the future being identified. This had also provided opportunities to change some internal processes and communication.

In respect of NLaG it had identified closer working relationships in the Lincolnshire area with an opportunity to discharge differently than it had been previously. Wendy Page added that LISA would also be embedded into the discharge process which would support patient flow when patients were discharged.

Dr David Sulch expressed concern regarding the reported “never event”. As Chair of the Quality & Safety Committees-in-Common, he requested that the investigation report be shared with the Committee to ensure learning was identified and embedded to prevent recurrence, while building on the improvements already made in this area.

Mr Peter Sedman advised that the investigation into the “never event” remained ongoing and that a clearer understanding of the contributory factors would be available once it had concluded.

Murray Macdonald requested that further discussion take place in the private meeting due to patient confidentiality. He expressed concern for the patient and family affected, acknowledging the distress caused. He noted his disappointment that the incident had occurred despite assurances that robust controls were in place and formally recorded the Board’s apology to the patient and their family.

Murray Macdonald highlighted the planned works within the HUTH Emergency Department and queried the potential impact on patient experience. Sam Peate advised that flooring replacement works were scheduled due to deterioration of the existing surface. To maintain service delivery, the majors area would be temporarily relocated to an adjacent space, with staff and key system partners informed of the arrangements.

Sam Peate further advised that incident command meetings would be held twice daily throughout the works to monitor operational impact and ensure patient care remained effective. Communications had also been issued to reassure patients that emergency services would remain available during this period. While the works

were expected to present operational challenges, it was emphasised that patients could continue to access care as required.

Jane Hawkard queried whether wider communications would be used to highlight alternative services available to patients, which could also support patient flow. Myles Howell advised that a programme of social media communications was being planned to support this.

Sam Peate reported that simulation exercises had been completed in preparation for the temporary changes. Julie Beilby highlighted the need to consider additional communication channels, noting that not all members of the local population had access to social media. Myles Howell agreed to review the communications approach to ensure information was shared as widely as possible.

Action: Myles Howell to review further options for communication in addition to those being shared on social media

2.3 **National Reports and Guidance - BIC(26)163**

Lyn Simpson referred to the report and asked that it be taken as read. It was noted that national reports were routinely shared with Board members when they became available.

3. PATIENT SAFETY UPDATE

3.1 **Monthly Patient Safety Update (including Assurance Committee Update) – BIC(26)164**

Hilda Gwilliams highlighted key areas within the report, including Infection Prevention and Control (IPC). She advised that the number of Clostridium difficile (C. difficile) cases was higher than anticipated. While improvements had been seen at HUTH in relation to Methicillin-Resistant Staphylococcus Aureus (MRSA), IPC remained a significant challenge. Regional meetings were taking place to share learning, as similar issues were being experienced elsewhere.

The Boards noted that IPC continued to be a focus of discussion at the Quality & Safety Committees-in-Common, reflecting the need for further improvement. An external review of IPC services had been commissioned, and IPC remained a key organisational workstream. Further Board development sessions were planned, and recommendations arising from the external review would be implemented.

In relation to patient experience, Hilda Gwilliams reported that the team continued to progress the recovery plan and review the overall patient experience approach. The organisation had also engaged with the regional team to learn from organisations that had achieved high levels of patient feedback. It was acknowledged that the current model required further development to enhance patient experience and support sustained improvement.

Any reviews undertaken would be reported to the Quality & Safety Committees-in-Common for assurance and actions required.

Murray Macdonald noted that IPC performance would continue to be monitored through the Committees. In relation to patient experience, he requested further

information on the alternative models being considered and the proposed approach to implementation.

Hilda Gwilliams advised that an engagement plan would be developed to support the transition to a new model, with feedback sought from patients and families throughout the process. Murray Macdonald added that the views of NLaG Governors should also be considered as part of the engagement and development work.

Action: NLaG Governors to be considered as part of the engagement work in respect of the patient experience model

Julie Beilby referred to the ongoing IPC challenges and noted that the Performance, Estates & Finance Committees-in-Common had been considering a new cleaning contract. She sought assurance that the proposed arrangements would support the required standards.

Hilda Gwilliams confirmed that she had reviewed the tender submission and was satisfied that it met the organisation's requirements. She advised that previous audit findings had identified areas where cleaning standards had not consistently met the requirements for specific organisms, and that this would be addressed through the new contractual arrangements and ongoing review process.

Julie Beilby referred to the patient safety incidents detailed in the report, noting that five had been recorded with fatal severity, and sought clarification on the associated risks.

Mr Peter Sedman explained that the classification related to incidents involving a patient death, but it was not yet known whether the incident had contributed to or caused the death. He advised that each case was being reviewed separately to determine this.

Julie Beilby requested that future reports provide greater clarity on the meaning of fatal severity incidents to avoid unnecessary concern. This was noted for future reporting.

4. STRATEGIC PROGRESS

4.1 Public Purse (including Assurance Committee Update) – BIC(26)165

Emma Sayner referred to the report and advised that it was supported by the Month 2 financial position, which had been included at Appendix A for information.

Emma Sayner thanked the finance teams for delivering the final accounts for both Trusts, which had been subject to external audit. She reported that the National Oversight Framework (NOF) had influenced the audit findings for both organisations.

The Board noted that both Trusts had received unqualified audit opinions on their year-end accounts. Significant progress in governance and value-for-money arrangements was recognised, although the auditors had identified the Trusts' CQC position as a significant weakness.

Emma Sayner reported that the Group was forecasting a £63 million deficit for 2026 / 27 and remained off plan. She advised that this position was largely driven by a significant reduction in income and the loss of non-recurrent financial support received in previous years.

Although a small reduction in the run rate had been achieved by Month 2, performance remained below the required level. Emma Sayner noted that, if the current run rate continued, the organisation would not deliver its financial plan. The Board acknowledged that the agreed plan was ambitious and would be challenging to achieve.

Emma Sayner advised that engagement sessions had been held with clinical leaders from another organisation to gain insight into their approach, which had proved valuable. She also noted that NHSE would be undertaking a review over the summer to support improvements in productivity and efficiency. The report included a summary of recovery plans and the key targets being delivered by care groups.

Emma Sayner further reported that the next phase of support had recently been confirmed. This would involve an NHSE funded team working with the organisation to gain a deeper understanding of the current position and support delivery of the agreed improvement objectives.

Jane Hawkard welcomed the additional support being provided to the organisation and expressed the hope that it would help drive improvements. She acknowledged that significant work remained, particularly in relation to delivering workforce savings. The Boards noted that some performance trajectories had begun to improve, although further progress was required to achieve the planned position.

Lyn Simpson welcomed the recognition that additional support was required to strengthen organisational capacity and capability and accelerate the pace of change. She expressed disappointment that delivery of the Cost Improvement Programme (CIP) had not progressed at the required pace and emphasised the need to strengthen Programme Management Office (PMO) oversight to identify and address areas where planned trajectories were not being achieved.

Julie Beilby expressed concern that, by Quarter 2, the organisation was only delivering part of the planned trajectory, increasing the level of overperformance required later in the year to achieve the agreed target. She emphasised the need for greater accountability for expenditure across the Group, recognising the scale of savings required.

Julie Beilby also noted that an escalation report within the Triple A reporting framework had used the assurance rating “not assured”, which was not an approved assurance category. She requested that assurance ratings be aligned to the agreed framework. It was further noted that a similar approach should be adopted within the Board Assurance Framework (BAF) to provide greater consistency and clarity in reporting.

Murray Macdonald, as Chair of the Performance, Estates & Finance Committees-in-Common, highlighted the importance of maintaining oversight of the organisation’s cash position. He noted that the current position was heavily reliant on external support funding, which presented a significant risk. The Boards acknowledged that,

without continued support, the organisation would face a considerably more challenging financial position.

He added that the Tower Block work with Humberside Fire and Rescue was near to its 12-month review, it was noted that confirmation for the capital work required had not been received. This would need to be highlighted and raised as an alert with them. It was acknowledged that there was no risk to patients in respect of this, however, this needed to be noted with Humberside Fire and Rescue as part of the 12-month review.

Emma Sayner agreed that the current position with cash was a real issue. In respect of the Tower Block she explained that Tom Myers had met with regional colleagues the previous day and advised that issues would be escalated as required due to progress being required.

5. OTHER ITEMS FOR ASSURANCE

5.1 Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report - BIC(26)166

Jane Hawkard referred to the report and advised that the meeting had been held in respect of the organisational Annual Accounts and Annual Governance Statement (AGS). She explained that all had been signed off, however, the Head of Internal Audit had highlighted conclusions in respect of governance, risk management, financial reporting & management and data captured & used by the organisation as detailed within the report. She added that there was significant work to be undertaken in respect of governance. In respect of the external audit reports both had been unqualified in respect of accounts which was positive. However, value for money opinions had not been as positive particularly around financial stability. In respect of HUTH weaknesses were raised in respect of governance arrangements and the CQC Maternity issues previously raised that remained outstanding. It was acknowledged that the CQC Maternity issue had been resolved and that confirmation was awaited from the CQC.

It was reported that the Committees had received a request to extend the dates on the digital internal audit actions, however, this had not been agreed to. Although it was understood why the request had been made the review had been declined due to this being reviewed regularly at the meeting with assurance being provided to say those deadlines would be met.

Jane Hawkard advised that the Equality Impact Assessment (EqIA) for the flooring in ED had been over 16, work continued to reduce this below 16. Jane Hawkard referred to the reports received at the meeting as detailed within the report.

Jane Hawkard advised that the Value Circle Actions Implementation Plan had been received by the Committees which had been amber / red in respect of governance and risk including other concerns raised due to no implementation of requirements. It had, therefore, been recommended that an additional Audit, Risk & Governance Committees-in-Common meeting be held due to the next meeting not being scheduled until November 2026.

Jane Hawkard reported that she had also had discussions with the Audit Chair at Newcastle NHS Foundation Trust to discuss learning opportunities with them. She

explained that that committee met more frequently, and so she felt that it might be beneficial to hold an additional Audit, Risk & Governance Committees-in-Common meeting in September 2026 to focus on governance and risk issues.

Lyn Simpson noted that governance and risk issues required further Board discussion, as oversight should not rest solely with the Committees. She advised that this work aligned with reviews being undertaken by Grant Thornton and Value Circle, with a private update to be provided to the Boards. Consideration was also given to a future Board Development session to support improvements in this area.

Murray Macdonald agreed that further discussion should take place in the private meeting and that clarification was required regarding the assurance responsibilities of the Committees.

Post Meeting Note:
Following discussion at the Private Trust Boards-in-Common meeting the Boards agreed not to hold an additional meeting of the Audit, Risk and Governance Committees-in-Common meeting. The Chair of the Committees suggestion was welcomed in respect of bringing forward the November 2026 meeting to October 2026.

6. OTHER ITEMS FOR APPROVAL

6.1 Premises Assurance Model (PAM) – BIC(26)167

Emma Sayner referred to the paper and advised that this had been approved at the Performance, Estates & Finance Committees-in-Common.

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

6.2 Care Quality Commission (CQC) Statement of Purpose – BIC(26)168

Hilda Gwilliams referred to the paper and confirmed this had been approved at the Quality & Safety Committees-in-Common.

The Trust Boards-in-Common approved the CQC Statement of Purpose.

6.3 Annual Quality Account – BIC(26)169

Dr David Sulch confirmed that the Annual Quality Account had been approved by the Quality & Safety Committees-in-Common.

Julie Beilby queried whether report summaries should routinely indicate when papers had been considered by Committees. Murray Macdonald acknowledged the point and noted recent improvements in this area.
The Boards reviewed the paper and confirmed their support.

The Trust Boards-in-Common approved the Annual Quality Account.

7. ITEMS FOR INFORMATION / SUPPORTING PAPERS

7.1 Items for Information / Supporting Papers

The following items for information were shared.

- Quality & Safety CiC Minutes – May 2026
- Finance Report – Month 2
- Audit, Risk & Governance CiC Annual Report 2025 / 26
- Audit, Risk & Governance CiC Minutes – April 2026
- Group Performance Report – NLaG & HUTH
- Trust Boards & Committees Meeting Cycle – 2026
- Board Assurance Framework (BAF)

Julie Beilby expressed concern regarding the low Board Assurance Framework score for the digital agenda. She also queried the 'reasonable' assurance rating assigned to patient access, noting that the Integrated Performance Report was received for information and that significant development work remained underway.

At this point Professor John Craig joined the meeting.

Julie Beilby further questioned the 'limited' assurance rating relating to patient access, noting the organisation's National Oversight Framework Segment 5 status and suggesting that the rating should be reviewed for consistency.

Murray Macdonald noted that concerns regarding the BAF had previously been discussed and advised that Keith Haynes would undertake a review of the framework. He noted that, while the BAF was currently presented to the Boards for information, it should form a more substantive agenda item and align with the Committees-in-Common BAF.

Lyn Simpson supported a monthly review of BAF ratings and summaries to ensure they accurately reflected current discussions, risks and organisational performance, rather than being carried forward from previous reports.

8. ANY OTHER URGENT BUSINESS

Murray Macdonald sought any other urgent business items; none were raised.

9. MATTERS FOR REFERRAL TO COMMITTEES-IN-COMMON

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

10. DATE AND TIME OF THE NEXT MEETING

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

Thursday, 10 September 2026 at 10.00 am in the Boardroom, Hull Royal Infirmary.

The meeting closed at 11.46 pm.

Murray Macdonald reported that the Golden Stars event was due to be held the following evening. He looked forward to attending and meeting colleagues that had been nominated.

Cumulative Record of Board Director's Attendance 2026/27

Name	Possible	Actual	Name	Possible	Actual
Alan Downey	4	3	Murray Macdonald	4	4
Lyn Simpson	4	4	Sam Peate	4	4
Julie Beilby	4	4	Alastair Pickering	4	4
Paul Bunyan	4	4	Emma Sayner	4	4
John Craig	1	1	Peter Sedman	4	4
Hilda Gwilliams	4	4	David Sharif	4	2
Keith Haynes	1	1	David Sulch	4	3
Jane Hawkard	4	4	Kate Wood	4	0
Jo Ledger	4	3			

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BIC(26)189

BOARDS-IN-COMMON - PUBLIC
ACTION TRACKER - PUBLIC

2026 / 27

ACTION TRACKER - CURRENT ACTIONS - 10 SEPTEMBER 2026

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
Boards-in-Common ACTION									
5.1	12.02.26	Nursing Establishment Paper - risk register score to be reviewed		Jo Ledger to review risk register score for staffing due to investment being approved	Jo Ledger	October 2026	To be reviewed in October once new recruits have commenced employment with organisation		
3.1	09.04.26	Monthly Patient Safety Update - IPR update shared		IPR to be shared with Boards once it had been redesigned	David Sharif	October 2026	The new IPR is being worked up across performance, workforce and safety and quality domains. The performance section has been trialled in the June and July PEF meetings and will be integrated together for the board meeting.		
5.2	09.04.26	Establishment Review of Safe Staffing		Safer Staffing paper to be shared with Boards in August 2026, to be shared six monthly thereafter	Hilda Gwilliams / Jo Ledger	October 2026	Update to be provided at October 2026 meeting		
6.2	09.04.26	Capital Plan - planning cycle to include plan		Sam Peate and David Sharif to include Capital planning within the Boards timetable	David Sharif / Emma Sayner	October 2026	Update to be provided at October meeting		
1.3	14.05.26	Patient Story - safeguarding capacity update		Report on safeguarding capacity to be shared with the Trust Boards-in-Common by Jo Ledger once the review had been undertaken	Jo Ledger	November 2026	Full service review being undertaken by Tracy Campell, Site Nursing Director and will be shared with Trust Board in November 2026.		
3.1	14.05.26	Monthly Patient Safety Update - More detailed information to be added to front sheets		David Sharif to communicate to report authors details to be included on front sheets including prior approval	David Sharif	October 2026	Update to be provided at October 2026 meeting. Progressed through Governance workstream and Board Goverance Manual.		
3.1	14.05.26	Monthly Patient Safety Update - Complex Cases Presentation		Complex cases presentation to be shared with Board members	Hilda Gwilliams / Wendy Page	October 2026	Update to be provided at October 2026 meeting		
4.2	14.05.26	Public Purse - Finance Strategy - milestones		Emma Sayner to share milestones relating to the Finance Strategy with the Performance, Estates & Finance Committees-in-Common	Emma Sayner	September 2026	Update to be provided at September 2026 meeting		
4.2	14.05.26	Public Purse - Triple A Report		Further discussion to take place regarding how the Triple A report highlights concerns requiring escalation to the Boards	David Sharif	October 2026	Update to be provided at October 2026 meeting. Progressed through Governance workstream and Board Goverance Manual.		
1.3	11.06.26	Patient Story - Sharing of Stories with staff		Myles Howell to work with the patient experience team to improve the sharing of patient stories with staff through communications	Myles Howell	July 2026	Library of patient stories now shared on Bridget, stories also to be shared more widely through the Learning Improvement Safety Academy (LISA)		
3.1	11.06.26	Monthly Patient Safety Update (including Assurance Committee Update) - Sepsis Six		Mr Peter Sedman to circulate Sepsis Six documentation to Board members	Peter Sedman	July 2026	Information has been shared with Board members.		
3.1	11.06.26	Monthly Patient Safety Update (including Assurance Committee Update) - Corridor Care Session in respect of changes and the impact of this		Session to be held with the Boards on changes made in respect of corridor care and how this had positively impacted patients and staff	Jo Ledger	September 2026	Vicky Sharman is leading on this. Jo and Vicky to meet 4/9/26 to discuss - verbal update to be provided at meeting		
3.1.2	11.06.26	Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH - Ultrasound capacity		Jo Ledger to provide update on concerns raised in respect of Ultrasound within future reporting	Jo Ledger	September 2026	Task & Finish meeting held supported by Grant Thornton		
3.1.2	11.06.26	Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH - Birth Rate Plus		Birth rate plus target dates to be added to the report to highlight progress being made	Yvonne McGrath	September 2026	Recruitment to BR+ is overall on track with just a few specialist roles outstanding mainly due to JDS		
3.1.2	11.06.26	Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH - update on progress following investment		Summary of successes within Maternity Service and progress made following the recent investment to include any current concerns that needed to be highlighted within the current reporting	Yvonne McGrath	September 2026	Once our Newly Qualified Midwives (NQMs) start we will be fully recruited on all sites and we have just received confirmation of a successful bid for the funding to supporting Early Career Midwives (ECM).		
4.1	11.06.26	Patient – Performance (including Assurance Committee Update) - CDC Activity		Sam Peate to provide information in respect of the CDC activity currently being used and how this was impacting on organisational activity	Sam Peate	September 2026	Update to be provided at September 2026 meeting		
4.2.1	11.06.26	Freedom to Speak Up (FTSU) Guardian Report – Quarter Four & Annual Report		Jo Ledger to provide information to the FTSUGs on the EQIA	Jo Ledger	July 2026	Information shared with the FTSUGs with a meeting arranged to discuss.		
6.2	11.06.26	NHS Equality Delivery System (EDS) Submission		Session to be scheduled for the EDS mid-point submission during the year	Lucy Vere	October 2026	Update to be provided at the October 2026 meeting.		
1.6	09.07.26	Fit & Proper Persons Test: Annual Declaration		Keith Haynes to confirm required details within the report and ensure this was updated	Keith Haynes	September 2026	The TBC register of interests entry has now been completed and register updated.		
2.2	09.07.26	Group Chief Executive's Briefing - Communication options to be shared with Public		Myles Howell to review further options for communication in addition to those being shared on social media	Myles Howell	September 2026	Update to be provided at the September 2026 meeting.		
3.1	09.07.26	Monthly Patient Safety Update (including Assurance Committee Update) - Patient Experience Model Update		NLaG Governors to be considered as part of the engagement work in respect of the patient experience model	Hilda Gwilliams / Jo Ledger	October 2026	Update to be provided at the October 2026 meeting.		
5.1	09.07.26	Audit, Risk & Governance CiC Highlight / Escalation - Issues raised during meeting - further discussion		Board members to address how issues raised would be addressed, further discussion to be held in private	Murray Macdonald	September 2026	It was agreed to bring forward the November 2026 meeting to October 2026.		

Key:

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

ACTION TRACKER - CLOSED ACTIONS

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
Boards-in-Common ACTION									
1.4	09.04.26	Questions from the Public & Governors - Response to be provided to questions asked		Updated response to question following meeting between Sam Peate and John Palmer to be provided at May 2026 meeting	David Sharif / Sam Peate	May 2026	Sam Peate met with John Palmer on the 15 April 2026		
1.4	09.04.26	Questions from the Public & Governors - Sam Peate to meet with John Palmer to discuss points raised		Sam Peate to arrange to meet with John Palmer	Sam Peate	April 2026	Sam Peate met with John Palmer on the 15 April 2026		
2.2	09.04.26	Group Chief Executive's Briefing - Board Development Session		Board Development Session on 247 staffing provision to include holiday periods and weekend cover	Paul Bunyan	May 2026	Item added to Board Development Sessions - date to be agreed		
2.3	09.04.26	National Reports & Guidance - Lead added to report for initiatives		Lead to be added to report to highlight who was overseeing initiatives	Lyn Simpson	May 2026	Update to be provided at May 2026 meeting		Sharepoint system introduced for all correspondence to be added to including lead executive, reports to continue being shared with the Boards
3.1	09.04.26	Monthly Patient Safety Update -Further detail included within report		Infection control and corridor care to be included within future patient safety reporting	Hilda Gwilliams / Jo Ledger	May 2026	Update to be provided at May 2026 meeting		Report now included in Patient Safety Report, to then be included in IPR future report.
5.1	09.04.26	Briefing on Ward Accreditation Programme - Indicators to be added		Appendix of indicators to be included within future reports	Hilda Gwilliams / Jo Ledger	May 2026	Update to be provided at May 2026 meeting		Information included in future reports
5.1	09.04.26	Briefing on Ward Accreditation Programme - Session with colleagues at organisation to be scheduled on system		Sam Peate to schedule session on ward accreditation programme with colleagues using the system from previous organisation	Sam Peate	May 2026	Session scheduled with colleagues at South Tees Hospital.		
6.1	09.04.26	Quality Priorities - further detail within front sheets of reports on approval process		Report authors to include required detail within reports in respect of prior approval process, using the front sheet as a minimum	Executives (David Sharif)	May 2026	Reminders issued. Will also form part of the guidance to accompany the AAA reporting across the Group.		
5.1	12.02.26	Nursing Establishment Paper - how investment would be managed on staffing		Executive report to be shared at the Workforce, Education & Culture Committees-in-Common on how the staffing investment would be managed in respect of reducing bank and agency staffing in areas where investment had been made	Executives (Jo Ledger)	June 2026	Paper presented to Workforce, Education & Culture Committees-in-Common in May 2026.		
5.3	09.04.26	The Value Circle Report		Value Circle Priorities to be clarified	David Sharif	June 2026	Item discussed at the May 2026 meeting, Value Circle to undertake a further session with the Boards in June 2026		
4.1	14.05.26	Monthly Patient Survey Results - Review other organisations in same tiering		Paul Bunyan to review staff survey results from comparator organisations within the same tier and report findings to the Boards	Paul Bunyan	June 2026	Data for the NOF 5 trusts has been isolated and benchmarked against the national average as well as the trusts in the NEY region. Information shared with Board members.		
7.1	14.05.26	Items for Information - CiC to move to virtual meetings		Committees-in-Common Meetings to be held virtually, amended diary invites to be circulated	David Sharif	June 2026	Administrators for the CiC updated meeting invites to virtual meetings		
4.1	12.03.26	Public Purse - model hospital data shared at PEF CiC		Model Hospital data to be included within reports to the Performance, Estates & Finance Committees-in-Common for oversight	Sam Peate	July 2026	Item to be discussed at the PEF CiC in June 2026; item on agenda for sharing		
1.4	09.04.26	Questions from the Public & Governors - review of administrative function to be undertaken		Performance, Estates & Finance Committees-in-Common to review administrative functions to provide assurance to the Trust Boards-in-Common	NED Chair, TBC / Sam Peate	July 2026	Item to be discussed at the PEF CiC in June 2026; item on agenda for sharing		
5.1	09.04.26	Briefing on Ward Accreditation Programme - Schedule of Dates		Hilda Gwilliams to share accreditation programme of dates with NED and governor colleagues	Hilda Gwilliams	June 2026	Dates were provided to the NEDs in June 2026		
6.1	09.04.26	Quality Priorities - insulin safe practice		Jo Ledger to review current position for insulin safe practice and incorporate into the Quality Priorities	Jo Ledger	June 2026	Reported that there has been a 20% reduction of incidents causing harm from insulin prescribing and medication errors.		
3.1	14.05.26	Monthly Patient Safety Update - PALS Concerns Update		Jo Ledger to provide an update on the success of the amnesty process for PALS concerns	Jo Ledger	June 2026	294 PALS concerns had been reviewed and that 237 of those had been closed following review. The process was to be reviewed for PALS concerns including additional capacity to continue sustainable change and improvements.		
5.1	14.05.26	Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report - Review of policies and procedures		Hilda Gwilliams and David Sharif to review policies and procedures that were outstanding to ensure they did not relate to patient safety	Hilda Gwilliams & David Sharif	July 2026	Review of overdue policy documents completed by Sarah McDougall, email sent to relevant SRO (Executive or Chief of Staff) including key information. Oversight and assurance to be tracked in GERAC.		
7.1	14.05.26	Items for Information - WEC CiC frequency		Further discussion required as to whether the Workforce, Education & Cultures Committees-in-Common continues to be held on a bi-monthly basis	David Sharif	July 2026	It has been agreed the WEC CiC would move to bi-monthly sequencing		
3.1	11.06.26	Monthly Patient Safety Update (including Assurance Committee Update) - Corridor Care query		Jo Ledger to review whether the zero target for corridor care was in respect of all areas or if this excluded ED	Jo Ledger	July 2026	Corridor care reduction programme includes all areas where care is carried out in non -designated clinical space. This includes Emergency Departments. There are two reporting metrics one for ED and one is for G&A beds which excludes ED. The ED data runs midnight to midnight and is the number in total of individual patients who exceed a 45 minute corridor care time in this attendance episode. The G&A bed data return is a snapshot of occupied corridor care spaces at 8am in the morning . This should read as 0 from July as there are no chairs in use in our corridors in our wards or assessment units. HHP Corridor Care slides circulated to Board members 7 July 2026.		
3.1	11.06.26	Monthly Patient Safety Update (including Assurance Committee Update) - TES achievement to be included within report for each hospital		Jo Ledger to provide details in reference to each hospital and the TES achievement against each within the report in the future	Jo Ledger	July 2026	Updated presentation circulated to NEDS including the trajectory and actual achievement of reduction against trajectory for end of June		
4.1	11.06.26	Patient – Performance (including Assurance Committee Update) - IQIG Reporting		Agreement of IQIG report to be shared with Board members until IPR had been updated	Sam Peate / Emma Sayner	July 2026	IQIG papers shared with Board Members.		
4.1	11.06.26	Patient – Performance (including Assurance Committee Update) - Harm Reviews being undertaken		Sam Peate to review whether harm reviews were being undertaken in relation to patients that were delayed for diagnostic testing	Sam Peate	July 2026	Any patients who have delay to treatment in line with the clinical harm process will be reviewed on completion of their Cancer or RTT pathway and any issues relating to delayed diagnostics would be picked up in these reviews. There is not a standalone process for diagnostics as all picked up via this route		
4.2	11.06.26	People (including Assurance Committee Update - IQIG Information - workforce		Paul Bunyan to circulate slides in respect of workforce from the IQIG meeting	Paul Bunyan	July 2026	Slides shared with Board members on 30 June 2026 and due to be presented to NHSE regional team on 3 July 2026.		
4.2	11.06.26	People (including Assurance Committee Update) - Lead CiC for CIP		Further consideration required in respect of which Committee-in-Common would be the lead for triagulation of performance, workforce and finance in respect of CIP	Emma Sayner	July 2026	Recommend PEF undertakes this role on triangulation.		
1.3	11.06.26	Patient Story - Library of patient stories		Hilda Gwilliams to review a process for a library of patient stories for reference	Hilda Gwilliams	July 2026	Electronic library developed in Bridget.		

Key:

Green	Completed

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)190

Name of the Meeting	**Trust Boards-in-Common (Public)**
Date of the Meeting	10 September 2026
Director Lead	Hilda Gwilliams, Group Chief Patient Safety Officer Peter Sedman, Deputy Group Chief Medical Officer
Contact Officer/Author	Richard Dickinson, Associate Director of Quality Governance Michela Littlewood, Associate Director of Quality Governance
Title of the Report	**Monthly Patient Safety Update (including Assurance Committee update)**
Executive Summary	The purpose of the report is to demonstrate the oversight of the patient safety processes that enable learning from harm, including patient experience. The safety domain of the National Outcomes Framework (NOF) forecast is reported for three infection elements. Identification of themes are included, with analysis and an overview in respect of the following areas: **Alert** • Infection control alert organisms monthly update with National Outcomes Framework KPI's, trajectories for in year targets are at risk for both Trusts. NOF shows quartile 4 c.difficile performance for both Trusts and e.coli blood stream infections at Northern Lincolnshire and Goole (NLAG). • There was a Never Event in June 2026 at Hull Royal Infirmary (HRI) which has progressed investigation to a draft report. • Patient Experience highest themes for the Patient Advice and Liaison Service (PALS) is - Delays (inc. Waiting Times & Cancellations), Complaints it is - Treatment provided. **Advise** • Patient safety incidents from July 2026. • Inquests update and no new Regulation 28 Prevention of future deaths letters. • Patient Experience - Quality improvement plans with care groups are in place. The Value Circle have completed a PALS review and there are plans for Complaints review. **Assure** • Current workstreams for Patient Safety Incident Response Framework (PSIRF) learning responses and Patient Safety Incident Investigation (PSII) tracking, with continued reduction of overdue cases. • There have been no further Never Events in July 2026. • Learning from experience examples demonstrate outcomes from investigations. • Group Chief Patient Safety Governance Officer is supporting colleagues and teams to continually put patient safety first,

	learn from experience, and keep improving, with plans contributing to the Integrated Improvement Plan. • Formal complaint average response times have improved from 117 in October 2025, to 49 working days in July 2026. **Recommendation** The Board is asked to take assurance from the processes outlined and the content of the report.
Background Information and/or Supporting Document(s) (if applicable)	None
Prior Approval Process	This report has been provided to the Quality and Safety Committees-in-Common.
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Monthly Patient Safety Report, July 2026

This report contains data from the reporting period of July 2026, prepared on 26/8/2026.

Section 1: Clinical Incidents

Definition

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

Incident Reporting

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

- Reporting rates

There is common cause reporting in NLAG. HUTH has had an increased rate of reporting which was previously reported and has now returned to with the upper and lower control limits.

- Distribution of harm levels

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

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

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

Figure 1 – Patient Safety Incident Overview Dashboards

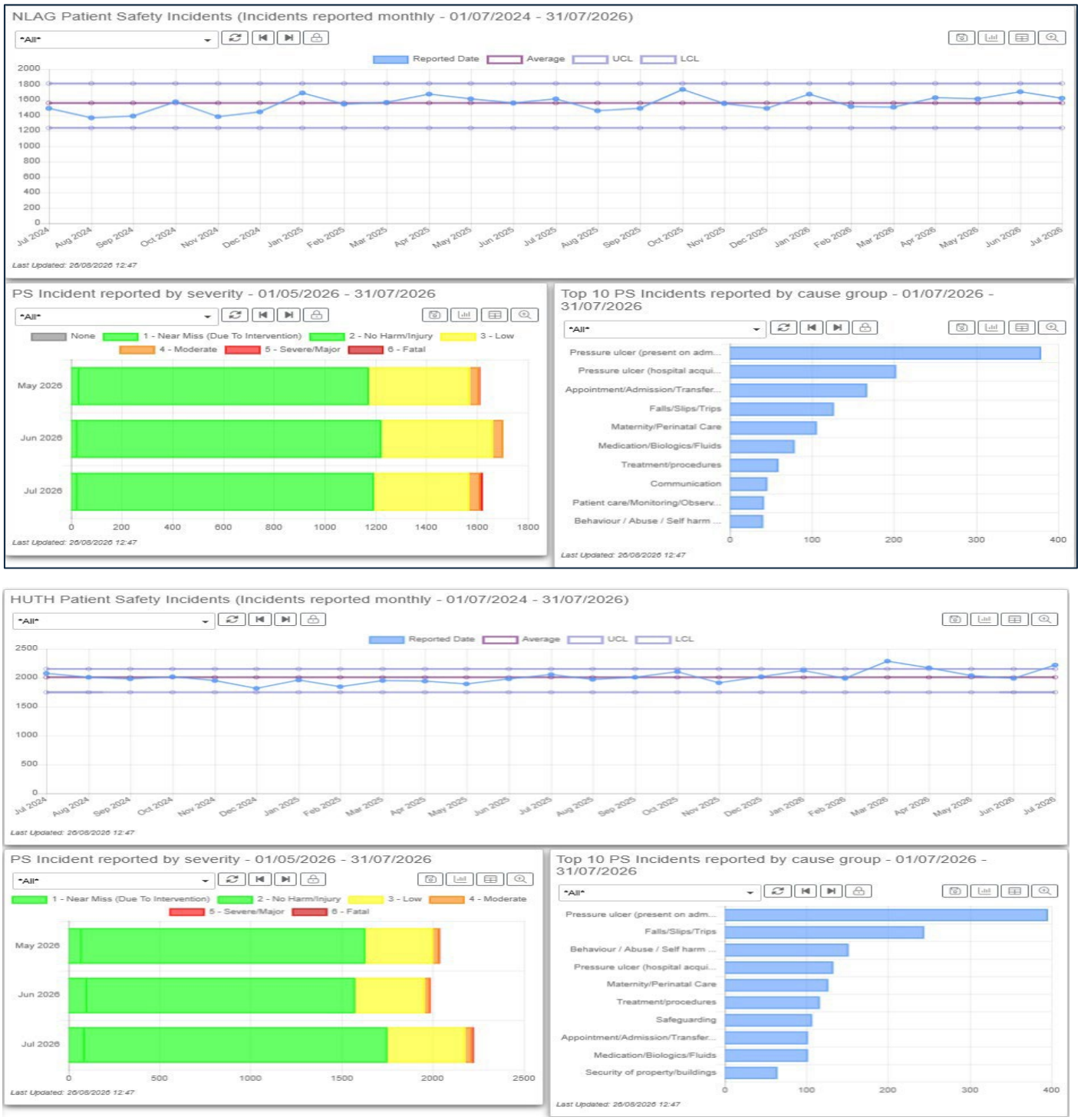


Figure 2: Patient Safety incidents with moderate or greater severity grading by Group and Trust.

Reported in July 2026	NLAG	HUTH	HHP
Fatal	1	2	3
Severe/Major	6	6	12
Moderate	45	38	83
Total	**52**	**46**	**98**

All 98 cases are under review by care group Nurse Directors and through relevant reporting routes of the Falls Group, Pressure Ulcer review groups and the Weekly Learning Response Panel.

Section 2: Infection Prevention Control (IPC)

Context

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

Quality and Safety Performance

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

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

Figure 3: HUTH current HCAI figures:

HUTH	2025/26 Target	M4	YTD rate	Proportion of infections against threshold	NOF score & band
C. Difficile	61	5	39	1.97	3.92
E. Coli	203	16	64	0.99	1.00
P. Aeruginosa	30	3	9	NA	NA
Klebsiella spp.	72	7	26	NA	NA
MRSA bacteraemia	0	0	0	2	2.24
MSSA bacteraemia	No target	7	26	NA	NA

Figure 4: NLAGCurrent HCAI figures:

NLAG	2025/26 Target	M4	YTD rate	Proportion of infections against threshold	NOF score & band
C. Difficile	18	6	15	1.89	3.90
E. Coli	57	8	33	1.72	3.91
P. Aeruginosa	5	2	6	NA	NA
Klebsiella spp.	34	2	9	NA	NA
MRSA bacteraemia	0	0	1	5	3.13
MSSA bacteraemia	No target	2	9	NA	NA

The position at month 4 shows May data as being over trajectory for 4 of the 5 targets at HUTH and 4 at NLAG. The NOF metrics remain quartile 4 for C.difficile across the two trusts, and for E.Coli at NLAG.

IPC improvement plans are part of the Quality Priorities workstreams, that also feed into the

integrated improvement plan, which is now established and good progress has been made in supporting delivery including:

- Governance and reporting arrangements established across priority workstreams.
- CAUTI programme integrated into the E. coli and Gram-negative bacteraemia workstream.
- Task and Finish Groups established for IPC education and training priorities.
- Device-Related Infection workstream mobilisation and implementation planning underway.
- Initial KPI measures, reporting requirements and data sources identified.
- External assessment visit undertaken by NHSE/ICB team 13 August 2026.

Further work is required to strengthen assurance and support delivery including:

- Workforce capacity and stakeholder engagement continue to require monitoring.
- Ongoing monitoring of IV-to-Oral Switch and Device-Related Infection workstreams is required.
- The Group-wide Vascular Access Service business case is scheduled for panel consideration on 2/9/26. outcomes and any impact on delivery will continue to be monitored.
- Work to incorporate the CQC findings and required actions into the IIP, including a gap analysis, has commenced

Section 3: Patient Safety Incident Response Framework (PSIRF)

Definition

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

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

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

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

PSII Position NLAG

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

- 2 cases are externally investigated by the Maternity and Newborn Safety Investigations (MNSI) Team hosted by the Care Quality Commission (CQC).

- 1 case is on hold due to a police force investigation, allergic reaction to penicillin from 2023.
- Of the remaining 11 cases:
  - 3 PSII reports are the final report stage with family engagement
  - 4 reports are being quality checked before presenting to the PSIRF Oversight Group to approve.
  - This leaves 4 cases being investigated and compiling reports, three of these being over 6 months.
- There are no cases declared in June or July 2026.

Figure 5: PSII open casework

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

*Footnote: * Police investigation*

Proportional Learning Response Position NLAG

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

The table below summarises the position at the end of July 2026, in relation to the total number of open Proportional Learning Responses is 26, with 8 cases in the quality checking process for completion. 8 reports are being written, and 10 cases are in progress.

Figure 6: Proportional Learning Responses

NLAG Proportional Learning Response	2025				2026							Grand Total
	Mar	Aug	Sep	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
Assurance			3		1	1		2		1		8
Report		1		1			2	1	1	2		8
Review	1				1		1	1		3	4	10
Grand Total	1	1	3	1	2	1	3	4	1	6	4	26

PSII Position HUTH

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

- For the reporting period up to the end of May, there are 31 open PSII cases with 4 of these being externally investigated by MNSI.
- 4 cases are going through draft report engagement with patients and their families.
- 9 PSII reports are at various stages of sign off through the Report QA process.
- 4 PSIIs have been completed over the past month, with one case declared in July.
- 14 cases remain under active investigation.

Figure 7: HUTH PSII open casework

HUTH PSII	2024	2025							2026					Grand Total
	Nov	Mar	Apr	Jun	Jul	Sep	Nov	Dec	Jan	Feb	Apr	Jun	Jul	
Grand Total	1	2	3	3	1	3	2	1	1	3	4	5	1	31

Proportional Learning Response Position

The table below summarises the current position as of July 2026, in relation to the total number of open Proportional Learning Responses is 44, with 6 cases completed in the previous month, 11 cases in the quality checking and sign off process.

Figure 8 - HUTH Proportional Learning Responses

HUTH Proportional Learning Responses	2024	2025								2026						Grand Total
	Dec	Feb	May	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	May	Jun	Jul	
In progress		1	2	4	1	2	0	1	1	3	2	3	1	5	7	33
Sign off process	1	0	1	0	0	1	1	1	1	1	1	1	2	0	0	11
Grand Total	1	1	3	4	1	3	1	2	2	4	3	4	3	5	7	44

Section 4: Never Events

Definition

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

Never Event Position

There has been one never event reported in June 2026 at HRI. There were no cases reported in August 2026. The investigation report is being taken through quality checking to progress learning relevant to the case.

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

Figure 9 – Safer Surgery Audit results in February to July 2026

Audit overview

Audit	Frequency	Compliance over last 6 periods					
(HHP) Invasive Procedure Safety Checklist DOCUMENTATION Audit (NatSSIPs2)	M	87.6%	87.5%	92.4%	88.9%	89.7%	92.8%
(HHP) Invasive Procedure Safety Checklist OBSERVATION Audit (NatSSIPs2)	M	100.0%	99.7%	99.8%	99.7%	99.4%	99.5%
(HHP) Safer Surgery List Brief Audit (NatSSIPs2)	M	94.6%	96.2%	95.1%	95.6%	95.3%	94.6%
(HHP) Safer Surgery List Debrief Audit (NatSSIPs2)	M	97.3%	97.8%	97.3%	96.9%	98.4%	95.9%
(HHP) STOP before you block audit (NatSSIPs2)	M	100.0%	100.0%	99.4%	99.0%	100.0%	98.9%

Further detailed reports, with site breakdown have been presented at the Clinical Effectiveness Group and shared with TACC care group for remedy.

Improvement actions include:

- A series of safety summits commenced on 8 May 2026 supporting improvements in patient safety and culture for TACC care group, covering Digestive Diseases and Families care groups so far.
- A Surgical Safety series of engagement sessions are planned throughout 2026, including professional standards setting.
- Implementation of the NatSSIPS2 theatre checklists for south bank is being supported with training and group wide audit of processes, checking documentation and direct observation.
- The learning from 2 completed investigations is also included in section 7 of this report.

Section 5: Coroner's Inquests

Definition

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

Coroner Case Position

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

The key themes from inquests include:

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

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

- Regulation 28 Letters

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

There have been no Regulation 28 Letters issued in July 2026.

Section 6: Patient Experience, Patient Advice Liaison Service (PALS) and Complaints

Context

The learning from harm Patient Experience, PALS and Complaint Section provides an update across the Group for the following Date range 1/7/2026 to 31/7/2026. Quality Improvement work led by Care Groups is now in place to improve the themes and trends identified from feedback. Any harms that are found and reviewed via PALS and complaints route are flagged to the Patient Safety Team and are jointly managed as appropriate for each case.

The Patient Experience team collect feedback via compliments, Friends and Family Tests, and other annual reports such as Picker and local surveys as required for agreed contracts. This information is provided in Quarterly Patient Experience reports.

PALS

There has been a total of 393 PALS cases received for the Group during July 2026 with 613 PALS resolved. Figure 10 below shows the breakdown. The percentage of PALS resolved within 5 days has improved across both sites.

Figure 10 - PALS Received and Resolved

PALS	July Received	June Received	July Resolved 5 Working days	June
HUTH	130 ^	159	36% ^	33%
NLAG	263 v	248	60% ^	54%
Total	393 ^	407		

Top themes include communication and appointment delays (including outpatient appointments, wait times & cancellations). Work is underway with the administration team to look at processes that may support earlier resolution.

Figure11 - HUTH PALS cases logged

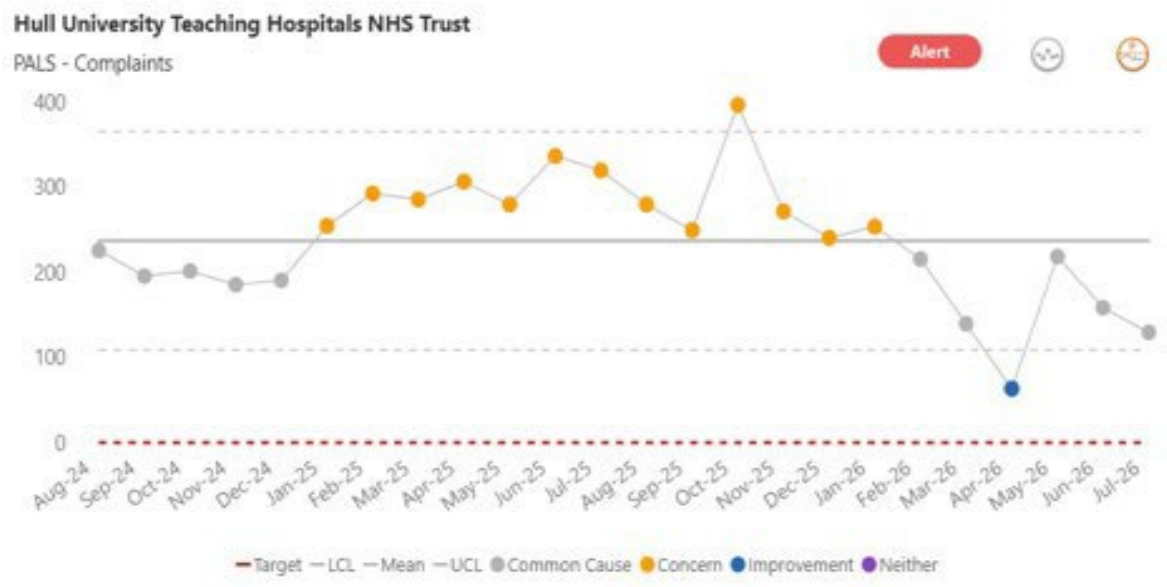
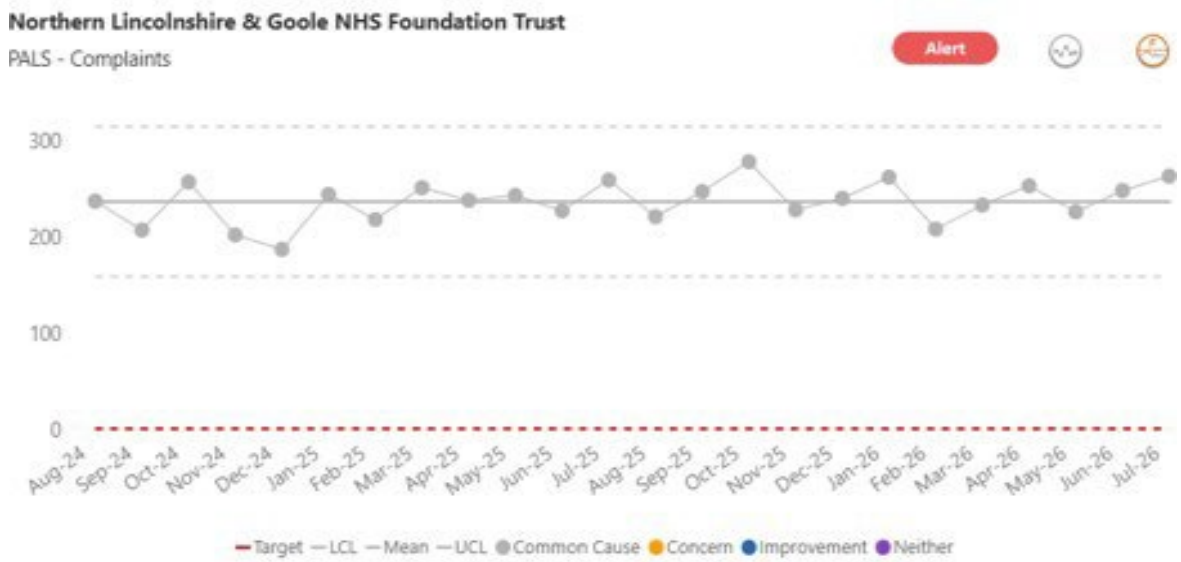


Figure12 – NLAG PALS cases logged



NLAG shows consistency in logging and reporting.

Figure13 - HUTH/ NLAG Combined PALS

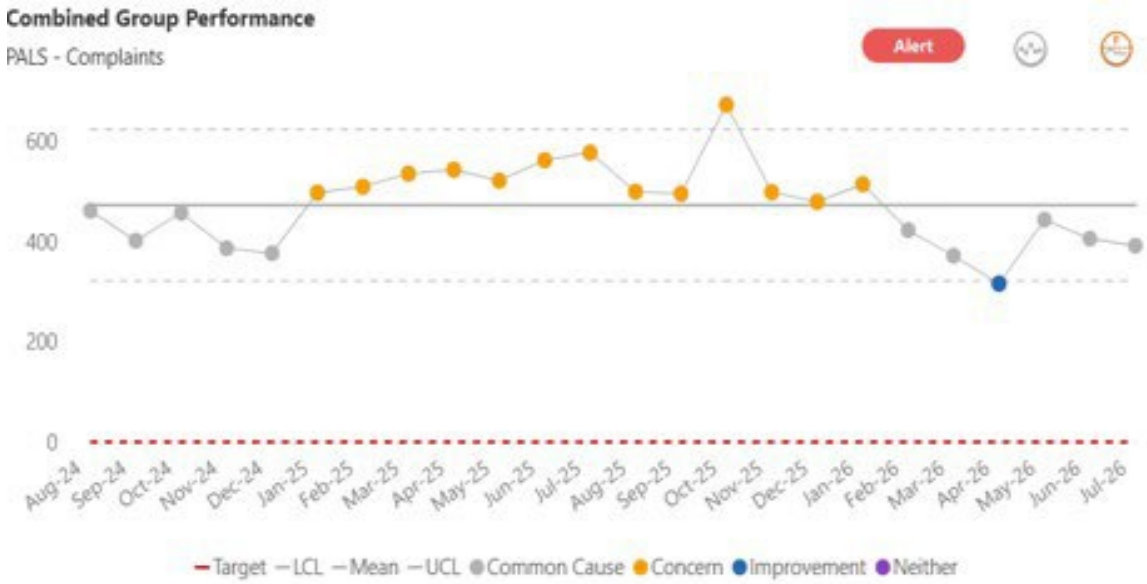


Figure 14 - Top 5 HHP PALS Themes and Learning

PALS Top 5 Themes	June	July	Percentage Difference	Trend
Communication	34%	38%	+4%	^
Delays (Inc OPA, Wait Times & Cancellations)	22%	27%	+5%	^
Treatment	19%	24%	+5%	^
Staff Attitude	9%	7%	-2%	v
Discharge	4%	4%	N/A	-

The issues of communication are associated with the delays in appointments which will be addressed by the Learning Improvement Academy work being undertaken with the organisational development team.

Complaints

Significant improvements have been demonstrated in the average response time for complaints with an average of 49 working days in July 2026 compared to 117 working days in October 2025.

Figure 15 - Complaints Received and Resolved

Complaints	July Received	June Received	July Resolved 60 working days *	June
HUTH	28 v	29	64% ^	58%
NLAG	45 ^	26	62% ^	72%
Total	73 ^	55		

*Percentage Target is 85% to resolve complaints within 60 days

Figure 16 - HUTH Complaints received

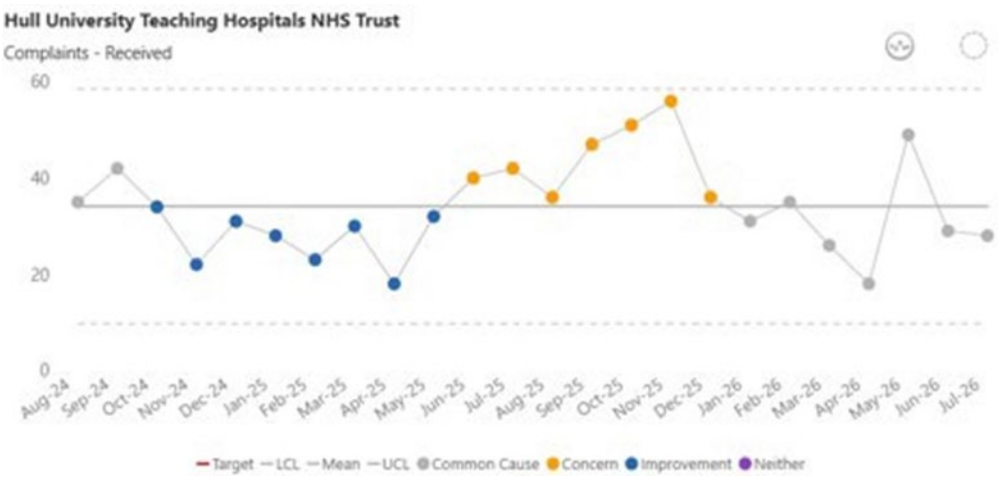


Figure 17 – NLAG Complaints received

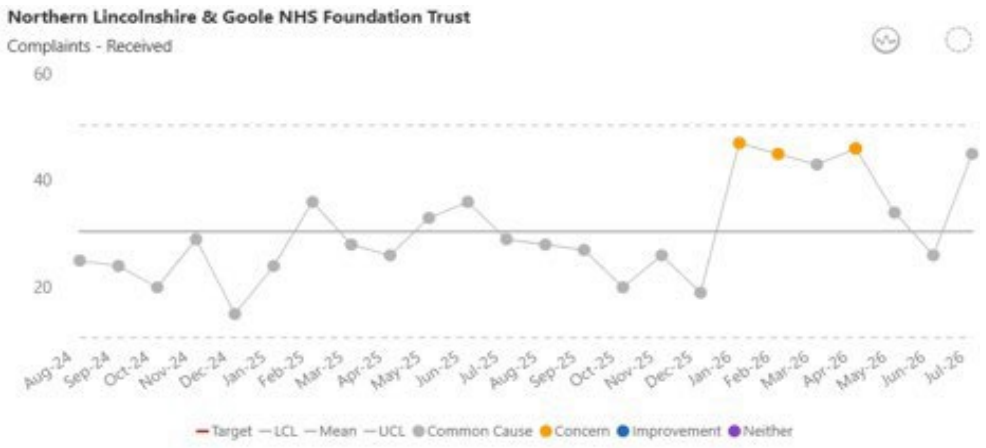


Figure 18 - HUTH/ NLAG Combined PALS

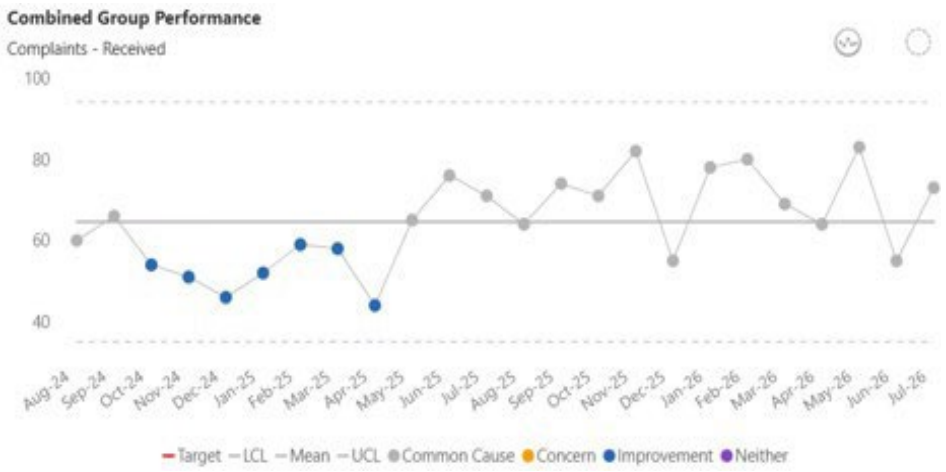


Figure 19 - Top 5 HHP Complaints Themes and Learning

Formal Complaints	June	July	Percentage Difference	Trend
Treatment	56%	61%	+5%	^
Communication (inc. record keeping)	17%	18%	+1%	^
Delays (inc. Waiting Times & Cancellations)	14%	11%	-3%	v
Attitude	7%	6%	-1%	v
Discharge	6%	4%	-2%	v

The main complaint theme is treatment (including medical and general clinical care).

PALS and Complaints Improvement Work

The improvement work is summarised below.

- ValueCircle Review undertaken identifying key lines of improvement work including benchmarking against PHSO standards.
- Ulysses system improvement work continues with the patient facing website. This will allow the public to log concerns from the HPP website, with the aim of real time feedback and improved response times to address concerns.
- Improved accessibility & visibility of PALS & Complaints service. The PALS perfect week supported a Plan, Do, Study, Act methodology to test out the care group closure of PALS by Specialist Surgery staff. This has been successful and will be rolled out across all care groups during September and October.
- Ulysses dashboard for care groups developed and tested with Specialist Surgery and Digestive Diseases with planned roll out across the Partnership in October.
- QI programme established and ongoing improvement work taking place across 12 Care Groups, who have developed their own tailored QI initiatives, ensuring Care Group accountability for their improvement.

MP concerns

A summary is provided below.

- 10 MP concerns were received in July 2026
- 15 MP concerns were open as of 31 July 2026
- 8 MP letters were closed during July 2026

An MP HPP Standard Operating Procedure (SOP) has been developed with agreed KPIs to ensure timely and effective responses.

The MP themes are consistent with the wider PALS and Complaints themes of waiting times, cancellations for surgery, discharge processes. Quality improvement work is underway to improve patient access and experience.

Parliamentary Health Service Ombudsman (PHSO)

The table below summarises PHSO activity across the Partnership.

Figure 20 - PHSO data for July 2026

PHSO	Investigating	Awaiting Provisional Report	Awaiting final report	Total
HUTH	2 v	2 <>	1 <>	5
NLAG	3 v	2 <>	1 ^	6

Section 7: Learning from experience safety actions

Key learning and safety actions from 4 completed PSIIs (2x Never Events – retained surgical swabs, 2x delayed recognition and management of deterioration and sepsis) are summarised below.

Key learning: Retained surgical swabs

- Internal environment: Learning identified distractions in a high-risk environment affected counting processes.
- Organisation: Gaps in knowledge were identified and existing policies required strengthening and standardising.

Key safety actions

- Simulation training to reinforce safe surgical counting and achieve >80% completion of Safer Surgery e-learning by theatre staff.
- Standardisation of documentation including checklists, Theatre Standards Policy, NatSSIPS.
- Monthly audit programmes.

Key learning: Deterioration and sepsis

- Tools and technology (admission and discharge processes): Learning identified missed opportunities in relation to early intervention for the management and treatment of deterioration and sepsis including antibiotic therapy.

Key safety actions

- Development and introduction of mandatory review pathways and checklists.
- Improved education and training in antimicrobial guidelines, deterioration and sepsis recognition and management including Time Zero recognition, observation and escalation processes.

Section 8: Summary

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

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

ADVISE, ALERT and ASSURE REPORT	
Meeting	Quality and Safety Committees-in-Common
Meeting date	23 July 2026
Chair	David Sulch, Non-Executive Director
Quoracy requirements met	Yes

1. **Key items discussed**

TO ALERT (Areas of non-compliance or matters that need addressing urgently)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Quality				
Operational Pressures	The relocation of the majors department at HRI had led to improved four-hour compliance and a reduction in patients waiting over 12 and 24 hours, with incident management arrangements in place to support ongoing escalation. Ambulance handovers remained a concern, particularly on the South Bank, but average handover times have improved to around 32-33	For information	Continued focus and an emphasis on maintaining recent improvements in ED performance and patient safety.	September 2026

	minutes with ongoing collaboration with EMAS and NHS England. Management of Listeria cases , including negative test results for recent cases.		Listeria – consideration of a look back exercise for deceased patients and ongoing consultation with UKHSA for national guidance.	
Integrated Performance Report	Improvements in mortality data and FFT data collection. Ongoing challenges with Never Events, safety alerts for medical beds, infection control and VTE compliance.	For information	The refresh of the IPR would be circulated to the Board for comments with an updated version presented to the CiCs in September 2026.	September 2026
Patient Experience	Stabilisation of the Patient Experience team was the key focus and included a recovery programme, rebranding, staff education and a review of the FFT contract.	For information	Work ongoing with The Value Circle regarding the recovery programme	September 2026
IPC	IPC performance updates included CDI rates, MRSA and ESBL outbreaks and education and audit improvements.	The CiC agreed that despite significant efforts and improvements, limited assurance remained due to the lack of positive outcomes.	• CDIF - Quality Improvement Plan in place. • MRSA – management process in place. • Outbreak management in place and in control. • Ongoing training	September 2026

			competency package. • ICNET digital had been introduced.	
CPE Outbreak – internal review	The report detailed the management of the CPE outbreak at NLAG and included, the number of affected patients and governance arrangements	For information	Actions in place include enhanced cleaning, surveillance and infrastructure improvements. The CiC discussed the ongoing risks regarding the ageing estate, particularly in specific wards, and the need to ensure these risks are fully recognised and addressed at board level.	Further updates to be received
Fuller 2 enquiry	Compliance gaps remain particularly in paediatric body stores. Security and access-control arrangements require strengthening. Governance arrangements are not yet mature. Concerns were raised regarding the separately managed Goole store and whether addition work was required there.	Limited assurance was received pending the establishment of the group, development of the action plan and confirmation of deliverable timescales.	Safeguarding policies updated guidance regarding deceased patients. DBS common standard is to be agreed. Funding requirements and deliverability remain unclear.	Further updates to be received

Never Events	The CiC agreed that Never Events should not be regarded as acceptable or routine.	For information	A focused piece of work on Freedom to Speak Up, particularly engaging with International staff.	September 2026
ADVISE (Areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Quality				
EQIA	Current position: • Established governance process. • Ongoing risk monitoring. • Reporting to committees and external regulators. • Risk-based escalation framework.	Committee agreed that EQIA maturity is improving but further development is needed	A four week task and finish group has been established. The EQIA policy review is underway. This is expected by August and will be presented to the CiC. A new EQIA template is being considered.	September 2026
Midwifery Services	A comprehensive update was received. Risks included scan capacity, induction of labour delays, preterm birth rates and neonatal nurse vacancies.	The CiC agreed reasonable assurance	A review of the outstanding Ockenden actions was ongoing to ensure they were either moved to business as usual, superseded or closed. Board approval was required	September 2026

	MNVP in its current for was being disestablished from 31 July 2026 and alternative routes were being explored. All CQC actions had been closed.		for progressing the implementation plan with the ODN and SPECOM to return the neonatal unit at Scunthorpe to full LNU status.	
Enhanced Therapeutic Observation Care	Security bed watches had been removed. Therapeutic interventions had been embedded into ward establishments.	The CiC noted the significant progress achieved and the positive cultural change delivered by the clinical teams.	Security bed watches had been replaced by 1:1 nursing. ETOC team to be established and built into the establishment.	
ASSURE (Areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Quality				
Board Assurance Framework review	The BAF to be revamped and aligned with the Integrated Improvement Plan. Risks and ratings will be clarified and a new digital risk added.	For information	Interim Board Secretary to lead the Improvement Group to refresh the BAF	September 2026
Research and Innovation Q1	The CiC received the update on research, innovation and development, reporting on recruitment targets, research culture, staff recognition and	Significant assurance was given	Highlights included: Prof Bandari had been awarded the William Cullen Award for renal research.	

	the expansion of research opportunities.		Mr Bharat Ravindran had won a HSJ digital award for an AI project in vascular. Respiratory Team had won a Royal College Excellent in Patient Care award.	
Nursing, Midwifery and AHP Strategy	The committee received assurance regarding delivery of the strategy and agreed to report this within the assurance section of its Board report. No significant risks, concerns or escalation issues were identified during committee discussion.	Significant assurance was given	The CiC was alerted to possible research opportunities that could not be fulfilled due to the vacancy freeze and no possibility of backfill.	
Annual reports	The following annual reports were approved by the CiC: Medicines Optimisation Organ Donation Legal Services PSIRF	Approved Approved Approved Approved	Legal Services – The importance of embedding learning from claims and inquests into clinical practice was emphasised, with suggestions for internal audit spot checks.	

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)192

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	10th of September 2026
Director Lead	David Sulch, Non-Executive Director and Maternity & Neonatal Safety Champion
Contact Officer / Author	David Sulch, Non-Executive Director and Maternity & Neonatal Safety Champion
Title of Report	Maternity & Neonatal Safety Champion's Report
Executive Summary	The Safety Champion notes the MOSS alerts at HUTH in June and July and is pleased to see the adaptation of the dashboards across the Group to reflect the learning identified during the MOSS review. The Safety Champion is concerned to note that this is currently no MNVP provision due to the LMNS ceasing on the 31st of July. The Safety Champion recognises the pressure maternity and neonatal have experienced over the summer months due to staffing and acuity. The Safety Champion acknowledges the ongoing steps to address concerns raised by staff, particularly in triage areas. The Safety Champion is delighted that the Registered Midwife Degree Apprenticeship has been approved and Midwifery Apprentices will commence in September. Patient Engagement Lead Midwife: The Safety Champion is assured that the appointment of this role will support hearing the Service User Voice. Risks & concerns to escalate: Ultrasound capacity across all sites continues to be a matter of concern for the Safety Champion due to the impact on safety and Savings Babies Lives Compliance.
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:

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

Executive summary:

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

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

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

Activities undertaken this month:

The Maternity & Neonatal Safety Champion's activities undertaken between June and August 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)
18th June 2026 Maternity & Neonatal Assurance Group
18th August 2026 Maternity & Neonatal Assurance Group

Northern Lincolnshire and Goole (NLaG)
18th June 2026 Maternity & Neonatal Assurance Group
18th August 2026 Maternity & Neonatal Assurance Group

Learning Lessons:	Service User Voice Feedback:	Staff Experience & Feedback:
The Safety Champion notes the MOSS alerts at HUTH in June and July and is pleased to see the adaptation of the dashboards across the Group to reflect the learning identified during the MOSS review. .	The Safety Champion is concerned to note that this is currently no MNVP provision due to the LMNS ceasing on the 31st of July.	The Safety Champion recognises the pressure maternity and neonatal have experienced over the summer months due to staffing and acuity. The Safety Champion acknowledges the ongoing steps to address concerns raised by staff, particularly in triage areas.

Good practice, improvements & innovation to share:

- **Midwifery Apprenticeship:** The Safety Champion is delighted that the Registered Midwife Degree Apprenticeship has been approved and Midwifery Apprentices will commence with in September.
- **Patient Engagement Lead Midwife:** The Safety Champion is assured that the appointment of this role will support hearing the Service User Voice.

Risks & concerns to escalate:

- Ultrasound capacity across all sites continues to be a matter of concern for the Safety Champion due to the impact on safety and Savings Babies Lives Compliance.

- The Safety Champion is concerned about the Caesarean Section capacity at HUTH.

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:

- 17th September 2026 Maternity & Neonatal Assurance Group

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)193

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	10 September 2026
Director Lead	Jo Ledger, Interim Group Chief Nurse
Contact Officer / Author	Yvonne McGrath. Group Director of Midwifery
Title of Report	Maternity and Neonatal Assurance Report
Executive Summary	Information on the Maternity and Neonatal 10 Point Plan assurance process and the National Triage Specification benchmarking document have been received. The first assurance submission is required by the 25th of September. Path to board approval prior will need to be agreed. **Alert** 1. Risk of not meeting element 3 of Saving Babies' Lives care bundle version 3.2 with regards to reduced scan capacity for those attending with RRFM (Pan Group). 2. Caesarean Section capacity at HUTH resulting in additional caesarean activity via Category 3 Caesarea Sections- over a 6-week period (29th June 2026- to 5th August 2026) an additional 26 caesareans beyond the planned elective lists, the majority of these were completed at HUTH, with three undertaken on the South Bank. The lack of caesarean capacity constitutes a patient safety risk and poor patient experience. 3. Gap in MNVP function since 31/07/2026- work ongoing to achieve both short and long-term solutions, however, this gap presents a risk for compliance with MIS. **Advise** 1. Induction of labour delays continue particularly at HUTH, this is multi-factorial and a number of actions are in place to address including an additional midwife on the long day on Maple Ward, an extra midwife on Labour Ward, allocation of a discharge midwife on Rowan all to support flow. The guidelines are also currently under review. 2. Continued monitoring of BSOTS compliance in Triage (HUTH) 3. Further MOSS Alert received at HUTH 10th July 2026 4. Rapid review of triage acuity at NLAG and options paper to adjust the model of how telephone calls and shift patterns has been drafted 5. DPOW- theatre maintenance needs to be urgently undertaken at DPOW- options paper written 6. Nitrous oxide Group in place to address the potential issues with Entonox use in maternity services- options paper written **Assure** 1. Return completed for the HUTH MOSS alert received on the 10th of July 2026 2. Agreement to proceed to recruit to the Registered Midwife Degree Programme.
Background Information and/or Supporting Document(s) (if applicable)	N/A

Prior Approval Process	Maternal and Neonatal Assurance Group
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Maternity & Neonatal Safety Assurance Report

Yvonne McGrath

August 2026

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Executive Summary

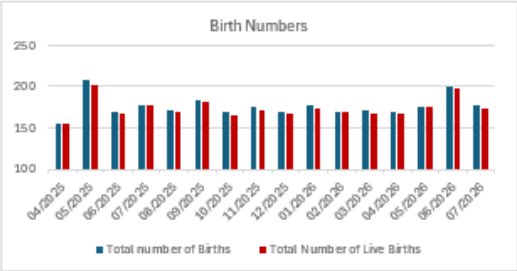
Performance, challenges, risks and interventions	
Information	1. Information on the Maternity and Neonatal 10 Point Plan assurance process and the National Triage Specification benchmarking document have been received. The first assurance submission is required by the 25th of September. Path to board approval prior will need to be agreed
Alert	1. Risk of not meeting element 3 of Saving Babies' Lives care bundle version 3.2 with regards to reduced scan capacity for those attending with RRFM (Pan Group). 2. Caesarean Section capacity at HUTH resulting in additional caesarean activity via Category 3 Caesarea Sections- over a 6-week period (29th June 2026- to 5th August 2026) an additional 26 caesareans beyond the planned elective lists, the majority of these were completed at HUTH, with three undertaken on the South Bank. The lack of caesarean capacity constitutes a patient safety risk and poor patient experience. 3. Gap in MNVP function since 31/07/2026- work ongoing to achieve both short and long-term solutions, however, this gaps presents a risk for compliance with MIS.
Advise	1. Induction of labour delays continue particularly at HUTH, this is multi-factorial and a number of actions are in place to address including an additional midwife on the long day on Maple Ward, an extra midwife on Labour Ward, allocation of a discharge midwife on Rowan all to support flow. The guidelines are also currently under review. 2. Continued monitoring of BSOTS compliance in Triage (HUTH) 3. Further MOSS Alert received at HUTH 10th July 2026 4. Rapid review of triage acuity at NLAG and options paper to adjust the model of how telephone calls and shift patterns has been drafted 5. DPOW- theatre maintenance needs to be urgently undertaken at DPOW- options paper written 6. Nitrous oxide Group in place to address the potential issues with Entonox use in maternity services- options paper written
Assure	1. Return completed for the HUTH MOSS alert received on the 10th of July 2026. 2. Agreement to proceed to recruit to the Registered Midwife Degree Apprenticeship and interviews take place on the 18th of August.

1. MATERNITY DASHBOARD OVERVIEW

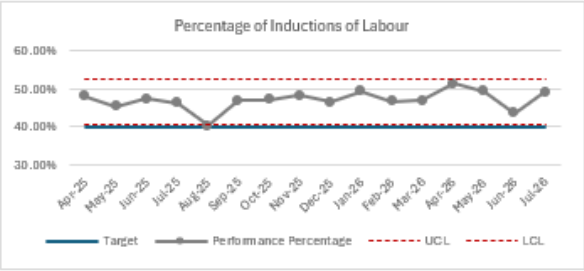
Maternity Overview - Diana Princess of Wales (DPOW)

Latest Month: July 2026

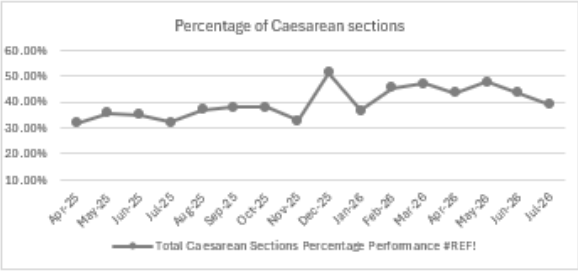
Number of Births / Live Births



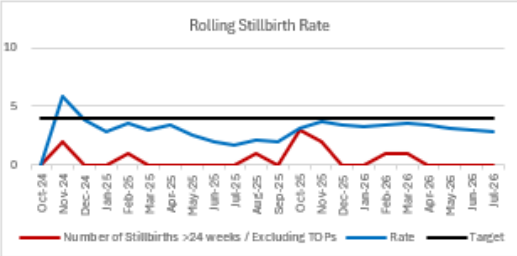
Induction of Labour Rate



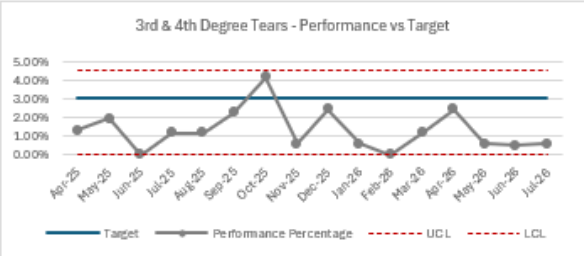
Caesarean Section Rate



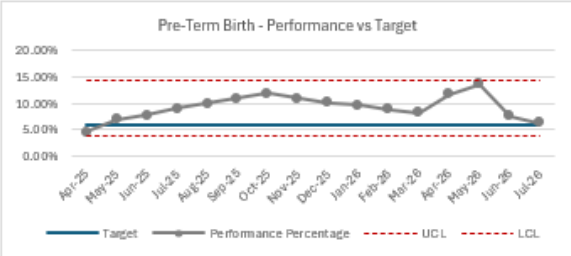
Rolling Stillbirth Rate (per 1000 births)



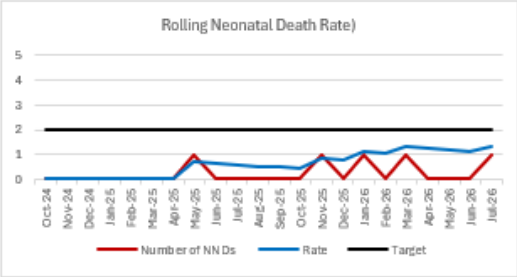
Third and Fourth Degree Tear Rate



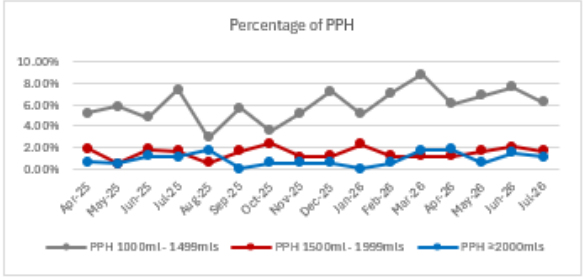
Preterm Birth Rate



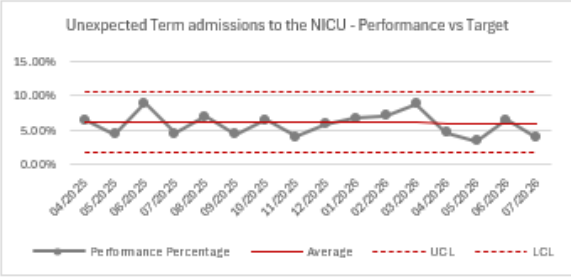
Rolling Neonatal Death Rate (per 1000 births)



Post-partum Haemorrhage Rate



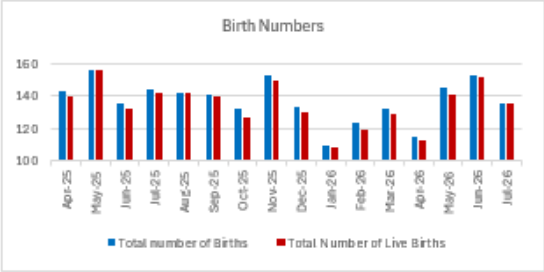
Unexpected Admission to NICU



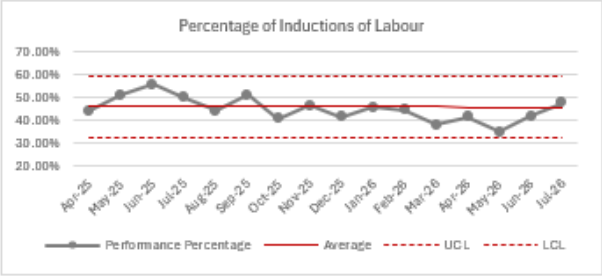
Maternity Overview - Scunthorpe General Hospital (SGH) & Goole District Hospital

Latest Month: July 2026

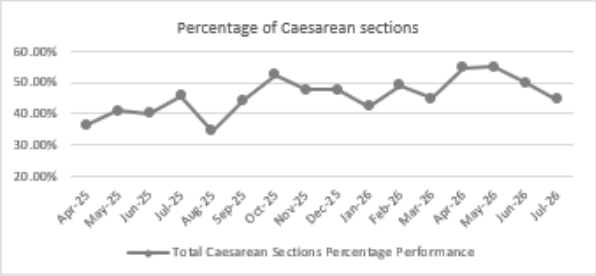
Number of Births / Live Births



Induction of Labour Rate



Caesarean Section Rate



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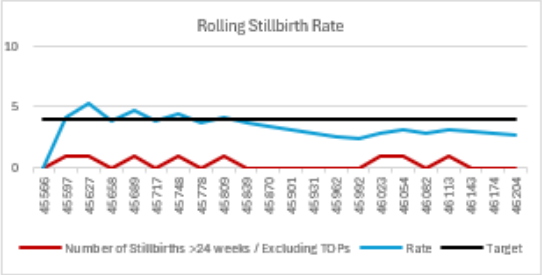
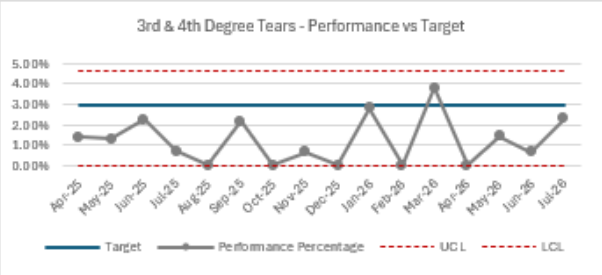


Third and Fourth Degree Tear Rate



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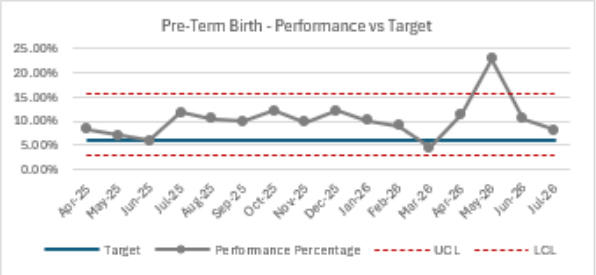

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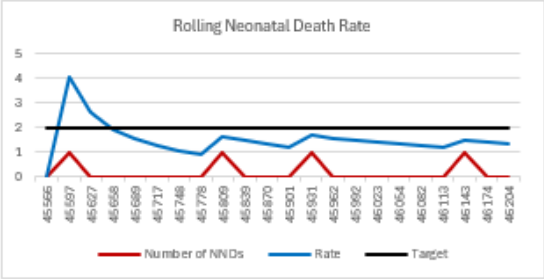

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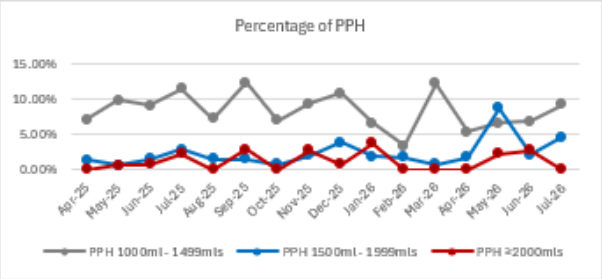

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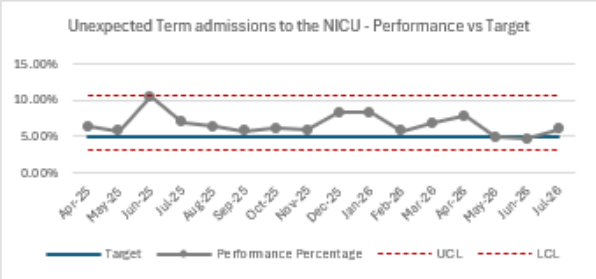
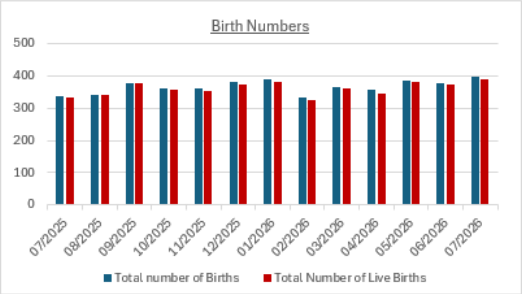


**The rolling stillbirth / neonatal death rates are based on data extracted from Badgernet. Issues noted in reporting when comparing to Power BI sourced data.*

Maternity Overview - Hull University Teaching Hospitals (HUTH)

Latest month: July 2026

Number of Births / Live Births



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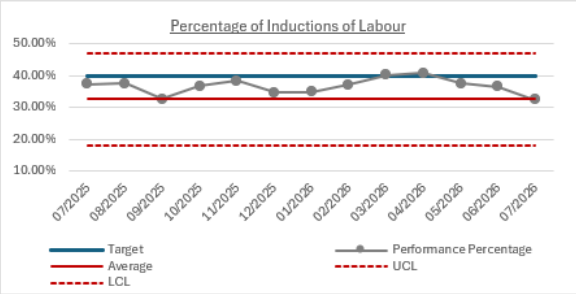

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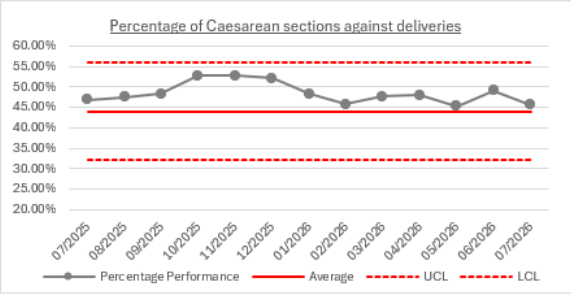

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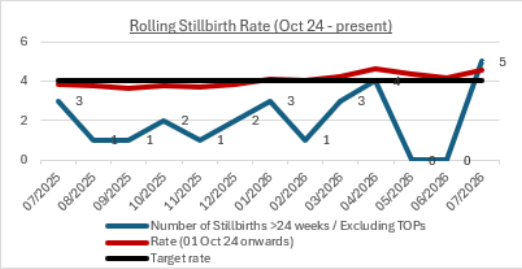

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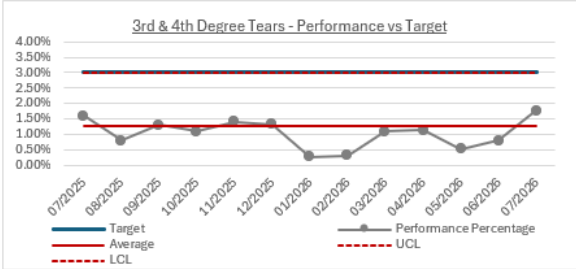

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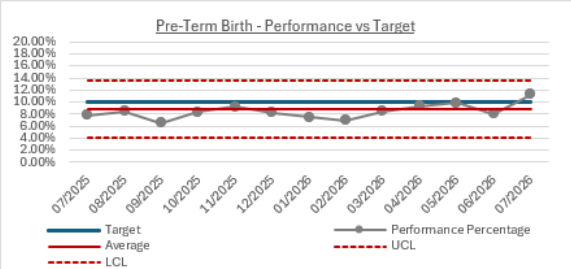

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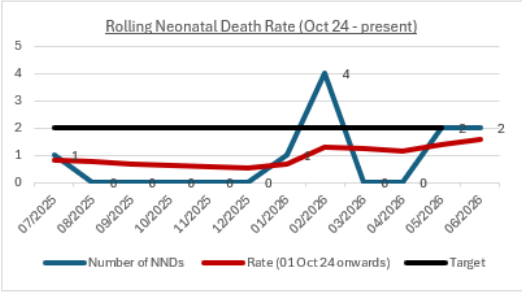

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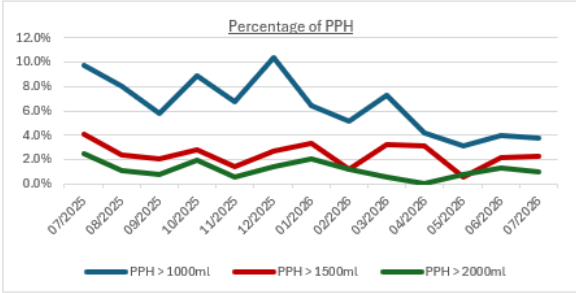

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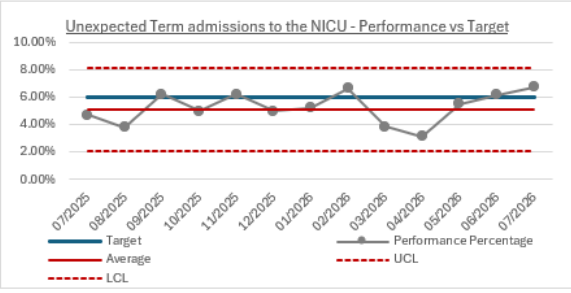


**The rolling stillbirth / neonatal death rates are based on data extracted from Badgernet. Issues noted in reporting when comparing to Power BI sourced data.*

Dashboard Commentary- July 2026 data

Diana, Princess of Wales Hospital

- Pre-term birth and ATAIN rates continue to trend downwards.
- Overall ATAIN rate for quarter 1 was 4.6% below the stretch target of <5%.

Scunthorpe General Hospital

- Pre-term birth rates continue to trend downwards.
- ATAIN is a fraction below the <6% target at 5.9%. The most common reason for admission is respiratory distress.
- Overall for quarter 1 the ATAIN rate for SGH was 4.9% below the stretch target of <5%.

Hull Royal Infirmary

- Increased ATAIN rate 6.14%- 5.56% excluding congenital anomalies. Respiratory concerns recorded in 61.9% of admission. No HIE or NND. July demonstrates a continued trend of longer neonatal admissions, with 52% (11) of completed admissions exceeding 72 hours. This suggests a cohort with greater clinical complexity and a higher proportion of babies requiring prolonged respiratory support or ongoing investigation, rather than purely transitional neonatal morbidity
- Stillbirth rate above target rate- no themes or trends identified on initial review
- 3rd/4th degree tear 5/7 primips (1 was P3 and 1 was P2) 4/7 waterbirths! 4 had delay in suturing and 6 had no clear debrief discussion document

2. PERFORMANCE METRICS

2.1 NHS Resolution Maternity Incentive Scheme Update

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

The risks are aligned to Saving Babies Lives compliance (element 3), and training compliance. Both Trusts achieved the mid-year training checkpoint for all staff groups (safety action B). The 'what good looks like' continues to be worked through with continual collection of evidence.

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

Green – Meets compliance
Amber – In progress & on track
Red - Not started/compliance risk
Blue – Fully Embedded

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

2.2 CQC Progress Update

Northern Lincolnshire and Goole NHS Foundation Trust

There are no open CQC actions for maternity services at NLAG.

Hull University Teaching Hospitals NHS Trusts

There are no open CQC actions for maternity services at HUTH.

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

Improvement work continues at both HUTH and NLAG with the overall aim of being fully compliant with the Saving Babies Lives Care Bundle Version 3.2. Current compliance is detailed in the table below for quarter 1 26/27. The key risks across the group relate to smoking in pregnancy, scan capacity (element 3) and pre-term birth / optimisation. The Pre-term Birth Lead Midwife has now been appointed. Data collection for Q1 26/27 is complete and the quarterly report provides more detail.

Quarter 1 26/27 – Performance	**HUTH**	**NLAG**
Element	**Current Compliance**	**Current Compliance**
Element 1: Smoking in pregnancy	80%	90%
Element 2: Fetal growth restriction	100%	90%
Element 3: Reduced fetal movements	50%	50%
Element 4: Fetal monitoring in labour	100%	100%
Element 5: Preterm birth	85%	81%
Element 6: Diabetes	100%	83%
Total	**90%**	**86%**

2.4 Maternity & Neonatal Safety Improvement Plan – Progress

The Maternity and Neonatal Improvement plan continues to be monitored by the Maternity and Neonatal Improvement Group. The table below provides a breakdown of progress for the remaining actions within each workstream.

Workstream	Number of Actions HUTH	Number of Actions NLAG
Culture		
Signed off and evidenced	-	-
Complete	6	-
In progress	7	1
Delays/issues	-	4
Safety		
Signed off and evidenced	-	-
Complete	-	-
In progress	7	-
Delays/issues	-	-
Experience		
Signed off and evidenced	-	-
Complete	2	-
In progress	3	5
Delays/issues	2	2
Assurance		
Signed off and evidenced	52	93
Complete	53	6
In progress	59	48
Delays/issues	26	27

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

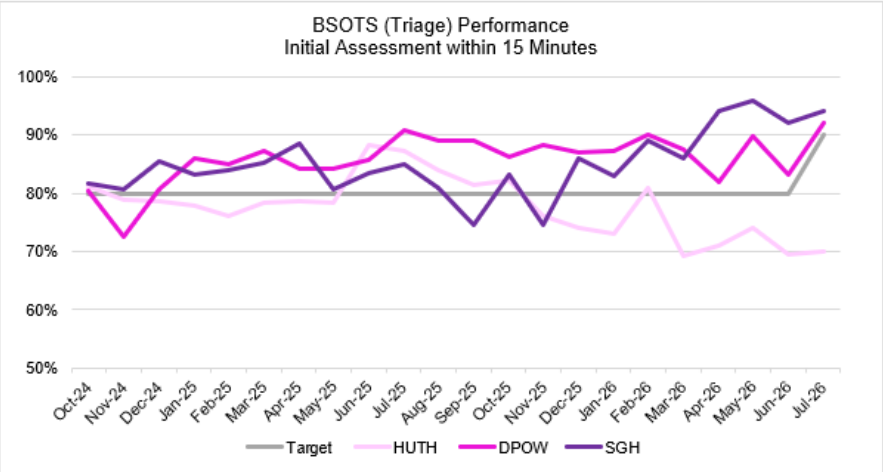
2.5 VTE Risk Assessment Performance

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

	VTE risk assessment completed (6 hours)	VTE risk assessment completed (14 hours)	VTE risk assessment completed (24 hours)	VTE risk assessment completed (postnatal)
HUTH	82%	92%	95%	99.5%
DPOW	81%	91%	93%	97.1%
SGH & GOOLE	71%	86%	90%	97.7%

2.6 BSOTS Performance

The chart and table below demonstrate ongoing performance with regards to women/birthing people being seen for initial assessment in Triage within 15 minutes of arrival for each hospital site and whether those categorised as red are seen within 15 minutes. Regular communications continued with staff, alongside daily and weekly monitoring of compliance. Concerns have been raised by triage staff and at both HRI and DPOW, Listening Events have been undertaken, a full review is planned in view of these concerns and the requirements of the NHSE 10 Point Plan. Initial reviews of data indicate that shift patterns need to alter to reflect activity. A new service national service specification for triage has also been received.



Seen within 15 minutes - Level of urgency: RED				
Month	**Target**	**HUTH**	**DPOW**	**SGH**
Jan 26	100%	100% (6/6)	100% (3/3)	N/A
Feb 26	100%	100% (12/12)	100% (2/2)	100% (3/3)
Mar 26	100%	88% (7/8)	100% (4/4)	100% (2/2)
Apr 26	100%	100% (10/10)	100% (4/4)	100% (2/2)
May 26	100%	100% (15/15)	100% (5/5)	100% (3/3)
Jun 26	100%	91% (10/11)	100% (5/5)	100% (3/3)
Jul 26	100%	60% (3/5)	100% (4/4)	100% (1/1)

3. PERINATAL MORTALITY

3.1 Perinatal Mortality Summary for the period

Perinatal deaths within month (July 2026)					
	Antepartum Stillbirth	Indeterminate stillbirth	Intrapartum stillbirth	Neonatal death	Infant death/post-neonatal
HUTH	4 (37+5, 28+2, 26+1, 24)	-	1 (38+3)	2 (16+6, 18+3)	-
NLAG	-	-	-	1 (26+5)	-

3.2 Details of PMRT Review Outcomes (June 2026)

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

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

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

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

Hull University Teaching Hospital NHS Trust

PMRT Reference	Grading of care (mother / baby)	Reviewed at Learning Response Panel	Date Reviewed at Learning Response Panel	Outcome
102356	A/B/A	N/A		
102365	A/A/A	N/A		
102412	A/A/A	N/A		
102422	C/C/C	Yes	June	Neonatal AAR declared. No further obstetric learning response recommended.

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 / Learning
102505 (External)	A	N/A	N/A	Mother and baby received shared care with other Trusts. No issues identified for NLAG. Action plan in place for other Trusts involved.
102460	A/B	N/A	N/A	The baby had to be transferred elsewhere for the post-mortem (do not perform post-mortem at NLAG). The parents were not provided with written support information around emotional issues before they left hospital – offered but declined by parents.
102412 (External)	A	N/A	N/A	It was not possible to ask this mother about domestic abuse at booking as she was seen remotely and was not alone. Reminder to Community staff to seek the opportunity to ask about domestic abuse at all appointments.

4. MATERNITY TRAINING COMPLIANCE

Hull University Teaching Hospitals NHS Trust

Month: Jul 26	Midwives	MSWs	Obstetricians (Consultants)	Obstetricians (Other doctors)	Anaesthetist Consultant	Anaesthetist (other)	Neonatal Consultants	Neonatal (Other doctors)	Neonatal Nurses	ANNP
Fetal Monitoring (MIS)	98%	N/A	100%	94%	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT (MIS)	98%	96%	100%	94%	100%	100%	N/A	N/A	N/A	N/A
Neonatal Resus (1 year MIS)	96%	N/A	N/A	N/A	N/A	N/A	100%	100%	94%	100%
Personalised Care	96%	96%	84%	84%	N/A	N/A	N/A		N/A	N/A

Northern Lincolnshire and Goole NHS Foundation Trust

Month: Jul 26	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%	100%	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT (MIS)	98%	97%	100%	100%	100%	100%	N/A	N/A	N/A	N/A
Personalised Care (SBLCB)	96%	91%	88%	81%	N/A	N/A	N/A	N/A	N/A	N/A
Care during Labour & PN	97%	N/A	72%	97%	N/A	N/A	N/A	N/A	N/A	N/A
Neonatal Resus (1 year) (MIS)	96%	N/A	N/A	N/A	N/A	N/A	97%	97%	95%	N/A
NLS (4 year) (MIS)	N/A	N/A	N/A	N/A	N/A	N/A	97%	89%	N/A	N/A

Airway competency assessment has been implemented at HUTH and NLAG- however, receipt of evidence is challenging and work is ongoing to address this.

5. SAFER STAFFING

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

Northern Lincolnshire and Goole NHS Foundation Trust

Month: Jun 26	Midwives						Midwifery Support Workers					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
DPOW	3204.3	3130.0	97.7%	3194.1	3028.4	94.8%	1620.0	1338.8	82.6%	1380.0	1350.0	97.8%
SGH	2484.3	2220.0	89.4%	2484.3	1874.3	75.4%	690.0	641.5	93.0%	915.0	737.3	80.6%

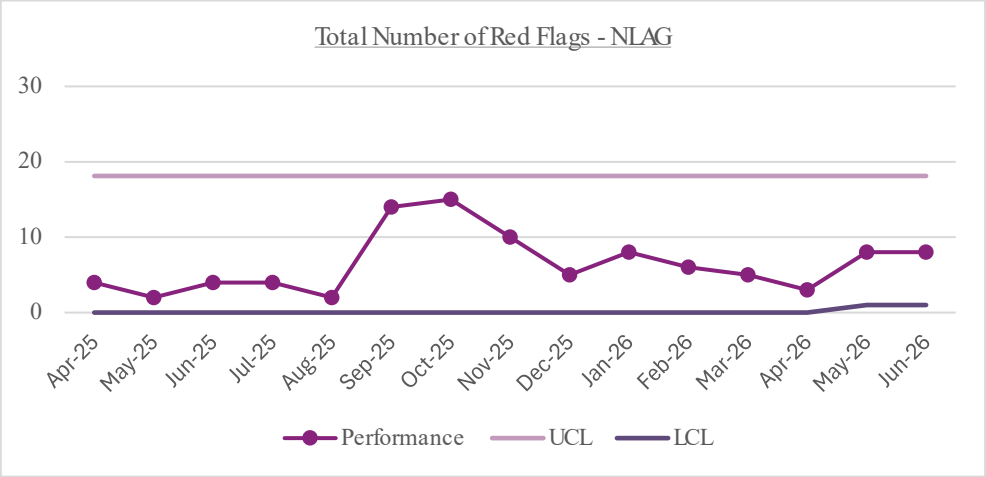
Month: Jun 26	Neonatal Nurses						Care Staff					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
DPOW	1725.0	1499.9	87.0%	1380.0	1344.2	97.4%	690.0	376.5	54.6%	690.0	472.1	68.4%
SGH	1380.0	1243.4	90.1%	1035.0	1064.0	102.8%	690.0	421.0	61.0%	690.0	551.2	79.9%

Hull University Teaching Hospitals (HUTH)

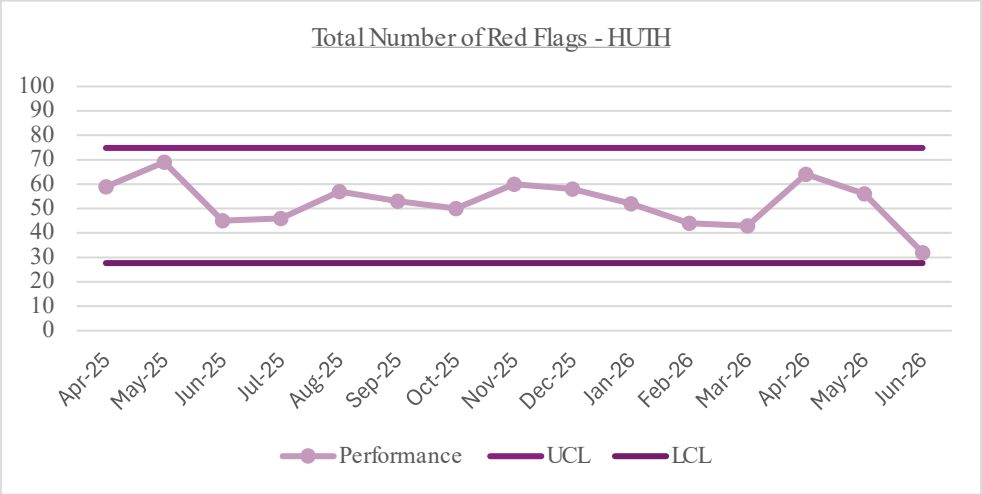
Month: Jun 26	Midwives						Midwifery Support Workers					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
HUTH	8420.75	7926.58	94.13%	5327.41	4812.50	90.33	3010.50	2451.67	81.44%	2620.00	2002.83	76.44%

Month: Jun 26	Neonatal Nurses						Care Staff					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
HUTH	6481.00	4998.58	77.13%	5935.00	4594.00	77.41%	444.00	376.00	84.68%	330.00	220.00	66.67%

5.2 Red flags



NLAG (Apr 25 – Jun 26)	
Measure	
Delayed or cancelled time critical activity	17
Missed or delayed care	18
Missed medication during an admission to hospital	5
Delay in providing pain relief	1
Delay between presentation and triage	2
Full clinical examination not carried out when presenting in labour	0
Delay between admission for induction and beginning of process	27
Delayed recognition of and action on abnormal vital signs	5
Any occasion when 1 midwife is not able to provide continuous 1:1 care	1
Community staff called to work in the unit	22
Total	98



HUTH (Apr 25 - Jun 26)	
Measure	
Delayed or cancelled time critical activity	258
Missed or delayed care	4
Missed medication during an admission to hospital or MLU	0
Delay in providing pain relief	3
Delay between presentation and triage	1
Full clinical examination not carried out when presenting in labour	0
Delay between admission for induction and beginning of process	516
Delayed recognition of and action on abnormal vital signs	1
Any occasion when 1 midwife is not able to provide continuous 1:1 care	1
Labour Ward Coordinator not supernumerary – Providing 1:1 Care	0
Coordinator unable to maintain supernumerary status - NOT 1:1 care	4
Total	788

Data inputting errors at HUTH identified through MOSS and under review in respect of delays in induction of labour.

Please note data for the following measures have been taken from the national Sitrep which is not always accurate. Work is ongoing to improve compliance.

5.3 Number of times services were suspended

Number of times services were suspended	HUTH			NLAG		
	Jun 26	July 26	Aug 26	Jun 26	July 26	Aug 26
Obstetric unit	1	0	-	1 divert to sister Trust	0	-
Midwifery led unit	0	0	-	-	-	-
Homebirth service	4	1	-	0	9	-
Neonatal unit (internal)	Unavailable	10	-	0	3	-
Neonatal unit (external)	Unavailable	11	-	0	4	-

5.4 Women experiencing delays to induction

Number of women whose commencement of induction of labour (IOL) is delayed >6 hours from point of admission for induction (home or ward). This metric has been added following the MOSS at HUTH. Significant amounts of missing data have been identified and actions to address are being taken forward. Therefore, the data below must be interpreted cautiously.

	HUTH			NLAG		
	Jun 26	July 26	Aug 26	Jun 26	July 26	Aug 26
Delays to induction > 6 hours	205	57	-	12	7	-

5.5 Women experiencing delays to elective Caesarean section > 24 hours

Number of women scheduled for an elective Caesarean section who had this delayed by more than 24 hours. This metric has been added following the MOSS at HUTH. Significant amounts of missing data have been identified, particularly at NLAG and actions to address are being taken forward. Therefore, the data below must be interpreted cautiously.

	HUTH			NLAG		
	Jun 26	July 26	Aug 26	Jun 26	July 26	Aug 26
Delays to Caesarean section > 24 hours	9	1	-	3	4	-

5.6 Homebirths (July 2026)

Site	No. of homebirths	No. birthing at home against medical advice	No. of births at home where there is an MDT plan in place	No. transferred into acute unit	No. of transfers with a delay
HUTH	3	0	N/A	1	0
NLAG	2	1	1	0	0

5.7 Staffing Vacancy Rates (June 2026)

Staff group	Vacancy rate HUTH	Vacancy rate adjusted (temporary staff usage) HUTH	Vacancy rate NLAG	Vacancy rate adjusted (temporary staff usage) NLAG
Midwifery	2.9%	1.0%	2.9%	-4.2%
Midwifery Support Workers	1.9%	2.6%	10.8%	1.9%
Obstetric Consultants	Power BI inaccurate	-	Power BI inaccurate	-
Resident Doctors	Power BI inaccurate	Power BI inaccurate	Power BI inaccurate	-
Neonatal Nurses	4.6%	4.3%	30.3%	24.0%
ANNP	5%	5%	N/A	N/A
Neonatal Consultants	Power BI inaccurate	Power BI inaccurate	Unavailable	Unavailable
Resident Doctors	Power BI inaccurate	Power BI inaccurate	Unavailable	Unavailable
Obstetric Anaesthetists	Power BI inaccurate	Power BI inaccurate	DPOW – 3 vacancies (2 due to start in August) SGH – 2 vacancies	
Resident doctors	Unavailable	Unavailable	DPOW – 4 vacancies (4 have been recruited to and are due to start July and August). SGH – 3 vacancies (2 of which have been recruited to and are due to start July and August).	

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

Risks, mitigations and escalations:

- Agreement to recruit four (two for each Trust) of our own Maternity Support Workers to the Registered Midwife Degree Apprenticeship Programme commencing in September. Interviews take place on the 18th of August.
- Awaiting feedback from bid submitted for the additional funding released to support recruitment of Early Career Midwives.

6 LEARNING LESSONS

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

Hull University Teaching Hospitals (HUTH)

MNSI number	IMD/Ethnicity	Qualify for EN?	Have the family received notification of role of referral?	Did the family require and received information in a format/language that was accessible for them?	Written Duty of Candour complete	Compliant with Duty of candour?	Details/update
MI-048987	WB – IMDD 8	Yes	Yes	Yes	Yes	Yes	37+6 actively cooled. Pre-terminal CTG. MLC (Seizure in pregnancy). Not risk assessed in ANC. Equipment shortage of sonicaid (did not affect outcome). MRI – HIE 3 (first since December 2023). **Draft report received, re-wording of recommendation requested. Following local process and PSIRF. Action plan awaiting final approval (planned August)**
MI-056540	WB – IMDD 1	No	Yes	Yes – but not available via MNSI. Easy read DoC generated.	Yes	Yes	Unbooked pregnancy. IPSB. LMP 42+5. Learning difficulties. Concerns escalated by MNSI to SLT (escalated to LRP and supported by A&E). **Interviews completed. Awaiting draft.**
MI-059599	WB – IMDD 6	No	Yes	Yes	Yes	Yes	40+2 delivery. IOL due to SUA. Early NND. CoD severe PPHN due to meconium aspiration syndrome. **Interviews completed. Awaiting draft.**
MI-064813	WB – IMDD 1	No	Yes	Yes	Awaiting (not due at time of report)	Verbal - Yes	38+3 G2 P1 at booking. Pregnancy interval <1 year. Had a CS previously. Attended triage ?SROM and contracting. Amnisure NEG. Uterine activity continues. Transferred to maple for analgesic. Normal CTG. Pain escalated. Transferred to Labour ward. IUFD and uterine rupture diagnosed. **Very early stages of process.**

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG)

MNSI number	IMD / Ethnicity	Qualify for EN	Have the family received notification of role of MNSI/EN	Did the family receive information in a format / language that was accessible for them?	Written Duty of Candour complete	Compliant with Duty of candour?	Details/update
MI-049981	9 / White British	No	Yes	Yes	Yes	Yes	Final report received, action plan to be drafted.
MI-056976	9 / White British	Yes (CLM1972012)	Yes	Yes	Yes	Yes	Investigation currently underway. Staff are being interviewed.
MI-058207	8 / White Irish	No	Yes (provided directly by MNSI)	Yes (provided directly by MNSI)	N/A	N/A	MNSI have the final clinical panel on the 24th August 2026. Report to be drafted by MNSI following this.

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

Hull University Teaching Hospitals

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
441184 – Ongoing urinary retention > 7 days post-delivery. Now self-catheterising. FU in place.	3/WB	Obstetric	Remained moderate (verbal and written completed but not uploaded)	To include service user perspective in planned MDT on bladder care using PSIRF methodology. Service user happy with this. Planned August.
441277 – E.coli MSI (IPC)	1/Asian	Obstetric	Downgraded to no-harm	Closed. MSU grew E.coli. No deviations from care found. Microbiology input required in care (resistant strain of E.coli).
442998 – MOH activated., 3.5L PPH, theatre for EUA and perineal repair. 4 units of blood given	1/WB	Obstetric	Awaiting MIRM review.	
443327 - ELCS known low Hb peri arrest on table. Transfer to ICU, arrested in CT.	4/WB	Obstetric	Awaiting MIRM review	
443193 – Intrapartum stillbirth and uterine rupture.	1/WB	Obstetric	Awaiting MIRM review	MNSI referral made.

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
439399 Linked to 439531 Term Infant admitted to NICU due to hypoglycaemia.		Obstetrics	Moderate	Verbal DoC given and explanation of rapid review. Rapid review undertaken. Discussed at Learning Response Panel and decision for an After Action Review with a view to look into a thematic review.
443152 - Birth injury - Neville Barnes Forceps in theatre. Facial trauma to left cheek, skin excoriated and multiple bruises.		Obstetrics	Moderate	Rapid review undertaken and will be going to Learning Response Panel.

6.3 Maternity Risk Register

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

Hull University Teaching Hospitals NHS Trust

Top three risks on risk register – Maternity / obstetrics & Neonates		
Specialty	**Risk**	**Level**
Maternity	Baby abduction risk within maternity services	High
Maternity	Maternal Diabetic and Maternal medicine ANC capacity and staffing	Moderate
Maternity	Obstetrics and Gynaecology Consultant staffing	Moderate
Neonatal	There is a risk that the nursing establishment does not meet the BAPM framework	Moderate
Neonatal	High risk of the spread of pseudomonas within the neonatal unit due to it being detected in the sinks	Moderate
Neonatal	Risk of increased drug administration errors due to not having electronic prescribing	Moderate

Northern Lincolnshire and Goole NHS Foundation Trust

Top three risks on risk register – Maternity / obstetrics & Neonates		
Specialty	**Risk**	**Level**
Maternity	Inappropriate accommodation (community midwives)	Moderate
Maternity	Ultrasound scan capacity	Moderate
Maternity	Antenatal clinic review capacity	Moderate
Neonatal	Proximity of clinical handwashing sinks to cot spaces	Moderate
Neonatal	Hybrid use of Badgernet and paper records in neonatal units	Moderate
Neonatal	Sluice on NICU (SGH) non-compliance with infection prevention standards	Moderate

7 SERVICE USER FEEDBACK

7.1 MNVP/Service User Feedback

MNVP feedback not available for July 2026 due to the service ceasing on the 31st July 2026. Work ongoing to address this gap. 0.4 WTE of the Patient Engagement Midwife role now in post.

7.2 Complaints Received

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

NLAG		HUTH	
No received:	3	No received:	1
The 3 complaints were related to concerns regarding: • 2 clinical care and treatment • 1 clinical care and attitude of staff		The 1 complaint were related to concerns regarding: • 1 care provided	

7.3 Friends and Family Test Feedback

Hull University Teaching Hospitals NHS Trust

In June 2026, 62 responses were received. Positive comments are provided alongside feedback regarding areas of improvement.

Score	Responses
1 (Very good)	42 (68%)
2 (Good)	11 (18%)
3 (Okay)	4 (6%)
4 (Poor)	2 (3%)
5 (Very poor)	3 (5%)

Positive feedback included:
“Staff were attentive, friendly and willing. Clear improvement in morale since last visit.”
“Staff actually care individual needs are met.”
“Constant checks, letting me know how things were progressing to be discharged.”

Areas for improvement included:
“Shorter waiting times between doctor’s visits.”
“Birthing partners to stay longer.”

Northern Lincolnshire and Goole NHS Foundation Trust

In March 2026, 14 responses were received for Maternity and 6 for Neonatal. Positive comments are provided alongside feedback regarding areas of improvement.

Maternity	
Score	**Responses**
1 (Very good)	12 (86%)
2 (Good)	1 (7%)
3 (Neither good nor poor)	0 (0%)
4 (Poor)	*1 (7%)
5 (Very poor)	0 (0%)
6 (Don't know)	0 (0%)

Neonatal	
Score	**Responses**
1 (Very good)	6 (100%)
2 (Good)	0 (0%)
3 (Neither good nor poor)	0 (0%)
4 (Poor)	0 (0%)
5 (Very poor)	0 (0%)
6 (Don't know)	0 (0%)

*The poor comment related to prolonged time from being able to go home to discharge time/communication issues.

8 LISTENING TO OUR STAFF

8.1 General Staff Feedback

- Close partnership working continues with the Lead Midwives for Education to optimise and support student midwife experience
- Review of triage acuity and staffing undertaken at DPOW and inclusive of SGH triage and options paper to be shared with staff.
- Work ongoing to address the concerns on triage- liaising with estates and facilities teams regarding temperatures.
- Several Tea Trollies have taken place at SGH and DPOW with positive feedback.

8.2 Safety Champion Feedback

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

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

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

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

Walkaround took place on 2nd July 2026 at Goole Midwifery Unit (postponed from 24th June 2026). No issues were raised by the staff on the unit.

Walkaround took place on 29th July 2026 at Diana Princess of Wales Hospital. The following issues were identified:

- Lights in theatre
- Lack of access to System 1
- Inappropriate referrals to Triage

9 NHS England's Ten Point Plan

No	Action
1	Listening to women and their families by rolling out Martha's Rule
2	Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit data that are acted
3	Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care
4	'Amos into action' staff listening exercise
5	Addressing inequalities in maternity and neonatal outcomes
6	Ensuring 24/7 safety and responsiveness of maternity and neonatal services
7	Trusts to review their homebirth services
8	Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach
9	Deliver safe and effective triage in maternity services (already committed by Government)
10	Post death care (already committed by Government)

9.1 Maternity Care Bundle

	HUTH	NLAG
1. Venous Thromboembolism	Review ongoing	Review ongoing
2. Pre-hospital and acute care	MEWS now implemented across the trust	MEWS now implemented in maternity
3. Epilepsy in pregnancy	Review ongoing – Epilepsy Action's Self-Assessment Benchmarking Tool currently being completed	Review ongoing- Epilepsy Action's Self-Assessment Benchmarking Tool completed with a score of 54%
4. Maternal Mental Health	Review ongoing	Review ongoing
5. Obstetric Haemorrhage	Review ongoing	Review ongoing

Comprehensive action plan will be shared at October MNAG.

9.2 Homebirth PFD

- Community Matrons now in post at both Trusts.
- Survey feedback received from SGH and HRI Community Midwives- options paper for HRI being worked up. DPOW midwives are currently completely the survey.
- Review of on-call payments across the Group ongoing.
- Community PROMPT will be launched at HRI in September- will be a Pan-Group offer from January 2026.
- Further NHSE guidance awaited- expected November 2026

10 Maternity Outcomes Signal System (MOSS)

Hull University Teaching Hospitals NHS Trust

Hull received a MOSS alert on the 18th of June and completed the Critical Safety Check within the required timeframes. The critical safety check is a rapid, structured review of intrapartum care operations by the perinatal leadership team, co-produced with staff working in these areas and approved by an accountable executive member of the Trust Board. The key points to note is that review of caesarean section decision to delivery times indicated that full compliance was not always achieve. No harm has occurred due to this in the period review (01/03/2026-31/05/2026)- going forward from this month this is now a metric on the maternity and neonatal dashboard.

A further MOSS alert was received on the 10th of July 2026.

Northern Lincolnshire and Goole NHS Foundation Trust

No alerts received. Drill planned for September 2026.

11 Perinatal Culture Improvement Plan

Rag Rating Matrix	
	Completed & embedded
	Completed & ongoing and / or not yet fully embedded
	In progress / on track
	Not yet completed / significantly behind agreed timescales

No	Recommendation	Actions / Key Milestones	Expected Impact	Progress (date)	Current RAG
NLAG					
2	NMC Exception Report	Action plan in place, informing all workforce of current concerns raised by students, Having PMA support in place for students to access whilst on placement, continue students clinics, remind midwives of their role and responsibilities in the teaching and supervision of students, Matron walkarounds to continue on the wards to have conversations with students, Matrons to attend the universities to introduce themselves to students to promote the student clinics and feedback of concerns, Promote continuity for students with supervisor, production of a joint Charter with Midwives and Student Midwives of the expectations from both sides, Encourage staff to call out poor behaviour of other staff, Off duty to be produced in advance for students to know their roster requirements, Complete audits on all clinical areas (cross site).	Improved placement experience for all students. Feel psychologically safe and comfortable to call out poor behaviour, increase support available to students in clinical placement, re-educate midwives on their professional behaviours and responsibilities in relation to the NMC code.	April 2026 - students removed from SGH labour ward for one bank holiday weekend. Listening forum with DOM/HOM/UNI/WEQ Matron within the week to discuss concerns. Feedback documented which was then read to LWCO by HOM the following week. Students now back on placement with no further concerns raised	
3	NLAG Behaviour Charter for Maternity	Document includes, behaviour framework based on the organisational values. Refers to the Civility Saves Lives campaign. Used the Capital Midwife Civility toolkit to guide aspects of the charter. Created MS form and displayed posters in clinical areas for staff to report concerns around psychological safety. RCOG civility posters displayed in clinical areas.	Provide information for staff to read, educate, and enhance their knowledge and recognition of civility and incivility. Inform them of the statistics around the impact of incivility.	Group staff charter in place. 11/8/26 - concerns with culture currently suggest this may need to be reopened.	
4	Student support	Awareness of support available to students whilst on clinical placement. PLF in post 18.75 WTE across the trust. Pastoral Lead available to students to access. Student clinical site specific with Matrons to enhance SMT visibility and encourage escalation of concerns. PLF to send out emails to students with links for the clinics.	Students will feel supported in their clinical environment. Wide range of support options available to students.	05/11/2025 Students sent a feedback code to complete for their placement experience. This data was collated and sent to SMT, Matrons and managers of the areas.	

No	Recommendation	Actions / Key Milestones	Expected Impact	Progress (date)	Current RAG
5	Staff to attend trust Civility and Respect training	The trust offer civility and respect training. The session is optional.	Educate staff on the impact of incivility. How to tackle the issues and change behaviours to reduce incivility in the workplace.	Course is optional. Discussion with OD facilitators and HOM to potentially add to action plan following SCORE survey for all maternity staff to attend the session. OD facilitators will accommodate sessions. Unable to locate training on ESR.	
6	Understanding cultural diversity workshop	The trust offer workshops by the EDI team. This workshop aims to explore cultural diversity, create an appreciation for its impact on team bonding. It aims to support team leaders in creating well-adjusted and thriving teams, exploiting the benefits of their cultural diversity.	Enhance staff knowledge on cultural diversity, unconscious bias and how our behaviours impact others.	As above	
9	Group People Strategy 2025-28	Our new Group People Strategy (2025-28) launched this week. It covers how we will recruit locally, nationally and internationally, onboard, engage, manage, develop and recognise and reward staff. It covers flexible working to give people a better work/life balance, reasonable adjustments, new roles, new ways of working, speaking up, developing our leadership capacity and capability and, importantly, how all managers should lead and inspire staff in order to provide great care to patients. The strategy is our plan to improve our specific workforce challenges and improve our organisational culture, together with more specific actions in response to the Staff Survey.	Improved investment in training & development, career opportunities and pathways, quality of leaders and support available to all staff.	14/07/2025 The People Strategy 2025-28 is available on Bridget for all staff to access.	
10	Group Staff Experience Work Stream	Implementation of working group for improving staff experience at work. To include R&R leads as Staff Experience Leads, Staff Voice Champions from all areas and bandings to act as advocates at meetings. To include MDT working inc. PMA lead, QI lead, FTSU Guardian. To emulate shared decision making concept in making the working environment and staff experience the best it can be. Frequency of meetings TBC	Improved staff morale, inclusion of staff in decisions and actions involving improvements within their working area. Staff feeling of value and inclusion.	No further update. To liaise with DOM and R&R lead at HUTH to clarify if still planning to implement.	

No	Recommendation	Actions / Key Milestones	Expected Impact	Progress (date)	Current RAG
11	Maternity Incivility Reporting Tool	Poster to display in clinical areas with QR code for staff to report acts of incivility.	Provide staff with the tool to escalate incidents of incivility to SMT. Hope to encourage engagement from staff in reporting incidents to enable actions to be taken.	No update, will liaise with HUTH R&R lead as this was paused due to seeking clarity for who will be responsible for collecting and disseminating the data.	
12	Group Staff Charter	The Staff Charter sets clear, consistent standards for conduct, fostering a safe, compassionate, respectful, and productive work environment aligned with our core values. It promotes a harmonious culture by preventing conflicts and guiding professional, accountable behaviour across the workforce. As a reference point for addressing conduct concerns and managing disciplinary actions fairly, it supports managers and HR in maintaining consistency. Embedded in induction and training, the Charter helps all staff understand expectations and integrate effectively, nurturing a respectful, cohesive, high-performing culture.	Create a safe, respectful, and positive workplace by setting clear behavioural standards, reducing conflicts, and supporting consistent, fair management of conduct issues. It will align all staff with the organisation's values, improve professionalism and accountability, and help new and existing employees understand and meet expectations, contributing to a cohesive, high-performing culture.	14/07/2025 Group charter available on Bridget for all staff to access. 11/8/26 - not seen around the unit and minimal discussions had around group values and expectations of professional standards/behaviours.	
13	Tea Trolley Walk rounds across both main sites	Plan monthly tea trolley at each main site as an opportunity to highlight specific services available to staff and provide staff with an opportunity to speak to pastoral midwife/PMA and guest facilitating the tea trolley that month.	Aim to improve visibility and awareness of support services available and bring this support to the staff in the work environment. This will hopefully improve staff knowledge of what support the organisation offers and increase engagement in services. Use guest speakers to promote support options within organisation and encourage engagement with messages. Themes, celebrations and links to services	Receiving frequent tea trolleys at both DPOW and SGH since 3/6/26, at least bi-monthly. Specialists midwives showing an interest in running their own trolleys and TRIM practitioner/HWB lead and F2SU Guardian have taken trolley round at each site.	

No	Recommendation	Actions / Key Milestones	Expected Impact	Progress (date)	Current RAG
HUTH					
1	Leadership 1-2-1 check and challenge meetings	All managers to have had a 1-2-1 bi-monthly, bi-monthly month Matron alternate month HoM and Matron.	Clarity of expectations and outline of workplan. Ability to escalate concerns and receive support from SLT. Staff will feel well-led, psychologically safe, inspired and held by the senior management team but also each other. Staff being promoted into new bands will be well supported by a buddy to learn and flourish in their new roles.	Confirm this is reliably and consistently happening	
2	Success profile: Learning Needs Analysis	What do managers need to carry out their roles? Management and leadership framework - self assessment against 5p's.	Clarity of expectations and outline of workplan. Understanding of gaps in knowledge and what is available to them through organisation for their development	Meeting with Nami and Matt Smith	
3	Increase engagement with staff survey, improving on 38% engagement in September 2025	Tea trollies, SLT encouragement through walkarounds, DOM newsletter,	Staff voice will be heard through this anonymous survey, contributing towards organisational targets and direction of leadership for teams		
4	Matron timeout day	ML self-assessment, professional standards, empowering teams, draw the line, introduction of flow coaching	With support from Hannah Parker, managers and leaders framework, pebbles in shoes, turn the ship around, distributed leadership, old power/new power	Meeting with Nami and Hannah 25/8/26	
5	Culture dashboard	Matt Smith to write and share. Measures: Patient safety, Medication errors, PMA data Patient complaints, Staff survey, Sickness rate, Retention figures/Turnover, Incivility tool figures, F2SU issues, Preceptorship feedback, Escalations to managers, QI projects/innovation engagements	The ability to have quick access to data when requested, supporting writing of board reports related to culture, recognition of themes, ability to anticipate areas requiring improvement	With support from Matt Smith	

No	Recommendation	Actions / Key Milestones	Expected Impact	Progress (date)	Current RAG
6	PMA activity	PMA Lead Midwife required, now 1:13 ratio PMA Midwife, restorative support sessions, career conversations, guidance with education and quality improvement, education faculty, role modelling professional behaviours and standards,	Staff will feel well-supported, psychologically safe, inspired and held by the Professional Midwifery Advocate team but also each other. Staff will be familiar with members of the PMA team and have access to a PMA Monday to Friday 8am - 4pm via email and mobile phone. Staff will have a choice about which PMA they use and are not obligated to access PMA at any time. Staff to understand benefits of A-EQUIP model delivered by PMA team.	Survey has gone out to PMA's of their recommendations for running of service. Data to be collated and discussed with HOMs at both Trusts to align service.	
7	Tea trolleys for hot topics	2-hour trolley around maternity unit and follow up post in Facebook group.	Use guest speakers to promote support options within organisation and encourage engagement with messages. Themes, celebrations and links to services.		

12 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		No				

Data measure	June 2026
Findings of reviews of all perinatal deaths using the real time data monitoring tool	PMRT reviews: 4. Occurred 24th June 2026. External reviewers present. 102356 – 22+6 NND (shared with York) - Graded A/B/A 102365 – 37+ early NND (Confirmed T18 palliative care) – Graded A/A/A 102412 – 23+6 early NND (Shared with NLaG) – Graded A/A/A. 102422 – 24+5 early NND (Shared with Mid. Yorks) – Graded C/C/C. Escalated to LRP. CTG and ARM performed outside of guidance. Professional reflections occurred. Position statement on CTG recommendations <26/40 made and approved via governance. Not a re-occurring theme.
Number of cases referred to MNSI/ENS	0
Findings of review of all cases eligible for referral to MNSI	N/A
Number of incidents graded as moderate or above and what action is being taken	5 – see item 6.2.
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report – item 4.
Service User Voice feedback	Please refer to body of report – item 9.
Staff feedback from frontline champions and walk-abouts	Issues regarding acuity and the IOL clinic being busy, however staff reported feeling heard.
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No
Coroner Reg 28 made directly to the Trust	0
Progress in achievement of CNST 6 safety actions	MIS Year 8 launched 31/03/2026. See item 2.1.
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	Place to work – 22% Receive treatment - 31%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours (reported annually)	91% - response rate 79% - within IQR

Northern Lincolnshire and Goole NHS Foundation Trust

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

Data measure	June 2026
Findings of review of all perinatal deaths using the real time data monitoring tool	3 cases were discussed at PMRT meetings during June 2026. CNST requirements met. Outcome detailed within section 3.2 of the report. The gradings of care are provided below: 102505 (external) A – No actions identified for NLAG 102460 A/B - Bereavement information not provided (offered but declined) 102412 (external) A – Reminder to community team regarding asking domestic violence questions
Number of cases referred to MNSI/ENS	0
Findings of review of all cases eligible for referral to MNSI	N/A
Number of patient safety incidents logged and what actions are being taken	208 maternity/obstetrics incidents (3 moderate) / 55 neonatal (2 moderate). Actions ongoing.
Training compliance for all staff groups in maternity related to the core competency framework	Please refer to report item 4
Service User Voice – themes	Communication – not felt listened to, delayed discharge and system access/efficiency.
Staff feedback from frontline champions and walk-abouts - themes	Walkabout at DPOW 29/07/26 highlighted concerns re access to System 1, theatre lighting and inappropriate referrals to triage.
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 6 safety actions	Please refer to report item 2.1.
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

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)193

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	10 September 2026
Director Lead	Jo Ledger, Interim Group Chief Nurse
Contact Officer / Author	Yvonne McGrath, Group Director of Midwifery
Title of Report	**Maternity Incentive Scheme Year 8 and Saving Babies Lives Progress Reports**
Executive Summary	

Executive Summary

See below for an overview of the current compliance against the safety action requirements.

Green – Meets compliance
Amber – In progress & on track
Red - Not started/compliance risk
Blue – Fully Embedded

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

At present, there is ongoing evidence collection for all 6 safety actions at both HUTH and NLAG.

Key risks:

- A5: Evidence outstanding of meeting notes or workforce reports showing that anaesthetic staffing pressures are monitored and discussed alongside maternity and neonatal activity.
- A6: Evidence outstanding of regular discussion of Caesarean birth capacity at maternity and theatre governance meetings, ensuring the whole pathway is understood and managed jointly.
- D1: Difficult to evidence adapted appointment formats and longer consultation times for those with language or communication needs.
- E1: Saving Babies' Lives compliance: antenatal scan capacity, smoking in pregnancy (quit rates at delivery) and pre-term birth rates/optimisation.
- F3: MNVP no longer in place. Only 1 NED Safety Champion currently in place with limited resource across the Group.

Steps for Sign Off:

Requirement	Date
MIS Evidence period	01 Apr – 30 No
Trust Board evidence sign off	By February
Submission of MIS year 8 declaration	By 02 Mar 2

The table below provides an overview of compliance for quarter 1 2026/27 based on the latest self-assessment using the national implementation tool.

% of interventions fully Implemented	Self-assessment	Self-assessment
Site	HUTH	NLAG
Element 1: Smoking in pregnancy	80%	90%
Element 2: Fetal growth restriction	100%	90%
Element 3: Reduced fetal movements	50%	50%
Element 4: Fetal monitoring in labour	100%	100%
Element 5: Preterm birth	85%	81%
Element 6: Diabetes	100%	83%
TOTAL	90%	86%

An audit and training plan has been developed to continually monitor and identify areas to improve the service and outcomes relating to the care bundle elements:

- Element 1: Reducing Smoking in Pregnancy
- Element 2: Fetal Growth: Risk assessment, surveillance, and management
- Element 3: Raising awareness for reduced fetal movements
- Element 4: Effective fetal monitoring during labour
- Element 5: Reducing pre-term birth and optimising perinatal care
- Element 6: Management of Pre-existing Diabetes in Pregnancy

Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Maternal and Neonatal Assurance Group
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

NHS Resolution
Maternity (and Perinatal) Incentive Scheme
Year Eight

HUTH & NLAG PROGRESS REPORT

August 2026

Yvonne McGrath – Group Director of Midwifery
Eloise Sims – HUTH Maternity Audit and Compliance Manager
Hayli Garrod – NLAG Maternity Audit and Compliance Manager

Background

NHS Resolution's Clinical Negligence Scheme for Trusts (CNST) applies to all acute trusts that deliver maternity services and are members of the CNST. Members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. Trusts that do not meet the six-out-of-six threshold will not recover their contribution to the CNST maternity incentive fund.

The Maternity Incentive Scheme Year 8 outlines a requirement for Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST MIS fund and they will also receive a share of any unallocated funds. The Trust has submitted full compliance against the 6 safety actions for the preceding three years.

What is evident throughout the scheme is the need for the Trust Board and Integrated Care System (ICB) to be cited on the safety of maternity services and therefore we have compiled this report and will continue to do so on a quarterly basis to ensure the **Quality and Safety Committees in Common** (acting on behalf of the Trust Board) is sighted on the ongoing work and the future plans.

The purpose of this report is to provide an overview of the changes from year 7 and update on the progress made on the 6 safety actions in respect of Maternity Incentive Scheme – Year 8 highlighting key risks and the mitigating actions taken.

Weekly MIS Year 8 Delivery Group monitoring meetings are established to review progress and address risks identified.

Executive Summary

See below for an overview of the current compliance against the safety action requirements.

Green – Meets compliance
Amber – In progress & on track
Red - Not started/compliance risk
Blue – Fully Embedded

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

At present, there is ongoing evidence collection for all 6 safety actions at both HUTH and NLAG.

Key risks:

- A5: Evidence outstanding of meeting notes or workforce reports showing that anaesthetic staffing pressures are monitored and discussed alongside maternity and neonatal activity.
- A6: Evidence outstanding of regular discussion of Caesarean birth capacity at maternity and theatre governance meetings, ensuring the whole pathway is understood and managed jointly.
- D1: Difficult to evidence adapted appointment formats and longer consultation times for those with language or communication needs.
- E1: Saving Babies' Lives compliance: antenatal scan capacity, smoking in pregnancy (quit rates at delivery) and pre-term birth rates/optimisation.
- F3: MNVP no longer in place. Only 1 NED Safety Champion currently in place with limited resource across the Group.

Steps for Sign Off:

Requirement	Date
MIS Evidence period	01 Apr – 30 Nov 26
Trust Board evidence sign off	By February 27
Submission of MIS year 8 declaration	By 02 Mar 27

Trust to determine external review following the LMNS ceasing. Previous arrangements were in place to review evidence prior to submission.

Safety action A – Workforce and capacity:
Board oversight of effective multidisciplinary (MDT) workforce and capacity planning. Ensuring the maternity and neonatal service have funded establishments for obstetric, midwifery, neonatal, anaesthetic, and perioperative teams meeting nationally recognised workforce standards.
Leads: Uma Rajesh, Maged Shendy, Lisa Pearce, Deborah Bray, Helen Yates, Madhavi Madhusudhana, Emma Smith, Yvonne McGrath

Requirement		HUTH Compliance	NLAG Compliance
A1	**Consultant attendance (obstetric workforce)** Compliance with RCOG "Roles and Responsibilities of the Consultant providing acute care" standard: ≥80% consultant presence in defined acute care situations.		
	Progress update: Audit complete for HHP, please refer to appendix A for summary of results demonstrating compliance.		

A2	**Short-term locum certification (obstetric workforce)** Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. Eligibility must be verified before first engagement and reviewed annually for all locums on the register.		
	Progress update: Audit data collection underway. Concerns regarding local ongoing monitoring since changing to Locum Nest.		

A3	**Neonatal workforce establishment (nursing & medical)** Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU), Special Care Unit (SCU)) and the neonatal nursing workforce calculator output (2020).		
	Progress update: Nursing benchmarking against BAPM standards undertaken (HHP) with actions agreed to move towards compliance. To be approved by Nurse Director and shared with Trust Board for approval. Three-year workforce phasing plan saved in evidence folder. Medical benchmarking to be undertaken at NLAG (planned for 21/08/26) and currently underway at HUTH. Plan for Trust Board submission October 2026.		

A4	**Midwifery workforce establishment** Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director and Head of Midwifery should be added where appropriate. Regional Chief Midwives are able to support this process if required.		
	Progress update: Midwifery staffing establishment aligns with Birthrate Plus reports for HUTH and NLAG.		

A5	**Anaesthetic workforce** Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2.		
	Progress update: Obstetric Anaesthetic rota evidence provided (demonstrating a duty anaesthetist available 24/7 for both HUTH & NLAG). **Risks:** Evidence outstanding of meeting notes or workforce reports showing that anaesthetic staffing pressures are monitored and discussed alongside maternity and neonatal activity.		

A6	**Planned Caesarean birth capacity mapping** Trusts must undertake annual demand–capacity mapping for planned Caesarean birth lists, covering the full pathway (preoperative assessment → theatre → recovery → postnatal ward). Trusts should use existing NHS England regional maternity SitRep data wherever possible to avoid duplication.		
	Progress update: Demand-capacity mapping completed for HUTH. NLAG yet to be completed. Maternity and Neonatal Assurance Report updated (July onwards) to allow monitoring of same days delays from SitRep data. **Risks:** Evidence outstanding of regular discussion of Caesarean birth capacity at maternity and theatre governance meetings, ensuring the whole pathway is understood and managed jointly.		

A7	**Board and governance oversight (as detailed in Safety Action F)** Trusts must have a governance system that ensures workforce and capacity risks are monitored, scrutinised and escalated appropriately. This should include a six-monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.		
	Progress update: HHP Bi-annual staffing report completed and submitted to Trust Board (June 26). Next report due November 26 and to be strengthened to include regular reporting of anaesthetic and perioperative staffing data.		

Safety action B – Training:
Effective Board oversight of maternity and neonatal MDT training and competency. Ensuring all maternity, neonatal and anaesthetic staff are trained, assessed and supported to maintain the knowledge, skills and behaviours required for safe, high quality multidisciplinary care.
Leads: Elaine Lindsay, Jenny Hemmingway (HUTH), Zoe Saunders, Laura Parker (NLAG)

A minimum of ≥90% compliance must be achieved for every required staff group at two points during the MIS year (April to November 2026): 30 November (mandatory MIS checkpoint), and one other Trust selected checkpoint, declared in advance through Quality Governance Committee. As declared through MNAG and QSC, HUTH and NLAG both achieved >90% training compliance for all staff groups with all training days as required at the first check point (31st July 2026).

Please see appendix 2 for training compliance for each staff group / competency as of 31st July 2026.

Requirement		HUTH compliance	NLAG compliance
B1	**Obstetric emergency training** Trusts must ensure that maternity staff attend annual multidisciplinary obstetric emergency training that incorporates local learning, human factors, communication, teamwork, escalation pathways and situational awareness. Anaesthetists working in maternity are required to attend at least half of the MDT training day as a minimum, during which obstetric emergencies requiring anaesthetic input. Trusts must ensure that an impacted fetal head (IFH) scenario is incorporated into obstetric emergency training by the end of MIS Year 8 as a preparatory step for Avoiding Brain Injury in Childbirth (ABC) implementation, aligning to the proposed ABC methodology. There is not an expectation that all staff will have received training.		
	Progress: Multidisciplinary obstetric emergency training in place at both HUTH and NLAG that incorporates the requirements detailed above. IFH will commence at HUTH from 22/09/2026 and in place at NLAG.		

B2	**Neonatal resuscitation** As a minimum, trusts must ensure that all staff who may act as an unsupervised first attender or primary resuscitator at any birth (including all midwives) complete annual neonatal resuscitation training and are assessed as meeting at least basic capability, as defined in the BAPM Neonatal Airway Safety Standard. Where further enhanced training is in place for additional staff groups, this should continue (e.g. NLS (Newborn Life Support) Course or equivalent).		
	Progress: Neonatal resuscitation training in place for all staff groups. BAPM Neonatal Airway basic capability assessment embedded at HUTH, awaiting evidence for medical staffing assessments for NLAG.		

B3	**Fetal monitoring training** Trusts must ensure that all staff who provide care in antenatal or intrapartum settings, whether substantively or when responding in escalation, complete annual fetal surveillance training.		
	Progress: Multidisciplinary training in place at both HUTH and NLAG, attendance monitored regularly.		

B4	**In situ multi-professional perinatal emergencies simulations** Trusts must deliver at least two in-situ multiprofessional perinatal emergencies simulations during the MIS reporting period. One that begins in a hospital area (e.g. labour ward, obstetric theatre, triage, ED, NICU) and another that begins in a community area. Where possible there should be involvement with relevant partners such as paramedics, ED and theatre teams. These should be based on local and/or national learning and include real time practice of escalation pathways.		
	Progress: **NLAG**: planned date to complete a community simulation (29/10/2026) within the Goole suite and simulation centre. Birth – ED Maternity simulation in ED – SimScape (Training between midwives and ED MDT) – awaiting report for SGH, yet to be undertaken at DPOW. **HUTH**: simulation planned in-hospital on 03/09/26, community simulation planned 30/09/2026 and a further in-hospital simulation on 08/10/2026.		

B5	**Training compliance oversight (as detailed in Safety Action F)** Trust Boards must have oversight of training compliance for all maternity and neonatal staff groups. Compliance must be reported quarterly through established governance routes, presented in a clear trend-based format (ideally using Statistical Process Control (SPC) charts), monitored against a trajectory towards 100 percent and working towards maintaining ≥90 percent compliance throughout the following year.		
	Progress: Training compliance reported in the Maternity and Neonatal Assurance report (shared at Governance, MNAG, Q&SC, Trust Board) monthly. Also reported/discussed at the Maternity and Neonatal Improvement Group. Trajectories in place for HHP, monitored weekly at MIS Delivery Group meeting.		

Safety action C:
Effective Board oversight of thematic learning and progress with actions arising from local and national reviews of adverse incidents.
Lead: Matthew Proctor, Jenna Cadden (HUTH) / Natalie Jenkin, Tracey Martin (NLAG)

	Requirement	**HUTH compliance**	**NLAG compliance**
C1	**Notify all qualifying events** All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR EN and MNSI as soon as possible after the death/diagnosis.		
	Progress: Local process and systems in place at HUTH and NLAG. Compliance above target, included within quarterly PMRT reports.		

C2	**Seek parents' views of care** For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.		

	Progress: Local process and systems in place at HUTH and NLAG. Compliance above target, included within quarterly PMRT reports.		

C3	**External multi-disciplinary reviewers** For a minimum of 60% of the deaths reviewed, external members of relevant specialties must be present at the multi-disciplinary review, and this should be documented within the PMRT.		
	Progress: Local process and systems in place at HUTH and NLAG. Attendance of external members recorded on PMRT and within the quarterly PMRT reports.		

C4	**Provide relevant information** Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.		
	Progress: National written and verbal information available for parents explaining MNSI, the EN scheme and the PMRT process is offered to all families. Translated versions can be requested from the national body when required. Local process in place at HUTH and NLAG where families are given more than one opportunity to ask questions.		

C5	**Offer parents a meeting with relevant specialists** Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.		
	Progress: Family debriefs are offered with the relevant Obstetric/Neonatal Consultant together with the Specialist Bereavement Lead Midwife and/or Quality and Safety Maternity Matron.		

C6	**Thematic reports of learning and actions** The Trust must produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify any disparities in outcomes. These thematic reports must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board at least quarterly. Reports should clearly demonstrate the measures implemented to address recurrent themes, and progress with these, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training.		
	Progress: Quarterly thematic report developed (available from quarter 4 2025/26 onwards). Local claims triangulation scorecard developed and embedded within thematic reports. Shared with Trust Perinatal and Board level Safety Champions at MNAG, Q&SC and Trust Board.		

Safety action D – Service-user voice and equity:
The voices and experiences of all women accessing maternity and neonatal services are used to drive local improvements, using local population demographics to understand and target efforts to support a reduction in inequities in experience and outcomes.
Lead: Yvonne McGrath

Requirement		HUTH compliance	NLAG compliance
D1	**Communication equity, language support and accessible information** Trusts should demonstrate continued progress towards ensuring that women and families, including those who may require translation, interpreting support, or reasonable adjustments, are supported to understand their care, options, and decisions at key points in the perinatal journey. Trusts should recognise that where information is not understood, consent may not be informed, valid or lawful. Reliance on family members, friends or informal interpretation must be treated as a patient safety, safeguarding and human rights risk.		
	Progress: Use of interpreter audit currently underway. Gathering evidence for both neonatal and maternity services for "what good may look like". Incidents triangulated with service user feedback and included with theming reports. **Risks:** Difficult to evidence adapted appointment formats and longer consultation times for those with language or communication needs.		

D2	**Service-user voice driving safety and quality improvement** Trusts must demonstrate that insights from women, families and carers using maternity and neonatal services are captured and used to inform service improvement plans. Trusts must use demographic data to understand their local population and demonstrate that the voices of women and families from different demographic groups, are actively captured and used to shape priorities within the service. Progress with this work should be monitored through established governance routes quarterly to ensure that actions lead to measurable improvements in safety, quality, or experience.		

Safety action E – Care bundles:
Board oversight of progress with implementation of Saving Babies' Lives Care Bundle (SBLCBv3.2), a plan to implement the Maternal Care Bundle by March 2027, and assurance that a guideline for neonatal pulse oximetry testing has been developed in line with national guidance.
Lead: Joanna Melia, Samantha Sockett, Yvonne McGrath, Tessa Dunning, Nicky Foster

	Requirement	HUTH compliance	NLAG compliance
E1	Saving Babies' Lives Care Bundle (SBLCBv3.2) - Quarterly reporting to the Trust Board The provider must report quarterly to the Trust Board on progress against full SBLCBv3.2 implementation. Quarterly reports should demonstrate how the Trust has prioritised the requirements of the SBLCB based on local progress, implementation status, and any relevant safety intelligence, including themes and learning from local adverse incidents. In light of the recent NHSE and RCOG fetal growth chart safety communication, Trusts should include a brief review within their local SBL priorities to confirm safe and appropriate fetal growth surveillance, confirming that fetal growth charts and surveillance pathways meet most recent national safety advice and identifying any local risks or improvement actions relating to fetal growth restriction (FGR) detection as highlighted.		

Progress: Quarterly reports developed and submitted to Trust Board quarterly. Current compliance for quarter 1 26/27 is detailed in the table below.

Risks: Antenatal scan capacity, smoking in pregnancy (quit rates at delivery) and pre-term birth rates/optimisation.

Quarter 1 26/27 – Performance	HUTH	NLAG
Element	**Current Compliance**	**Current Compliance**
Element 1: Smoking in pregnancy	80%	90%
Element 2: Fetal growth restriction	100%	90%
Element 3: Reduced fetal movements	50%	50%
Element 4: Fetal monitoring in labour	100%	100%
Element 5: Preterm birth	85%	81%
Element 6: Diabetes	100%	83%
Total	**90%**	**86%**

Fetal growth charts/pathways

Both HUTH and NLAG currently use the Perinatal Institute GROW 2.0 fetal growth charts, which have been in place for many years. Both Trusts are also currently compliant with the surveillance pathways as required in SBLVB c3.2 guidance.

E2	**Maternal Care Bundle – Implementation Plan** In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the Maternal Care Bundle by March 2027. Progress with implementation is reviewed quarterly through established governance routes.		

Progress: Benchmarking and population of audit tool underway with regular reviews to develop the action plan.

E3	**Neonatal pulse oximetry testing** Trusts must develop a standardised, equitable, and governance approved guideline for neonatal pulse oximetry testing, aligned to the BAPM framework. The guideline must describe the required clinical processes, data entry standards, and pathways for all birth settings (including homebirths) to ensure that every baby receives pulse oximetry screening between 2 and 24 hours of age, with clear escalation processes for babies in the amber and red pathways.		
	Progress: HHP guideline in place aligned with the BAPM framework. Minor amendments to be made to include the process and escalation of pulse oximetry for homebirths.		

Safety action F:
The Trust Board has effective oversight of the quality and safety of their maternity and neonatal services.
Lead: Yvonne McGrath, Nicola Foster, Tessa Dunning, Helen Smith

Requirement		**HUTH compliance**	**NLAG compliance**
F1	**Board Oversight of Maternity and Neonatal Quality and Safety** Trusts must demonstrate that, through established governance routes, the Board routinely receives, reviews and responds to a comprehensive assessment of maternity and neonatal quality and safety. This assessment should cover training, workforce, staff and service user experience, and progress against the care bundles at the frequencies outlined in Safety Actions A–E. Trusts must also ensure that findings arising from detailed scrutiny at the Quality Governance Committee (or equivalent) are formally escalated to the Executive Board, providing full oversight in line with good governance practice and the expectations of the Perinatal Quality Oversight Model (PQOM). Where Trust level mitigation to concerns is insufficient, escalation to Regional Midwifery Officer teams should be documented, alongside PQOM aligned actions.		
	Progress: Regular Board-level maternity and neonatal quality and safety reports submitted monthly to Maternity and Neonatal Assurance Group and Quality & Safety Committee. Submitted to Trust Board bi-monthly in line with the PQOM.		

F2	**Maternity Outcomes Signal System** Trusts must evidence that the critical safety check (Annex 1 of the MOSS standard operating procedures) was completed in the event of signals, or that a test drill (Annex 9) was carried out if no signals occurred. An accountable trust board executive (i.e. Chief Nurse, Chief Medical Officer or Executive Trust Board Safety Champion) must approve completed checks, including drills. This will be externally validated through regional assurance - services must send a completed copy of critical safety check(s) or test drill to regions, for forwarding to the national team at england.moss@nhs.net		
	Progress: HHP standard operating procedure in place. Hull received a MOSS alert on the 18th of June. A further alert was received on the 10th of July 2026. The Critical Safety Checks were completed within the required timeframe and shared with ICB and regional colleagues as advised. NLAG have not received any MOSS alerts to date, drill scheduled to take place in September 2026.		

F3	**Maternity and Neonatal Board Safety Champions** Trusts must demonstrate that Maternity and Neonatal Board Safety Champions are actively supporting the perinatal leadership team (including the MNVP Lead where they are in commissioned in line with MNVP guidance), in creating and embedding a positive local safety culture, with regular two-way communication and clear escalation to the Trust Board where any concerns are identified.		
	Progress: NED Maternity and Neonatal Safety Champion in place with regular update reports submitted to Trust Board. MNAG chaired by Board Safety Champion with support to perinatal leadership team where risks are identified/escalation is required. **Risks:** MNVP no longer in place. Only 1 NED Safety Champion currently in place with limited resource across the Group.		

F4	**Perinatal Culture Improvement Plan** Trusts must demonstrate that they have an agile perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact, and is reviewed by the Trust Board at least six monthly.		
	Progress: Refreshed culture improvement plans in place for HUTH and NLAG. Included in the Maternity and Neonatal Assurance Report for Trust Board oversight (August 2026). Further work is ongoing with the Organisational Development team.		

Appendix 1 – Consultant Attendance Audit Results

HUTH:

HUTH - Compliance of Consultant Attendance for Clinical Situations (June 2026)
Methodology: Spot check audit complete from 01/06/2026 – 30/06/2026
Compliance: 24/27 (89%)

Clinical scenario requiring consultant to be present	Number of occasions	Consultant attendance
Trial of instrument in theatre	11	10 (90.9)
Caesarean birth at full dilatation	2	2 (100%)
Caesarean birth for women with BMI >40**	5	4 (80%)
3rd – Perineal tear	2	2(100%)
Caesarean birth at < 32/40	2	2(100%)
PPH, EBL >2	1	1(100%)
Any patient in obstetrics with EBL >1.5L and ongoing bleeding	2	2(100%)
Consultant called to attend ***	1	1(100%)
Caesarean birth with placenta praevia*	1	0 (0%)

*A case of placenta praevia, consultant was home and offered to come in. ST5 and ST7 present. Situation was under control with no concerns
** 1 case of women with BMI >40, ST7 present in theatre
*** 1 case of woman with fibroid in the lower segment and consultant was called to attend, she needed a myomectomy of the fibroids in the lower segment

There were 3 occasions where consultant did not attend for as documented above. However, the operating surgeon (registrar) was signed off as competent to perform the procedure and consultant was informed and updated.

SGH & Goole - Compliance of Consultant Attendance for Clinical Situations
Total number of women delivered during April / May / June 2026: 399
Number of occasions where consultant was called to attend: 38/399 (9.5%)
Compliance: 37/38 (97%)

Clinical scenario requiring consultant to be present	**Number of occasions**	**Consultant Attendance**
Consultant requested to attend	18	18
Eclampsia	2	2
High levels of acuity (i.e. second theatre open / unit closure)	3	3
Trial of instrumental delivery in theatre	1	1
Any other scenario agreed prior to shift commencing in line with level of experience	5	5
Caesarean birth at < 32/40	2	2
Caesarean birth for major placenta praevia	1	1
PPPH>2 litres where the haemorrhage is continuing and massive obstetric haemorrhage protocol has been instigated	1	1
LSCS at full dilatation	3*	2
LSCS birth for a woman with a BMI >50 / team brief requested	1	1
Premature twins <30/40	1	1

*1 Consultant on call contacted via phone but call went to voicemail. Rang but no answer from consultant. Attempted via switchboard but no answer.

DPOW - Compliance of Consultant Attendance for Clinical Situations
Total number of women delivered during April / May / June 2026: 540
Number of occasions where consultant was called to attend: 42 (7.8%)
Compliance: 41/42 (98%)

Clinical scenario requiring consultant to be present	Number of occasions	Consultant Attendance
Consultant requested to attend	*20	19
Trial of instrumental delivery in theatre	9	9
LSCS at full dilatation	3	3
Caesarean section in a woman with a body mass index greater than 40	3	3
Caesarean birth at < 32/40	5	5
Vaginal breech delivery	2	2

*Consultant did not attend - further details required from audit form for learning purposes

Appendix 2 – Training compliance (Mid-year checkpoint)

HUTH:

Month: Jul 26	Midwives	MSWs	Obstetricians (Consultants)	Obstetricians (Other doctors)	Anaesthetist Consultant	Anaesthetist (other)	Neonatal Consultants	Neonatal (Other doctors)	Neonatal Nurses	ANNP
Fetal Monitoring (MIS)	98%	N/A	100%	94-100%	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT (MIS)	98%	96%	100%	94-97%	100%	100%	N/A	N/A	N/A	N/A
Neonatal Resus (1 year MIS)	96%	N/A	N/A	N/A	N/A	N/A	100%	100%	94%	100%

DPOW:

Multidisciplinary Training Compliance	MIS								
Current Compliance: 30/07/26	PROMPT			Fetal Monitoring			Neonatal Basic Life Support		
	Num	Den	Compliant %	Num	Den	Compliant %	Num	Den	Compliant %
Staff Group									
Midwives	130	132	98%	130	132	98%	128	132	97%
MSW / HCAs	46	47	98%						
Obstetric Consultants / SAS Grade doctors	12	12	100%	12	12	100%			
Obstetric Doctors (other grades)	14	14	100%	13	13	100%			
Anaesthetic Consultants / SAS Grade doctors	21	21	100%						
Anaesthetic Doctors (other grades)	4	4	100%						
Neonatal Consultants (Includes Specialty Doctors)							17	17	100%
Neonatal Doctors (other grades)							14	15	93%
Neonatal Nurses							29	30	97%
ANNPs							0	0	N/A
TOTAL	227	230	98.7%	155	157	98.7%	188	194	96.9%

SGH:

Current Compliance: 30/07/26	PROMPT			Fetal Monitoring			Neonatal Basic Life Support		
	Num	Den	Compliant %	Num	Den	Compliant %	Num	Den	Compliant %
Staff Group									
Midwives	116	118	98%	113	118	96%	113	118	96%
MSW / HCAs	37	39	95%						
Obstetric Consultants / SAS Grade doctors	13	13	100%	13	13	100%			
Obstetric Doctors (other grades)	11	11	100%	9	9	100%			
Anaesthetic Consultants / SAS Grade doctors	23	23	100%						
Anaesthetic Doctors (other grades)	4	4	100%						
Neonatal Consultants (Includes Specialty Doctors)							12	13	92%
Neonatal Doctors (other grades)							16	16	100%
Neonatal Nurses							25	27	93%
ANNPs							0	0	N/A
TOTAL	204	208	98.1%	135	140	96.4%	166	174	95.4%

NHS
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FAMILY SERVICES DIVISION

Saving Babies Lives V3.2 Quarterly Report
HUTH and NLAG

Reporting period: Quarter 1 2026/27

Yvonne McGrath – Group Director of Midwifery

August 2026

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

United by Compassion:
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Background
The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The Three-Year Delivery Plan for Maternity and Neonatal Services set out that providers should fully implement Version three by March 2024. A new implementation tool was made available to help maternity services to track and evidence improvement and compliance with the requirements set out in Version Three.

The update of SBLCBv3.2, maintained an approach of continuous improvement. Within each element the focus is on a small number of outcomes with fewer process measures. Implementation of the elements require a more comprehensive evaluation of each organisation's processes and pathways and an understanding of where improvements can be made.

Introduction
The aim of this report is to provide a quarterly update on the implementation of all six elements of the Saving Babies Lives care bundle v3.2.

MIS Year 8 introduces a more targeted local approach to Saving Babies' Lives Care Bundle with Trust Board oversight of progress of implementation on a quarterly basis. It is expected that Trusts maintain high level of compliance whilst making meaningful improvements and moving towards embedding this as business as usual. In previous years the LMNS have carried out peer assurance reviews, however this is no longer required.

Saving babies lives audits for quarter 1 2026/27 have been completed to provide continued assurance that that both Trusts are maintaining a consistent level of compliance against the agreed interventions whilst striving to improve in areas that have not been achieved.

Executive Summary
The table below provides an overview of compliance for quarter 1 2026/27 based on the latest self-assessment using the national implementation tool.

% of interventions fully Implemented	Self-assessment	Self-assessment
Site	**HUTH**	**NLAG**
Element 1: Smoking in pregnancy	80%	90%
Element 2: Fetal growth restriction	100%	90%
Element 3: Reduced fetal movements	50%	50%
Element 4: Fetal monitoring in labour	100%	100%
Element 5: Preterm birth	85%	81%
Element 6: Diabetes	100%	83%
TOTAL	**90%**	**86%**

Please refer to page 9 for a detailed breakdown for each site.

An audit and training plan has been developed to continually monitor and identify areas to improve the service and outcomes relating to the care bundle elements:

- Element 1: Reducing Smoking in Pregnancy
- Element 2: Fetal Growth: Risk assessment, surveillance, and management
- Element 3: Raising awareness for reduced fetal movements
- Element 4: Effective fetal monitoring during labour
- Element 5: Reducing pre-term birth and optimising perinatal care
- Element 6: Management of Pre-existing Diabetes in Pregnancy

Overview of Compliance / Actions Taken

Element 1 Reducing Smoking in pregnancy

Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing and ensuring in-house treatment from a trained tobacco dependence adviser is offered to all pregnant women who smoke, using an opt-out referral process.

Quarterly audit %	Actions taken and progress made
HUTH **80%**	Compliant interventions: 8/10 Non-compliant intervention: 1.4, 1.6 Ongoing difficulty achieving this element regarding smokers who are referred for tobacco dependence treatment who set a quit date, are verified as non-smokers at 4 weeks and 36 weeks. It appears to be a theme regionally. The TDTT to continue to trial different communications methods as discussed regionally and have recently implemented 'significant others' as part of the scheme. Significant improvement in 1/3 requirements in this measurement. There has been a drop in compliance this quarter with referral as per opt out, compliance 89%, target 90%. Public Health Lead Midwife to continue to discuss this on Personalised Care Day but to send out an email/digital update alongside SBL newsletter. Furthermore, will discuss at the next community meeting.
NLAG **90%**	Compliant interventions: 9/10 Non-compliant requirement: 1.6 Ongoing difficulty achieving this element of the Care Bundle regarding smokers who are referred for tobacco dependence treatment who set a quit date, are verified as non-smokers at 4 week and 36 weeks. The TDTT team continue to engage with pregnant women who are identified as smokers at any point throughout their pregnancy. Engagement following referral remains an issue despite the incentive scheme introduction.

Element 2 Risk assessment and surveillance for fetal growth restriction

Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Quarterly audit %	Actions taken and progress made
HUTH **100%**	Compliant interventions: 20/20 Deep dive conducted for vitamin D recommendation at booking. This is now a mandatory field and compliance on BadgerNet unit reports significantly increased. Digital blood pressure machine implementation plan continues. In view of the LMNS disbanding, further advice to be sought via the national SBL team.
NLAG **90%**	Compliant interventions: 18/20 Non-compliant requirement: 2.1, 2.7 2.1 - In July 2026 System C circulated a BadgerNet Advisory Notice (QMMD-447) advising users that issues had been identified during quarter 1 relating to the fetal growth and pre-eclampsia (aspirin) risk assessment completion. This is the first time compliance has been under the 95% target . In cases where it was reported a risk assessment had not been completed, a local review was undertaken on approximately half of the cases and the majority had a risk assessment 99% completed with one or two questions left blank. The missing fields appears to make no difference to Badgernet compliance reporting, as cases reviewed in July 2026 with one or more missing fields were classed as meeting the standard on the report. The issue has been escalated to the Digital Midwife who is exploring if the fields within the checklist can be made mandatory and ascertain why compliance has dropped this quarter. 2.7 – Audit currently underway to assess compliance for women/birthing people having uterine artery doppler within the specified time period following pathway changes. Early findings indicates an increase in compliance at DPOW, however further review of Viewpoint data is required. SGH data is yet to be completed.

Element 3: raising awareness for reduced fetal movements

Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

Quarterly audit %	Actions taken and progress made
HUTH **50%**	Compliant interventions: 1/2 Non-compliant intervention: 3.2 3b There are 3 aspects to intervention 3.2 3b. The intervention specifies that women presenting with recurrent reduced fetal movement should have an ultrasound scan by the end of the next working day. Compliance with this intervention is inconsistent as capacity and demand remains an issue. Q2 25/26 compliant in this measure but the previous 3 quarters have now fallen to 71% (target 80%). This is on the risk register and has been escalated to MNAG, QSC and Board.
NLAG **50%**	Compliant interventions: 1/2 Non-compliant requirement: 3.2 The intervention specifies that women presenting with recurrent reduced fetal movement should have an ultrasound scan by the end of the next working day. Compliance with this intervention is inconsistent as capacity and demand remains an issue. In previous quarters, the intervention was predominantly met as women/birthing people had a fetal growth scan within the 14 days prior to attendance due to a high-risk pregnancy and/or being on the serial scan pathway.

Element 4: Effective fetal monitoring during labour

Quarterly audit %	Actions taken and progress made
HUTH **100%**	Full compliance declared with 5/5 interventions. Although there is not the requirement for this to be reported to the LMNS, the Fetal Monitoring team continue spot check audits. All guidelines are in place as required and documented on the implementation tool. Training >90%.
NLAG **100%**	Full compliance declared with 5/5 interventions. Although there is not the requirement for this to be reported to the LMNS, the Fetal Monitoring team continue spot check audits. All guidelines are in place as required and documented on the implementation tool.

Element 5: Reducing preterm birth and optimising perinatal care

Reducing the number of preterm births and optimising perinatal care when preterm birth cannot be prevented.

Quarterly audit %	Actions taken and progress made
HUTH **85%**	Compliant interventions: 22/26 Non-compliant interventions: 5.1, 5.2, 5.19, 5.20. 5.1 – HHP Preterm birth lead midwife is required to complete the pre-term birth team. The post has been recruited to but not yet commenced in the role. 5.2 – The preterm birth rate across the trust is higher than the national average, a deep dive has been completed and findings below. 5.19 - Compliance for giving a full dose of antenatal steroids was below the 55% target at 42%. Low compliance is attributed to clinical presentation / no time to administer the full course prior to delivery, or where the woman/birthing person has already received a full course earlier in pregnancy and a further course has not been given. 5.20 – 5c Target 90%, compliance 67%. 2 birthing people were reviewed due to non-compliance. Both had emergency caesarean sections due to fetal distress. It could be argued there was not the opportunity in 1 of the cases to administer magnesium sulphate. Newsletter to be sent to staff for education on this measure and 5.19.
NLAG **81%**	Compliant interventions: 21/26 Non-compliant requirements: 5.1, 5.2, 5.18, 5.19, 20 5.1 – HHP Preterm birth lead midwife is required to complete the pre-term birth team. The post has been recruited to but not yet commenced in the role. 5.2 - The preterm birth rate across the trust remains higher than the national average. A deep dive is underway to gain a further understanding of any issues and early analysis of the first cohort of cases has identified areas for targeted improvement. 5.18 – 2 babies were born off pathway. All off pathway babies are reviewed as part of clinical governance processes. 5.19 – Compliance for giving a full dose of antenatal steroids was below the 55% target at DPOW. Low compliance is attributed to clinical presentation / no time to administer the full course prior to delivery, or where the woman/birthing person has already received a full course earlier in pregnancy and a further course has not been given. 5.20 – 1 woman was identified for inclusion at SGH during the quarter. Delivery occurred at 26 weeks gestation and it was not possible to given Magnesium sulphate.

Element 6: Management of Pre-existing Diabetes in Pregnancy

This covers the management of pre-existing diabetes for women with Type 1 or Type 2 diabetes, as the most significant modifiable risk factor for poor pregnancy outcomes. This element recommends MDT pathways and an intensified focus on glucose management within maternity settings, in line with the NHS Long Term Plan and NICE guidance. It includes using HbA1c to risk stratify and provide additional support / surveillance, and consistently offering access to evidence-based continuous glucose monitoring and pregnancy-specific hybrid closed loop technology to improve glucose control.

Quarterly audit %	Actions taken and progress made
HUTH **100%**	Compliant with 6/6 interventions.
NLAG **83%**	Compliant interventions: 5/6 Non-compliant requirement: 6.1 6.1 to separation of pre-existing and gestational diabetes clinics is required to meet this intervention. SGH clinics now separate, work ongoing at DPOW to formalise plans for separation/additional medical input.

Action Planning

As part of the quarterly submission, separate reports and action plans are devised for each of the elements. All agreed actions are detailed within the reports and monitored until completion. These are shared at audit meetings and logged on AMaT.

Fetal growth charts/pathways

Both HUTH and NLAG currently use the Perinatal Institute GROW 2.0 fetal growth charts, which have been in place for many years. Both Trusts are also currently compliant with the surveillance pathways as required in SBLVB c3.2 guidance.

Safety intelligence, themes and learning

Element 5 continues to be the area where improvement is required, however this remains a challenge due to the nature of presentation and opportunity to optimise birth. It is hoped that once the preterm birth midwife has commenced their post in August, greater focus can be placed on improvement. Mutual aid to neighbouring Trusts continues to be offered to women in pre-term labour due to the lack of NICU cots across the network. A deep dive has been completed at HUTH and is underway at NLAG.

Key themes identified at HUTH were that there was a concentration of cases in certain postcodes, with social deprivation as recurring factor. Smoking remains present in a subset of cases and previous obstetric history and preterm birth risk factors were frequently documented. There was a strong use of antenatal corticosteroids but variation in magnesium sulphate and neonatal bundle elements. It was noted that there was variable documentation quality in transferred in cases.

Recommendations made for quality improvement included monthly thematic review dashboard, geographical hotspot monitoring, focused MDT reviews of recurrent themes, enhanced public

health collaboration and equity-focused maternity outreach in deprived communities. This will be shared with the preterm birth lead once they have commenced their post.

Ultrasound capacity continues to be a concern across the Group with a further decline in compliance. Actions are underway to address this. The Director of Midwifery met with the Senior Leadership Team and Chief nurse, with a plan for additional support to review capacity-demand and evidence. This is impacting compliance for different elements of SBL for both Trusts and is currently on the risk register.

Appendix A: Breakdown of Compliance

Q1 26/27 data (April - June 2026)

Element 1: Reducing Smoking in pregnancy							
Intervention	**Process/ outcome indicator**	**SBL Interventions**	**Target HuTH**	**Q1 HUTH**	**Target NLAG**	**Q1 SGH**	**Q1 DPOW**
1.1	1a i)	Percentage of women where CO measurement is recorded at booking.	90%	98%	90%	95%	93%
	1a ii)	Percentage of women where CO measurement is recorded at 36 weeks	80%	94%	80%	93%	94%
1.2		CO testing offered at all other antenatal appointments - V3.2 update.	Guideline in place				
1.3	1a iii)	Percentage of women where their smoking status at booking is recorded	80%	99%	80%	99%	98%
	1a iv)	Percentage of women where their smoking status at 36 weeks is recorded	80%	98%	80%	96%	98%
	N/A	Percentage of women where their smoking status is recorded at all antenatal appointments – V3.2 update.	Guideline in place		Guideline in place		
1.4	1b)	Percentage of smokers* that have an opt-out referral at booking to an in-house tobacco dependence treatment service	90%	89%	90%	100%	93%
1.5	N/A	NRT should be offered to all smokers as soon as possible	Guideline in place				
1.6	1c)	Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date.	40%	22%	40%	25%	12%
	1e)	Percentage of smokers that set a quite date are identified as CO verified non-smokers at 4 weeks	40%	56%	40%	55%	25%
	1d)	Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks.	40%	14%	40%	33%	29%
1.7	N/A	Percentage of women who have documented evidence of immediate feedback to the named maternity health care professional when a woman does not book or attend appointment with their in-house tobacco dependence treatment service	50%	100%	80%	93%	73%
1.8	N/A	Percentage of staff within date training compliance on the use of a CO testing and discussion of results	80%	92%	90%	94%	
1.9	N/A	Percentage of staff providing maternity care with annual in date training compliance on the delivery of VBA making an opt-out referral and maternity pathway processes	90%	92%	90%	94%	
1.10	N/A	Percentage of individuals delivering tobacco dependence treatment interventions who are fully trained to NCST standards	90%	100%	90%	100%	

Element 2: Fetal Growth: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction							
Intervention	**Process/ outcome indicator**	**SBL Interventions**	**Target HuTH**	**Q1 HUTH**	**Target NLAG**	**Q1 SGH**	**Q1 DPOW**
2.1	N/A	Percentage of women booked who had a completed risk assessment undertaken for Aspirin	95%	99%	95%	92%	93%
2.2	N/A	Percentage of women booked who are recommended vitamin D supplementation	95%	95%	95%	95%	95%
2.3	N/A	Assess smoking status and manage findings as per element 1	Guideline in place				
2.4	2a)	Percentage of pregnancies where a risk status for FGR is identified and recorded at booking.	80%	100%	80%	99%	100%
2.5	N/A	During risk assessment trusts are encouraged to use information technology platforms to facilitate accurate recording and correct classification of risk by staff	SBLv3 GROW Tick list (system supplier evidence)				
2.6	N/A	Blood pressure should be recorded by using a digital monitor that has been validated for use in pregnancy	Implementation Plan			Implementation Plan	
2.7	N/A	Percentage of women booked that are identified as high risk for FGR who have had a uterine artery doppler assessment between 18+0 and 23+6 weeks gestation	80%	93%	80%	Audit in progress	
2.8	2c)	Percentage of perinatal mortality cases where the identification and management of FGR was a relevant issue	N/A	0%	N/A	11%	
2.9	N/A	When an ultrasound-based assessment of fetal growth is performed Trusts should ensure that robust processes are in place to review which risk pathway a woman is on and agree a plan of ongoing care	Guideline in place				
2.10	N/A	Women who are at low risk of FGR following risk assessment should have serial measurement of symphysis fundal height (SFH) at each antenatal appointment after 24+0. The first measurement should be carried out by 28+6. Measurements should be plotted or recorded on charts by clinicians trained in their use - V3.2 update.	Guideline in place		Guideline in place		
2.11	N/A	Staff who perform SFH measurement should be competent in measuring, plotting (or recording), interpreting appropriately and referring when indicated.	Training plan in place		Training plan in place		
2.12	N/A	Women who are undergoing planned serial scan surveillance should cease FH measurement after serial surveillance begins. SFH measurement should also cease if women are moved onto a scan surveillance pathway in later pregnancy for a developing pregnancy risk	Guideline in place				
2.13	N/A	Women who are at increased risk of FGR should have ultrasound surveillance of fetal growth (3-4 weekly)	Guideline in place				
2.14	N/A	When FGR is suspected an assessment of fetal wellbeing should be made including a discussion regarding fetal movements and if required computerised CTG	Guideline in place				
2.15	N/A	Umbilical artery Doppler is the primary surveillance tool for FGR identified prior to 34+0 weeks and should be performed as a minimum every 2 weeks	Guideline in place				
2.16	N/A	When FGR is suspected, the frequency of review of estimated fetal weight (EFW) should follow the guidance in Appendix D or an alternative which has been agreed with local ICSs following advice from the provider's Clinical Network and/or regional team	Guideline in place				
2.17	N/A	Risk assessment and management of growth disorders in multiple pregnancy should comply with NICE guidance or a variant that must be agreed by both the local ICSs and the regional maternity team	Guideline in place				
2.18	2d)	Percentage of babies <3rd birthweight centile born >37+6	<48%	44%	<48%	24%	
2.19	2b)	Percentage of pregnancies where an SGA fetus is antenatally detected (between 3rd & <10th centile)	-	50%	-	31%	

Intervention	Process/ outcome indicator	SBL Interventions	Target HuTH	Q1 HUTH	Target NLAG	Q1 SGH	Q1 DPOW
2.20	N/A	Opinion on timing of timing of birth for fetuses with declining growth velocity and EFW <10th, where risk factors are present, should be made in consultation with specialist fetal growth services or fetal medicine services depending on Trust availability	Guideline in place				

Element 3: Raising awareness of reduced fetal movement							
Intervention	**Process/ outcome indicator**	**SBL Interventions**	**Target HuTH**	**Q1 HUTH**	**Target NLAG**	**Q1 SGH**	**Q1 DPOW**
3.1	N/A	Information from practitioners, accompanied by an advice leaflet (for example, RCOG or Tommy's leaflet available in multiple languages) on RFM, based on current evidence, best practice and clinical guidelines, to be available to all pregnant women by 28+0 weeks of pregnancy and FM discussed at every subsequent contact	Guideline in place				
3.2	3a)	Percentage of women who attend with RFM who have a computerised CTG	95%	100%	95%	98%	98%
	3b)	Proportion of women who attend with recurrent RFM* who had an ultrasound scan to assess fetal growth	80%	71%	80%	59%	48%
	3c)	Percentage of stillbirths which had issues associated with RFM management identified using PMRT	-	0%	-	11%	
	3d)	Induction of labour when RFM is the only indication before 39+0 weeks' gestation V3.2 update.	Guideline in place		Guideline in place		

Element 4: Effective fetal monitoring during labour							
Intervention	**Process/ outcome indicator**	**SBL Interventions**	**Target HuTH**	**Q1 HUTH**	**Target NLAG**	**Q1 SGH**	**Q1 DPOW**
4.1	4a)	Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors and situational awareness	90%	98%	90%	98%	
	4b)	Percentage of staff who have successfully completed mandatory annual competency assessment	90%	98%	90%	98%	
4.2	N/A	There is a structured risk assessment at onset of labour to determine the most appropriate fetal monitoring method - V3.2 update.	Guideline in place		Guideline in place		
4.3	4d)	The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury where failures of intrapartum monitoring are identified as a contributory factor	-	0%	-	0%	
		Regular (at least hourly) systematic review of maternal and fetal wellbeing, with a clear guideline for escalation.	Guideline in place		Guideline in place		
4.4	N/A	A separate clinical review should be undertaken to help provide an objective holistic review, for example 'Fresh Eyes'. All intrapartum CTGs at least hourly or 4 hourly fresh eye review when IA is utilised.	Guideline in place		Guideline in place		
4.5	4c)	Identify a dedicated lead midwife and lead obstetrician with expertise to focus on and champion best practice	In place				

Element 5: Reducing pre-term birth and optimising perinatal care							
Intervention	**Process/ outcome indicator**	**SBL Interventions**	**Target HuTH**	**Q1 HUTH**	**Target NLAG**	**Q1 SGH**	**Q1 DPOW**
5.1	N/A	Each provider trust should have: an Obstetric Consultant lead for preterm birth, an identified local preterm birth/perinatal optimisation Midwife Lead, a Neonatal Consultant lead and an identified Neonatal Nursing lead	-	Midwife to start	N/A	Midwife required	
5.2	5l)	Incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a) in the late second trimester (16+0 to 23+6)	<0.5%	0.2%	<0.5%	0.8%	0.4%
		b) preterm (24+0 to 36+6)	<6%	7%	<6%	10.2%	9.2%
	5k)	Percentage of PMRT cases annually where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	-	0%	N/A	0%	
	5i)	Mortality to discharge in very preterm babies. Percentage of babies born below 32 weeks gestation who die before discharge home, or 44-week post-menstrual age (whichever occurs sooner)	<6.5%	25%	6.5%	0%	0%
5.3	N/A	Assessment of all women at booking for their risk for preterm birth and stratification to pathways - Guideline in place.	Guideline in place		Guideline in place		
5.4	N/A	In the assessment of women presenting in suspected preterm labour, evaluated digital tools are now available (QUIDS, QUiPP) to improve predictive accuracy of triage and enable collaborative decision making	Guideline in place				
5.5	N/A	Networked Trusts should agree on the use of these tools within their ICS/LMNS	Guideline in place				
5.6	N/A	Risk assessment and management in multiple pregnancy should comply with NICE guidance or a variant that has been agreed with the local ICS following advice from the provider's regional maternity team	Guideline in place				
5.7	N/A	Assess smoking status (see Element 1) and implement appropriate intervention to ensure the pregnancy is smoke free before 15 weeks	Guideline in place				
5.8	N/A	Assess all women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C or an alternative which has been agreed with the local network or ICS following advice from the provider's clinical network	Guideline in place				
5.9	N/A	Symptomatic women require assessment and use of decision-assist tools for preterm birth – V3.2 update due to discontinuation of Ffn.	Guideline in place				
5.10	N/A	Assess each woman with a history of preterm birth to determine whether this was associated with placental disease and discuss prescribing aspirin with her	Guideline in place				
5.11	N/A	Test for asymptomatic bacteriuria in women who are assessed as being intermediate or high risk of preterm birth by sending off a MSU for culture and sensitivity at booking. Following any positive, repeat MSU to confirm clearance – V3.2 update.	Guideline in place				
5.12	N/A	Asymptomatic women should have access to transvaginal cervix scanning (TVCS) to assess the need for further interventions such as cervical cerclage and progesterone supplementation	Guideline in place				
5.13	N/A	Every provider should have referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories	Guideline in place				

Intervention	Process/ outcome indicator	SBL Interventions	Target HuTH	Q1 HUTH	Target NLAG	Q1 SGH	Q1 DPOW
5.14	N/A	Women identified to be at increased risk of preterm birth should be made aware of the signs/symptoms of preterm labour and encouraged to attend their local maternity unit early if these occur	Guideline in place		Guideline in place		
5.15	N/A	Ensure the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth – V3.2 update.	Guideline in place		Guideline in place		
5.16	N/A	Women identified to be potentially at increased risk of imminent preterm birth, where active survival focused care is planned, should be made aware of optimisation interventions that may be offered.	Leaflet approved		Leaflet approved		
5.17	N/A	Acute tocolysis may be used when short term delay is desirable	Guideline in place				
5.18	5a)	Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU)	80%	100%	80%	0%	0%
5.19	5b)	Percentage of babies born between 22+0 to 33+6 who receive a full course of antenatal corticosteroids within 1 week of birth – *see report for potential exceptions.*	55%	42%	55%	85%	38%
5.20	5c)	Percentage of babies being born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth	90%	67%	90%	0%	100%
	5h)	Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with brain injury: IVH grade 3 or 4 – V3.2 update.	<15%	16%	N/A	0%	0%
	5h)	Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with brain injury: cPVL – V3.2 update.	<15%	20%	N/A	0%	25% (1)
5.21	N/A	All women in preterm labour <37 weeks gestation should be offered intravenous intrapartum antibiotic prophylaxis irrespective of whether they have ruptured amniotic membranes – V3.2 update.	Guideline in place		Guideline in place		
5.22	5d)	Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth	72%	90%	72%	73%	77%
5.23	5e)	Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5– 37.5°C and measured within one hour of birth	70%	70%	70%	94%	82%
5.24	5f)	Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within the first 2 days of life	52%	63%	52%	87%	66%
5.25	N/A	For babies born <34 who need invasive ventilation, VTV should be used in combination with synchronised ventilation as the primary mode of respiratory support – V3.2 update.	Guideline in place		Guideline in place		
5.26	N/A	For <30 weeks, caffeine reduced the chance of death or disability. Caffeine citrate should be started within the first 3 days of life.	Guideline in place		Guideline in place		

Element 6: Management of Pre-existing Diabetes in Pregnancy							
Intervention	**Process/ outcome indicator**	**SBL Interventions**	**Target HuTH**	**Q1 HUTH**	**Target NLAG**	**Q1 SGH**	**Q1 DPOW**
6.1	6a)	Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one-stop clinic, providing care to pre-existing diabetes only, which routine offers MDT review and has the resource and skill set to address all antenatal care requirements.	In place		In place at SGH / DPOW in progress		
6.2	6f)	The percentage of women with type 1 who were offered a pregnancy-specific HCL system during pregnancy – V3.2 update.	45%	100%	80%	100%	100%
	6d)	Demonstrate appropriate expertise to onboard and manage pregnant women using pregnancy-specific HCL – V.3 update.	In place		In place		
6.3	6c)	Women with Type 2 diabetes should have an objective record of their blood glucose levels in hospital record and be offered alternatives (IE CGM_ if not monitoring or glycaemic targets aren't achieved.	Guideline in place				
6.4	6g)	The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women) Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups	80%	88%	80%	100%	100%
6.5	N/A	Women with diabetes and retinopathy requiring treatment during pregnancy and/or kidney impairment (CKD 2 with significant proteinuria i.e. PCR>30; or CKD 3 or more) should be managed in a regional maternal medicine centre where care can be delivered in a single MDT clinic.	Guideline in place				
6.6	N/A	Recognising the very high risk of fetal death (stillbirth rate 160 per 1,000 births) associated with diabetic ketoacidosis (DKA), all pregnant women presenting to secondary care with DKA should have ongoing multidisciplinary Consultant input and be cared for in line with the jointly agreed trust policy.	Guideline in place				

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)193

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	10 September 2026
Director Lead	Jo Ledger, Interim Group Chief Nurse
Contact Officer / Author	Yvonne McGrath. Group Director of Midwifery
Title of Report	**PMRT and Theming Report**
Executive Summary	This report provides combined assurance to the Trust Board, Maternity Safety Champions and Board-Level Safety Champions that robust processes are in place across HUTH and NLAG to identify, report, review and learn from perinatal deaths, patient safety incidents and maternity investigations in line with MBRRACE-UK, PMRT, PSIRF and Maternity Incentive Scheme (MIS) Year 8 requirements. Across both organisations, all eligible perinatal deaths were reported to MBRRACE-UK within required timescales, with PMRT reviews demonstrating effective multidisciplinary scrutiny, identification of learning, and oversight of actions. HUTH reported 30 eligible MBRRACE notifications during the MIS Year 8 period and achieved 100% compliance with the requirement to notify eligible cases within seven days. NLAG reported 7 PMRT reviewed cases during the MIS Year 8 period. Both organisations remain on track to achieve full compliance with MIS Year 8 standards. Thematic analysis incorporated learning from PMRT reviews, PSIRF investigations, MNSI reviews, local governance processes, claims data, MOSS reviews and service user feedback. The most consistent themes identified across the Humber system were: • Communication and escalation of concerns. • Documentation quality and compliance with established pathways. • Adherence to clinical policies and risk assessment processes. • Fetal monitoring, clinical interpretation and timely escalation. • Bladder care and postnatal urinary retention pathways. • Women's experience of care, particularly feeling listened to and involved in decision making. Health inequalities were a recurring feature across reviews. Women experiencing adverse outcomes were disproportionately represented from areas of greater deprivation and were more likely to have identified social vulnerabilities, safeguarding concerns, language barriers or mental health needs. These findings have informed ongoing work to strengthen personalised care, improve access to services and target interventions towards higher-risk populations. Review findings demonstrated that most cases had either no care concerns identified or issues that were unlikely to have altered the outcome. However, a small number of cases identified opportunities for improvement relating to communication, clinical decision-making, pathway adherence and multidisciplinary working. No recurring evidence of system-wide failures affecting outcomes was identified, although several themes require continued monitoring and improvement. Significant quality improvement activity is underway across both organisations, including improvements to bereavement care processes,

	fetal monitoring education, preterm birth surveillance, safeguarding assessment, bladder care pathways, escalation processes and communication systems. Learning from reviews is being embedded through multidisciplinary training, governance meetings, patient safety newsletters, simulation programmes and regional collaboration.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Maternal and Neonatal Assurance Group
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 Hospitals
NHS Foundation Trust

Family Services Division: Maternity Services

Thematic Analysis and Safety Recommendations

Quarter 1 2026/27

Date: July 2026

Author: Tracey Martin

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Executive Summary

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

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

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

The thematic review detailed within the report is based on 10 safety incidents that were published or closed during quarter 1 (9 PMRT cases and 1 MDT After Action Review). There were no eligible cases for Early Notification Reporting and no MOSS alerts during the quarter. NHSR claims scorecards are published annually, for the purposes of this report any themes, learning and recommendations from the most recent publication (October 2025) have been included for triangulation along with the local claims triangulation scorecard (Appendix 1).

Themes identified following the PMRT reviews are detailed below. Task factors were identified in the MDT/PSIRF incident but not in relation to other themes identified through the PMRT.

- Bereavement pathway documentation incomplete (task factors)
- Kleihauer bloods not being tested as per policy due to staff being unaware of the policy (staff competence & policy)
- Postnatal investigations not offered despite indication (task factor)
- Mothers not seen alone and not being asked about domestic abuse (task factor/policy).

Scope / Definition

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

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

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

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

The findings of the thematic review will be tabled at the Maternity and Neonatal Assurance Group meeting and shared with Trust Board on a quarterly basis. Where necessary it will be shared with other agencies / Commissioners to enable wider systemic learning in line with the Patient Safety Incident Response Framework (PSIRF) principles.

Background

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

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

All perinatal and neonatal deaths are subjected to early MDT rapid review to identify immediate learning and further reviewed in line with the National PMRT process. Of the 10 incidents detailed in the report, 9 relate to PMRT (6 declared at NLaG and 3 declared externally) and 1 incident related to an MDT review. The external reviews are part of a joint PMRT review process with actions and themes identified accordingly.

Investigation Process and Methodology

The process was based on the following methodology:

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

This process was supported by the following:

- Review of medical records (electronic and paper records)
- Patient experience conversations/reflections of their care experience
- Consultation with external fetal medicine consultant and external neonatologist)
- Input/views from Maternity and Neonatal Voice Partnership Lead (MNVP).

Analysis

Safety incidents during quarter 1 were reviewed and scored by the Patient Safety Midwife for Maternity Services using the attached data collection tool in Microsoft Excel to identify recurrent themes across all incidents.

Patient Safety Events Included in this Review

NLAG Worksheet - Thematic Review Tem

Date	Incident Reference	Level of Harm Reported & Grading	Ethnicity IMD Decile	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result
05/05/26	102342	No Harm – A/A	White British / 4	Antepartum stillbirth at 35+6 weeks gestation	Rapid Review/PMRT	Escalation required to pathology to ensure Kleihauer bloods are tested as per policy. Discussion with transfusion nurse specialist to confirm Kleihauer bloods are required, Reminders and discussions to the pathology team have been undertaken.
18/05/26	102001	No Harm – B/B	White British / 8	Antepartum stillbirth at 38+5 weeks gestation	Rapid Review/PMRT	Reminder to be given to staff via PMRT newsletter relating to: • Appropriate use of risk assessment checklists • Offering infection screening for mother and baby • Offering postnatal investigations where indicated. Feedback provided to clinician involved regarding Badgernet documentation and publishing entries on the system.

Date	Incident Reference	Level of Harm Reported & Grading	Ethnicity IMD Decile	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result
02/04/26	101307	No Harm – B/A	White British / 2	Antepartum stillbirth at 35+6 weeks gestation	Rapid Review/PMRT	Learning lessons have been disseminated and included on Obstetric and Maternity huddles (relating to management of preterm labour, action when infection markers are raised, correct use of Dawes Redman). Clinical guidelines have been circulated for all staff to refamiliarise themselves. Scans reviewed by Radiology team to assess if within 20% margin as baby was small for gestational age at birth but not identified as IUGR. No concerns following review.
02/04/26	100801	No Harm – B/A	White British / 7	Antepartum stillbirth at 29+5 weeks gestation	Rapid Review, Learning Response Panel & currently MNSI/PMRT	Discussion with community managers to provide education to community midwives regarding correct level of care for women. Inclusion of bereavement pathway documentation on mandatory training study week (MDT). Explore reinstating bereavement safety champions in clinical areas.
13/04/26	101451	No Harm – A/A	White British / 3	Antepartum stillbirth at 25+0 weeks gestation	Rapid Review/PMRT	No issues or actions identified.
28/04/26	102812	No Harm – C/A	White British / 4	Neonatal Death at 25+2 (external)	Rapid Review/PMRT	External Neonatologist discussion around obstetric training in scanning for fetal heart anomalies identified that region wide training is required to support diagnosis of true fetal distress or branch block.

Date	Incident Reference	Level of Harm Reported & Grading	Ethnicity IMD Decile	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result
09/06/26	102505	No Harm - A	Pakistani / 7	Neonatal Death at 23+4 (external)	Rapid Review/PMRT	No issues or actions identified for NLAG.
09/06/24	102460	No Harm – A/B	White British / 1	Antepartum stillbirth at 25+3 weeks gestation	Rapid Review/PMRT	No issues or actions identified for NLAG.
09/02/26	102412	No Harm - A	White British / 1	Neonatal Death at 23+6 (external)	Rapid Review/PMRT	No issues identified. However it was identified that the mother was not asked about domestic abuse as she was seen remotely and was not alone.
04/11/25	358674	Moderate	White Other (Slovakian) / 1	Attended category 1 LSCS for APH at 34+5 weeks. In-utero transfer from Sheffield. Paediatric registrar scrubbed at the theatre table. Baby born and placed in a neo-help bag on the theatre table, baby lifted off the table by the registrar and dropped to the floor. Immediate call for paeds consultant made and neonatal resuscitation commenced. Baby very pale, no respiration and heart rate >100.	Rapid Review / MDT Review / PSIRF Oversight Meeting	Resuscitaires will be stationed at the end of the theatre table. • Education provided by way of videos to staff and • a SIM. • Use of 3 metre oxygen and air piping, to reduce • potential trip hazards. • Discussion with all Paediatricians who attend • Caesarean Sections to remind them of the importance of getting a safe hold of the baby prior to transferring them to the resuscitaire. • Any locum Paediatricians to be informed at their • induction of the Trust's specific expectations of tasks and procedures relating to receiving the baby at Caesarean Section.

Findings

It has been identified through the thematic review of the 10 eligible cases from Q1 that the main theme relates to task factors (policies not being followed, documentation not completed appropriately and staff education).

Areas for improvement:

- Please refer to the above table and local claims scorecard triangulation for action being taken.

IMD and Ethnicity
8 of the women/birthing people were White British ethnicity and 7 were from an area of less than 5 on the IMDD.

Themes identified through incident reporting
During quarter 1 there has also been a notable increase in the number of incidents reported relating to inappropriate bladder care and bladder injuries at both DPOW and SGH. A review of all incidents is being undertaken to identify any themes.

Service User Feedback
The top theme identified from service user feedback via the Maternity and Neonatal Voice Partnership (MNVP) and complaints continues to relate to women feeling they are not being listened to.

Incident Reporting – Communication issues
During the quarter there were 4 incidents reported on Ulysess where the cause was "communication failure from staff to patient/parent/carer". 1 incident related to language barriers and not able to get an interpreter via language line. No themes were identified and the actual impact to patients/families were either no harm or low harm.

Review of 2024/2025 Annual Maternity Claims Scorecard

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

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

- At least one case demonstrates risks associated with operator competence and inadequate senior supervision during complex obstetric procedures.

Safety Recommendations

For local safety recommendations/actions being taken please refer to the table detailed on pages 5 to 7 and the local claims triangulation scorecard (Appendix 1).

Annual Maternity Claims Scorecard - Recommendations

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

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

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

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

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

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

Supporting Documents

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

Appendix 1 – NLAG Claims Q1 26/27 Claims Scorecard

Northern Lincolnshire and Goole NHS Foundation Trust - Maternity Incentive Scheme, Quarter 1 2026/27

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 Q1 26/27

Information not available.

Incidents Q1 26/27

Top 5 incidents by volume:

- Staffing levels affecting patient care (59)
- In utero transfer (26)
- Delay in treatment or procedure (24)
- PPH - over 1500mls (22)
- Delay in induction of labour (21)

Number of incidents reported on Ulysses for Obstetrics / Maternity: **549**

Complaints Q1 26/27

There have been 10 new complaints (6 DPOW / 4 SGH) received relating to the following categories:

- 1 Clinical care and documentation
- 1 Clinical care
- 4 Clinical treatment
- 2 Clinical care and treatment
- 1 Communication
- 1 Medication error

Clinical Audits Registered Q1 26/27

- Saving Babies' Lives Q1 (Elements 1 – 6)
- Evaluation of use of STV in antenatal CTG DPOW & SGH
- Fetal Monitoring Quality Audit
- National Audit of Postnatal VTE
- WHO Checklist Audit
- Enhanced Recovery after Caesarean Section

Deep Dive Reviews Q1 26/27

In progress:

- Postpartum Haemorrhage (>1500mls) following an increase at SGH.
- ATAIN (TWD)
- Induction of Labour
- Preterm birth
- Bladder care / bladder injury

Learning Q1 26/27

- Increase in the number of incidents reported relating to inappropriate bladder care and bladder injuries at both DPOW and SGH identified.
- Feedback continues to be received from women and families through complaints and MNVP regarding communication concerns and not feeling listened to.
- Preterm birth deep dive early findings indicate that deliveries are planned, particularly for women with diabetes in pregnancy.
- PPH review is still underway but early learning at SGH indicates work is required to improve documentation of fluid balance.
- The number of term admissions to NICU relating to hypothermia is an emerging trend specifically at DPoW and has been escalated to the Trust Head of Midwifery by the ATAIN review team. Reviews suggest contributory modifiable factors include estates (room temperatures), adherence to the warm care bundle, staffing factors, parent education and documentation of thermoregulation management of babies.
- Reduced antenatal scan capacity remains an issue, impacting SBL element 3 compliance for women attending with RRFM. Risk added to risk register.

Themes Q1 26/27

- MNVP feedback, Bereavement Midwife feedback, incidents and complaints continue to indicate women feel they are not being listened to.
- Triangulation of incident and early deep dive data from the PPH review has identified incomplete documentation and management of fluid balance.
- Bereavement documentation checklists not completed appropriately.
- Findings from ATAIN reviews are consistent with previous findings, highlighting respiratory distress as a trend. Most ATAIN cases involve babies requiring oxygen support to maintain adequate oxygen saturation levels.

Action Plan Q1 26/27	Not started / In progress / Complete
Review of all bladder injuries to be undertaken (Trustwide) to circumstances and management of each case.	01 September 2026
Bladder care task and finish group to be established	First meeting took place 15/07/26
Bladder training already embedded into mandatory training weeks cross site and ad hoc sessions already put on for staff to access.	In place and ongoing
Pelvic health champions (x 2 at DPOW and 1 at SGH) identified – x2 booked on training already, to book the others.	In place and ongoing
Review of Triage staffing levels to be undertaken by Director of Midwifery / Head of Midwifery	01 September 2026
A new maternity forum taking place where ATAIN cases will be taken to share learning re: counselling mode of delivery when EFW is 90th centile	In place and ongoing
A monthly Learning from ATAIN memo is circulated to staff highlighting a selected case where there is a particular area of learning that addresses a theme/trend.	In place and ongoing
MNVP Ceasing on 31/07/2026. Regional conversation about future of MNVP ongoing. Patient Engagement Lead Midwife now appointed. Plan to expand Ask a Midwife and further develop actions and strategies to ensure the voices of women and families are heard.	30 September 2026
Bereavement documentation updated and PMRT process amended for women and families to provide feedback/ask questions.	Complete

Appendix 2 – Sample Data Collection Template

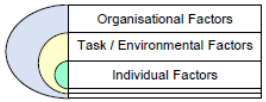
Patient Safety Incident Reference									Recurrence of theme across all incidents	Were any of these factors identified as an area of good practice? (Y/N - if Y, make a note of good practice as evidence for the report)
Contributory and Mitigating Factors - score 1 if they apply										
Domain	Components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

Appendix 3 – PSIRF Contributory & Mitigating Factors Classification

NHS

Patient Safety Incident Response Framework

Contributory and mitigating factors classification – Print only in A3



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

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

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

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

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

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

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

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

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

NHS
Hull University Teaching Hospitals
NHS Trust

Family Services Division: Maternity Services

Thematic Analysis and Safety Recommendations

Quarter 1 2026/27

Date: August 2026

Author: Matthew Proctor

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Executive Summary

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

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

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

The thematic review detailed within the report is based on 226 safety incidents that occurred during quarter 1, consisting of 2 new MNSI, 10 new PMRT, 2 ongoing PSIRF MDT reviews; 3 thematic reviews completed reviewing 212 incidents (ATAIN, low cord gases and late pre-term admissions).

There were 3 eligible cases for a MOSS review, and the amber alert was completed. NHSR claims scorecards are published annually, in lieu of the latest report, the quarter 1 scorecard (Appendix 3) will be used for the purposes of this report.

Scope / Definition

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

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

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

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

Background

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

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

Investigation Process and Methodology

To systematically identify, review, and learn from themes emerging in patient care through incident reporting, ensuring continuous quality improvement and patient-centred care, the following is utilised:

- **Patient-centred approach:** Patient experience and outcomes are central to all reviews
- **Open safety culture:** Psychological safety enabling staff to speak openly about concerns
- **Twice-weekly MDT review meetings:** Inclusive participation from all relevant professions
- **Learning over blame:** Focus on system improvement rather than individual fault
- **Evidence-informed practice:** Guided by national and local policies and best practice**:**
  used to identify cases for MDT thematic review. Examples include:
  Patient safety incidents (moderate to severe harm)
  Near misses with learning potential
  Recurrent themes (e.g., postnatal readmissions, medication errors, birth injuries)
  Delayed care, missed diagnoses, or deterioration events
  Safeguarding concerns
  Complaints or significant patient feedback
  Staff concerns raised through open-door channels
- **Supporting staff collate relevant information including:**
  Clinical records
  Incident reports
  Staff interviews
  Patient and family feedback
  Input/views from Maternity and Neonatal Voice Partnership Lead (MNVP).
  Policies and standards applicable to the case
  Alignment to current national and local guidance is identified
  Cases are anonymised where appropriate

Analysis

Safety incidents during quarter 1 were reviewed and scored by the Quality and Safety Maternity Matron identifying recurrent themes across all incidents.

Patient Safety Events Included in this Review

Date	Incident Reference	Level of Harm Reported	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result of any Previous Review
02/04/2026	MI-056540 PMRT 103182	Moderate	Unbooked intrapartum stillbirth (LMP 42+5) Awaiting formal diagnosis of learning disability	• Local MDT review • MOSS • Awaiting PMRT	• Escalation from MNSI regarding concerns about care to A&E leads and governance team
14/05/2026	MI-059599 PMRT 103769	Moderate	Early NND following meconium aspiration syndrome	• Local MDT review • ATAIN • MOSS • Awaiting PMRT	• Fetal monitoring led teaching on the importance of timely CTG reviews and documentation • Communication issues identified and this has been fed back to the local fetal medicine teams.
10/04/2026	PMRT 103272	No Harm	Delivered at Bassetlaw hospital at 33+1. Transferred to HUTH NICU and care re-orientated.	• Awaiting shared PMRT	• N/A
13/04/2026	PMRT 103278	Low Harm	35+4 antenatal still birth. Attended with reduced fetal movements.	• Local MDT review • Awaiting PMRT	• Learning shared with all staff regarding making each contact count and explore DNA's
12/04/2026	PMRT 103310	Low Harm	Unbooked pregnancy. 15 years of age. Non-English speaking. Concerns regarding trafficking.	• Local MDT review • Safeguarding review • SWARM with A&E	• A&E equipment and environment reviewed • Obstetric additional equipment 'grab bag' being created

Date	Incident Reference	Level of Harm Reported	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result of any Previous Review
23/04/2026	PMRT 103470	No Harm	35+1 antenatal stillbirth. Attended with reduced fetal movements.	• Local MDT review • Awaiting PMRT	• Diabetic team to review process of why the glucose tolerance test did not occur and to review their pathway. • Labour ward communication regarding the importance of timely partogram completion
26/04/2026	PMRT 103471	No Harm	34+3 antenatal still birth. Attended with reduced fetal movements	• Local MDT review • Awaiting PMRT	• Learning shared regarding pre-term birth surveillance clinic HUTH inclusion criteria (multiple fibroids) • 'White coat' syndrome and confirmation bias shared with staff due to the patient's profession. • Exploration of how non-obstetric settings close the loop with our service • Images reviewed independently as baby unexpectedly born < 10th centile
20/04/2026	PMRT 103686	Low Harm	Attended triage with reduced fetal movements with an abnormal antenatal CTG at 28+6. Category 1 emergency caesarean delivery. NND day 20.	• Local MDT review • Awaiting PMRT	• N/A
04/06/2026	PMRT 104059	Moderate	Neonatal death 31+4 following unsuccessful resuscitation. Known multiple congenital abnormalities. Undiagnosed bony malformation of the skull identified at birth.	• Local MDT review • Awaiting PMRT	• Engagement with Leeds FMU lead and review of images via MDT • Communication issues identified and this has been fed back to the local fetal medicine teams. • Interim debrief planned

Date	Incident Reference	Level of Harm Reported	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result of any Previous Review
16/06/2026	104245	No Harm	20-day old baby attended A&E via 999 ambulances having been found in the parent's bed with no signs of life.	• Local review • ATAIN • CDOP • MOSS	• Review of safe sleep advice and assurance of process • CDOP JAR completed
Q1	-	-	Late pre-term delivery thematic review of pre-term delivery (152 admissions)	• Perinatal forum education • MNIG • Local Governance meeting	• In findings of report
Q1	-	-	ATAIN Q1 (55 admissions)	• Perinatal forum education • MNIG • MNAG • Local Governance meeting	• In findings of report
Q1	-	-	Low cord gas thematic review (5 deliveries)	• Perinatal forum education • MNIG • Local Governance meeting	• In findings of report
11/05/2026	430865	Moderate	Bladder dome injury and day 3 identification of ureteric injury	• Local MDT review • LRP review • MDT review (PSIRF)	• Urology and Obstetric MDT review planned to design and embed a standardised communication and escalation pathway

Date	Incident Reference	Level of Harm Reported	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result of any Previous Review
04/06/2026	434429	Moderate	Urinary retention and non-adherence to pathways	• Local MDT review • LRP review • MDT review (PSIRF)	• Pan-group guidance now in place to provide consistency of information and pathways • Education and communication strategy being developed to embed to all midwives and obstetric staff 'VESSI' principles • Referral and service review by the physiotherapy lead • Exploration of digital prompts on the EPR system
16/07/2026	441184	Moderate	Urinary retention and non-adherence to pathways	• PALS pathway • Inclusion in MDT review (PSIRF)	• Pan-group guidance now in place to provide consistency of information and pathways • Education and communication strategy being developed to embed to all midwives and obstetric staff 'VESSI' principles • Referral and service review by the physiotherapy lead • Exploration of digital prompts in the EPR

Findings

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

Bladder care

Within quarter 1, 3 incidents occurred regarding bladder care/injury identified following delivery. These incidents have demonstrated a confusion with local guidance and a lack of standardised escalation or communication pathways. This has been identified during the PSIRF MDT response meetings held and subsequent actions on improving and embedding MDT understanding of VESII principles are being developed. These will be approved via PSIRF panel meeting and local governance processes.

ATAIN

There has been a sustained increase in neonatal admissions within quarter 1. Although under national targets of 6% (4.95%), continue to be reviewed thematically with low cord gas, or any other severe outcome are individually reviewed within an MDT forum.

Moderately raised lactate results (4-8) are often early indicators of potential admissions. There are no current concerns with the management and review of these.

3 admissions were directly related to meconium aspiration syndrome and persistent pulmonary hypertension. Statistically meconium is present in 20% of all labours, highlighting the unpredictable nature of the meconium.

There has been a steady rise in the performance of emergency 'non labouring' caesarean sections (78%), this will be indirectly and directly affecting admission rates due to an increased delay in the physiological adaptation to life; the opportunity to consider steroid optimisation in emergency admissions under 39 weeks gestation (i.e. with an abnormal CTG following reduced fetal movements).

The highest number of admissions are to families from the HU8, HU9 and HU17 postcodes. These admissions are also triangulated with presentation of reduced fetal movements. This, with the MOSS alert, initiated a more detailed look into the perinatal inequalities and demographics of our users.

- **Communication was the most consistent theme identified across reviews. Recurring issues included:**
    - Inconsistent clinical messaging
    - Documentation omissions
    - Delayed escalation of concerns
    - Variable interpretation and communication of clinical findings
    - Patient uncertainty regarding when to seek help
- **Ethnicity of women reviewed:**
    - White British: 71%
    - Black African: 19%
    - Other White Background: 6%
    - Pakistani: 3%

- **Analysis demonstrated that approximately 74% of reviewed cases involved women living within the more deprived Index of Multiple Deprivation (IMD) deciles.**
    - 32% of reviewed cases involved women with identified social vulnerabilities. Common factors included:
    - Limited support networks
    - Recent migration to the UK
    - Safeguarding concerns
    - Financial hardship
    - Increased reliance on community support services
- **39% of reviewed women had identified perinatal mental health needs. Recurring themes included:**
    - High levels of anxiety
    - Frequent attendances for reassurance
    - Increased need for continuity and consistent communication
    - Concerns regarding understanding of care plans
- **16% of reviewed women had a recognised disability or additional support need. Positive examples of care included:**
    - Autism-informed communication strategies
    - Trauma-informed approaches
    - Adaptation of environments and care processes
    - Inclusion of partners and support networks

Pre-term birth summary

Since MIS year 7, the organisation has thematically monitored the late pre-term (34-36+6) admissions to the neonatal unit. There is no national target for this but for quarter 1 it is 3.78% (42 admissions compared with 32 in Q1 2025-2026).

152 admissions were admitted and the findings were similar to the ATAIN review findings. There was a concentrated admission postcode of the HU7, HU3, HU9 and HU5 districts.

Women experiencing late preterm birth were disproportionately represented from areas of higher deprivation, suggesting a strong association between socioeconomic factors and preterm birth risk. Recurring themes included smoking during pregnancy, previous obstetric complications, and recognised preterm birth risk factors.

The review is advising HUTH develop of a focused public health and maternity strategy within identified postcode hotspots with strengthened collaborative working, with local authority and community services, to address wider determinants of health.

Moreover, it is recommended to further strengthen the smoking cessation support pathways with earlier intervention, routine follow-up and targeted outreach to high-risk groups. Although this is in progress, there are still high levels of smoking reported.

Finally, it is recommended to improve compliance with the Preterm Birth Pathway through standardised documentation and clinical prompts will be aiding by a pre-term birth specialist midwife to centrally lead and co-ordinate care (now in post).

MOSS

The MOSS amber alert was completed and led by the Head of Midwifery and followed both the NHS England methodology and the locally approved SOP.

The main finding requiring further surveillance was the adherence and mitigation of emergency section timings. To aid this, it has been added to the maternity dashboard to maintain oversight and prompt timely actions as required.

AMAT registered PLGF QI

The PLGF QI aim was to improve compliance with NICE PLGF recommended testing, understanding and utilising human factor ergonomics to improve compliance in a statistically significant manner. Base line of the preceding months was 125 tests performed (mean), aiming to improve this by 30% within 4 months.

The focus was on targeted obstetric and midwifery education, reinstatement of e-learning and regular shop floor teaching sessions. The change has focused on human factors and challenging existing knowledge of why certain investigations are performed (i.e. blood pressure series etc). HUTH have also focused more on education reinforcement of pre-eclampsia as a placental dysfunction, with earlier consideration with early onset growth restriction now being considered.

There is an unintended consequence of this improvement, the trust must ensure the continuation to only recommended PLGF in line with local and NICE guidance. This is being audited due to remain cost effective in the use of the test.

The success of this project reinforces the need for continued education and surveillance with a rotational staff base.

Data demonstrates a 72% increase in testing directly following this QI project (Launched January), mean weekly rate 50.1 (SD +/- 8.8). This continues to be monitored.

Learning from 2026/2027 NHS resolution Quarter 1 scorecard (appendix 3)

Within quarter 1, the top 5 incidents by volume are:

- Unexpected admission to NICU/Term admission – 68
- Postnatal readmission – 22
- PPH >1500ml – 21
- Communication failure between departments – 18
- Delays or missed care >60 mins – 11

Number of incidents reported on Ulysses for Obstetrics / Maternity: 255

These have demonstrated further thematic learning of:

- Emergency caesarean section timings reviewed in MOSS alert – ongoing oversight and monitoring
- Sepsis tool on badgernet has inconsistent use. This has been a point of education from the patient safety team.
- Improved safeguarding professional curiosity and escalation
- MOH (>2000ml) incorporated into existing MDT review format (NHSE maternal care bundle requirement) – rate is below national average.
- Increased (3) meconium aspiration related PPHN – highlights unpredictable nature of meconium. Occurs in 20% of all labours.

Safety Recommendations

MNSI

- All learning and action plans are first agreed at local governance processes prior to PSIRF closure.
- Reports and safety recommendations are shared with all obstetric and midwifery staff via the monthly patient safety newsletter
- Action plans are monitored monthly within the maternity patient safety team.
- All action plans/safety recommendations are added to the incident reporting system.
- **Staff aware to dial 9999** – communication strategy and poster in all clinical areas to remind staff to dial 9 for an outside line prior to 999 if requesting an ambulance.
- **Staff to be supported in transfer to theatre from the MLU/Labour ward when a fetal heart cannot be located** – Simulation training is planned to embed this recommendation.
- **BSOTs oversight –** Ongoing improvement project and audit. Has MNAG and MNIG oversight.
- **Attendance in A&E -** guidance now approved and incorporates MEWS into it and escalation pathways.
- **Digital system** – Education via the PROMPT agenda highlights and enables discussion of the system barriers and education as to why '0' was not inputted in relation to the fetal heart value.

PSIRF responses

- All learning and action plans are first agreed at local governance processes prior to PSIRF closure.
- All action plans/safety recommendations are added to the incident reporting system.
- Reports and safety recommendations are shared with all obstetric and midwifery staff via the monthly patient safety newsletter
- Action plans are monitored monthly within the maternity patient safety team
- These are ongoing within the quarter

PMRT

- All graded C/D are escalated to the learning response panel for transparency and discussion if further learning responses may be indicated.
- Action plans are monitored monthly within the maternity patient safety team.
- All action plans/safety recommendations are added to the incident reporting system.
- **Pre-term birth surveillance process –** Communication strategy developed and implemented by the patient safety team.
- **Referrals to the bereavement service –** The early pregnancy team and the clinical leads have been made aware of the importance of early referrals for the maternity bereavement team.
- **Completed PLGF QI project –** will continue to be thematically observed
- **Intrapartum CTG <26/40 –** Humber health partnership approved position statement clarifying roles and responsibilities has been approved in lieu of national/international evidence-based practice within labour.

Supporting Documents

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

Appendix 1 - SEIPS Worksheet: Safety Investigations & Learning Reviews

Work System Design Facilitators & Barriers

External Influences
- Ockenden and Amos reports

Environment
- N/A

Organisation
- Staffing

People
- Badgernet education
- IMDD/Deprivation of service users

Tasks
- Toolkits not being utilised
- Bladder care not standardised

Equipment
- N/A

Process

Work Processes

- Badgernet education did not cover the lowest recordable heartrate they could documented.
- Toolkits not utilised in sepsis management.
- IMDD/Deprivation of service users
- Bladder care principles and policy alignment.

Outcomes

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

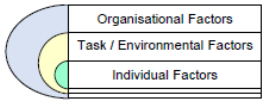
- Led to an inaccurate documentation of a fetal heart when one wasn't present.
- Unable to audit sepsis management accurately
- IMDD/Deprivation of service users linked to poorer obstetric outcomes
- Lack of standardised approach leads to lack of standardised processes and education.

Appendix 2 – PSIRF Contributory & Mitigating Factors Classification

NHS

Patient Safety Incident Response Framework

Contributory and mitigating factors classification – Print only in A3



External context factors	Components
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Societal factors	• Values • Beliefs

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

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

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

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

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

The process was based on the following methodology:

- Gathered all relevant evidence
- Established the factual circumstances surrounding each event
- Analysed the evidence
- Identified the most significant safety factors and safety issues that contributed to the event being investigated
- Formulated findings and safety recommendations
- Consultation with a subject specialist (e.g., external consultant, MNSI)

Appendix 3 – Quarter 1 Claims score card

Hull University Teaching Hospital - Maternity Incentive Scheme (SA C) Quarter 1 2026/27

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

NHS Humber Health Partnership

Claims Scorecard 01 April 2015 – 31 March 2025 (84 claims)	
Top injuries by volume: 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 Q1 26/27

Requested but not available

Incidents Q1 26/27

Top 5 incident by volume:

- Unexpected admission to NICU/Term admission – 68
- Postnatal readmission – 22
- PPH >1500ml – 21
- Communication failure between departments – 18
- Delays or missed care >60 mins – 11

Number of incidents reported on Ulysses for Obstetrics / Maternity: 255

Complaints Q1 26/27

There have been 7 new complaints received relating to the following

- Concerns with care provision
- Concerns regarding communication
- Concerns with delays in care

Clinical Audits Registered Q1 26/27

- (HUTH) – Saving Babies' Lives – Elements 1-6
- (HUTH) Adherence to Sepsis Screening on the Labour Ward
- (HUTH) Re-audit of Consultant attendance in Clinical Situations – Obstetrics
- (HUTH) Re-audit of Spot Check WHO Checklist

Deep Dive Reviews Q1 26/27

- Low cord gas thematic review completed – no actions
- ATAIN review highlighting more prevalence within 3 postcodes and associated RFM
- MOSS review completed – 3-month requirement of data/information range (No actions)

Learning Q1 26/27
• Emergency caesarean section timings reviewed in MOSS alert – ongoing oversight and monitoring • Sepsis tool on badgernet has inconsistent use – learning shared • Improved safeguarding professional curiosity and escalation • MOH (>2000ml) incorporated into existing MDT review format (NHSE maternal care bundle requirement) – rate is below national average. • Increased (3) meconium aspiration related PPHN – highlights unpredictable nature of meconium. Occurs in 20% of all labours.

Themes Q1 26/27
• Q1 ATAIN 4.95% (target <6%) • 78% of admissions to the NICU are from emergency caesarean sections with an increase in non-labouring emergencies • MOSS alert triggered due to term stillbirths and neonatal deaths within 28 days. Process led by HUTH HoM. • Bladder care post delivery

Action Plan Q1 26/27	Not started / In progress / Complete	
Quality Improvement project to be registered regarding Hypertension and PLGF	April 2026	
Pre-term optimisation thematic review commenced	June 2026	

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Humber Health
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FAMILY SERVICES DIVISION

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - MIS Year 8, Safety Action C

National Perinatal Mortality Review Tool (PMRT)

NLAG Quarterly Report (Quarter 1 2026/27)

Yvonne McGrath
Group Director of Midwifery – Family Services Care Group

July 2026

1. INTRODUCTION

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

1.1 MBRRACE-UK reporting requirements and PMRT support:

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

2. STANDARDS

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

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Standard
a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	**100%**
b) All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**95%**
c.i) Multi-disciplinary PMRT reviews should be started within two months of the death.	**95%**
c.ii) A multidisciplinary PMRT should be completed within six months of the death of a baby.	**75%**
d) An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	**60%**
e) Quarterly reports should be submitted to the Trust Board to include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	**100%**

3. SUMMARY

3.1 Eligible Incidents

There has been a total of 9 incidents reported to MBRRACE-UK via the PMRT between the 01 December 2025 and the 30th June 2026:

Quarter	Eligible for full CNST Assessment	Eligible for notification only	Not eligible as baby still alive
December 2025	0	0	0
Q4 (01 Jan – 31 Mar 26)	4	0	0
Q1 (01 Apr – 30 Jun 26)	3	2	0
Total	**7**	**2**	**0**

Of the 9 incidents, 7 were eligible for review and full assessment against CNST standards and 2 cases were reported to MBRRACE but were for notification only (1 termination of pregnancy, 1 neonatal death at 21 weeks) and therefore not eligible for full assessment against CNST standards or review.

Of the 7 perinatal deaths, 1 self-referred (did not meet reporting criteria) to Maternity and Neonatal Safety Investigation (MNSI) and was accepted for investigation.

In addition, please note there are 6 further cases reported to MBRRACE where the deaths occurred at other Trusts but NLAG contributed to the care of the mother and/or baby. It is the responsibility of the other Trusts to complete the PMRT process with joint input from NLAG.

3.2 Summary of all incidents reviewed through PMRT in Quarter 1 2026/27 (Appendix B)

There have been 9 incidents reviewed through the PMRT process, 6 where the death occurred at NLAG and 3 where the deaths 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 9 cases are as follows:

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

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

- 1 case had no issues identified that would have had an impact on the outcome
- 0 case had issues identified that would have had no impact on the outcome
- 0 case 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>

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

- 2 cases had issues identified that would not have had an impact on the outcome
- 0 cases had issues identified that may have had a difference to the outcome.

3.3 CNST Compliance as per MIS Year 8 Standards (Appendix C)

The Trust achieved full compliance for cases reported in MIS year 8. 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 E of the MIS, the Trust must demonstrate implementation of all elements of the Saving Babies' Lives Care Bundle Version 3.2. 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
Q4 25/26	102786	Antepartum stillbirth	24+1	10/03/26	10/03/26	650g	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Not yet met	Yes
	102460	Antepartum stillbirth	25+3	12/04/26	12/04/26	200g	SGH	SGH	SGH	Yes	No	Yes	Yes	Yes	Yes
	102342	Antepartum stillbirth	35+6	02/02/26	02/02/26	2710g	Out of country transfer to DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Yes	Yes
	102001	Antepartum stillbirth	38+5	09/01/26	09/01/26	3260g	SGH	SGH	SGH	Yes	No	Yes	Yes	Not yet met	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 26/27	104382	Late fetal loss	22+3	19/06/26	19/06/26	235g	SGH	SGH	SGH	Not yet met	No	Yes	Not yet met	Not yet met	Not yet met
	103970	Neonatal death	37+0	27/05/26	27/05/26	2080g	SGH	SGH	SGH	Not yet met	No	Yes	Yes	Not yet met	Not yet met
	103450	Antepartum stillbirth	32+5	23/04/26	23/04/26	1810g	SGH	SGH	SGH	Yes	No	Yes	Yes	Not yet met	Not yet met

Appendix B – Summary of all incidents reviewed through PMRT in Q1 of 2026/2027

Case	Cause of Death	Grading of Care	Mother's ethnicity/ IMDD	Issues Identified	Actions	External representative present at MDT PMRT / contributed	Discussed at Learning Response Panel?
102342	Antepartum stillbirth	A/A	White British / 4	mother did not have Kleihauer test despite it being requested.	Escalation required to pathology to ensure Kleihauer bloods are tested as per policy. Discussion with transfusion nurse specialist to confirm Kleihauer bloods are required, Reminders and discussions to the pathology team have been undertaken.	Yes Contributed and agreed with the grading of care	N/A
102001	Antepartum stillbirth	B/B	White Irish / 8	At first presentation with reduced fetal movements this mother was not appropriately risk assessed (checklist not used). Although indicated this mother was not offered infection screening for herself and her baby. Although indicated this mother was not offered appropriate postnatal investigations for underlying metabolic and/or haematological abnormalities.	Reminder to be given to staff via PMRT newsletter. Badger entries not published on the system – feedback to be provided to clinician involved.	Yes Discussions and questions raised for guidance around pre-eclampsia. Contributed and agreed with the grading of care	N/A
101307	Antepartum stillbirth	B/A	White British / 1	Missed opportunity to intervene earlier for preterm labour. Raised infection markers not acted upon. Incorrect use of Dawes Redman. The baby was small for gestational age at birth, scans were indicated and performed but the baby was not identified as IUGR. Although indicated this mother was not offered further postnatal investigations for herself and/or her baby (mum declined all PN support and follow up).	Learning lessons have been disseminated and included on Obstetric and Maternity huddles, DCG190 has been circulated for all staff to refamiliarise themselves. Scans have been reviewed, no concerns with growth noted and within 20% margin.	Yes Contributed and agreed with the grading of care	N/A

100801	Antepartum stillbirth	B/A	White British / 7	This mother has a history of thrombosis which was not managed appropriately in her pregnancy. This mother has a history of Genital Herpes, PN DVT and her antenatal care was not appropriate given this history. Cherished care pathway not fully completed, therefore it is not possible to tell from the notes if: • the parents were offered the opportunity to exercise their religious/spiritual/cultural wishes • if the parents were told where their baby was being taken to and why when he/she was taken to the mortuary • if the parents were offered the opportunity to take their baby home.	Reminder to be added to the PMRT newsletter. Community managers to discuss at next Team meeting. For inclusion on Mandatory training week. Explore reinstating bereavement safety champions.	Yes Contributed and agreed with the grading of care	N/A
101451	Antepartum stillbirth	A/A	White British / 4	No issues or actions.	N/A	Yes Contributed and agreed with the grading of care	N/A
102812 (External)	Neonatal Death	C/A	White British / 3	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.	For inclusion in the PMRT newsletter. To address in Team meetings with managers. ? community It has been identified that region wide training is required to support diagnosis of true fetal distress or branch block.	Yes External Neonatologist attend, discussion around obstetric training in scanning for fetal heart anomalies. Contributed with grading of care	N/A Acted appropriately within the scope of practice as discussed at rapid review.

102505 (External)	Neonatal Death	A	Pakistani / 7	Mother and baby received shared care with other Trusts. No issues identified for NLAG. Action plan in place for other Trusts involved.	N/A	Yes Contributed and agreed with the grading of care	N/A
102460	Antepartum stillbirth	A/B	White British / 2	The baby had to be transferred elsewhere for the post-mortem (do not perform post-mortem at NLAG). Bereavement care - the parents were not provided with written support information around emotional issues before they left hospital – **offered but declined by parents.**	N/A	Yes Contributed and agreed with the grading of care	N/A
102412 (External)	Neonatal Death	A	White British / 1	It was not possible to ask this mother about domestic abuse at booking as she was seen remotely and was not alone.	Reminder to Community staff to seek the opportunity to ask about domestic abuse at all appointments.	Yes Contributed and agreed with the grading of care	N/A

Grading of care
Stillbirth:

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

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

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

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

Neonatal death:

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

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

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

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

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

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

Appendix C – Summary of CNST

Compliance as per MIS Year 8 standards (01/12/25 – 30/06/26)

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Dec 25	Q4 Jan – Mar 26	Q1 Apr – Jun 26	Q2 Jul – Sep 26	Q3 Oct – Dec 26
Have all eligible perinatal deaths from 1 December 2025 onwards been notified to MBRRACE-UK within seven working days?	100%	N/A	4/4 (100%)	5/5 (100%)		
Cases applicable for PMRT review are applicable to the following standards (n=7)						
For at least 95% of all deaths of babies who died in your Trust from 1 December 2025, were parents' perspectives of care sought and were they given the opportunity to raise questions?	95%	N/A	4/4 (100%)	1/1 (100%) 2 not yet met – in 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 2025 been started within two months of each death?	95%	N/A	4/4 (100%)	2/2 (100%) 1 not yet met – in timeframe		
Multi-disciplinary reviews should be published within six months of the death.	75%	N/A	2/2 (100%) 2 not yet met – in timeframe	3 not yet met		
An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	60%	N/A	4/4 (100%)	3 not yet met		
Quarterly reports should be submitted to the Trust Executive Board.	100%	Submitted Jan 2026	Submitted Apr 2026	To be Submitted Aug 2026		

Appendix D: Learning Points and Key Themes:

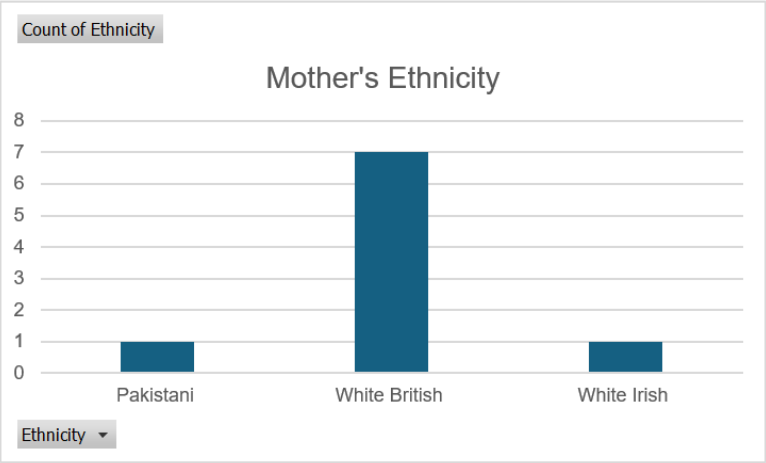
Key themes and or learning identified from **Q1** cases PMRT or continued from previous quarterly reviews are as follows:

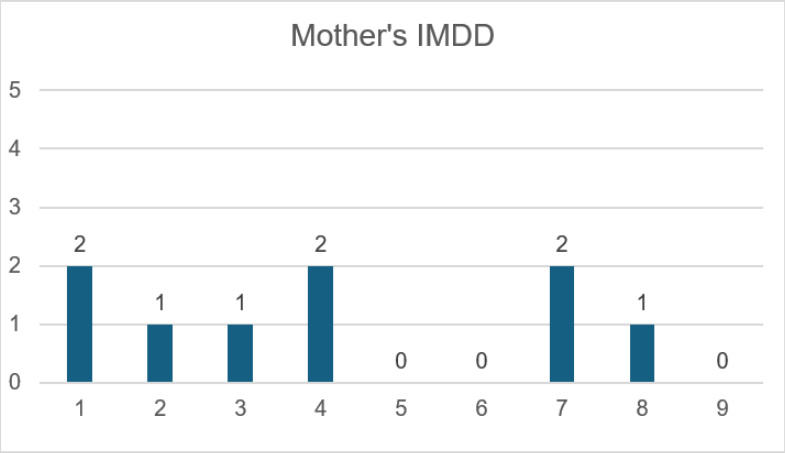
- Documentation of bereavement care requires improvement as it is not always possible to tell from the notes whether the bereavement pathway was followed or the required information was offered/provided
- Kleihauer bloods not being tested as per policy continues from previous quarters
- Postnatal investigations not offered despite indication
- Mothers not seen alone and not being asked about domestic abuse.

Parental Feedback
Feedback received from a service user: We felt able to access triage at any time, was able to ask questions and felt able to take the lead to make a decision based on each situation. I felt supported for my physical and mental health.

Communication issues / themes identified
None identified during the quarter.

Ethnicity/IMDD Breakdown
The tables below show the mother's ethnicity and multiple deprivation index for the 9 cases discussed in PMRT meetings during the quarter. The majority (78%) of mothers were of white British ethnicity. In regard to the IMDD data, 67% were under decile 5 and from deprived areas.





Appendix E: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified (PMRT review completed)			
		Q4 Jan – Mar 26	Q1 Apr – Jun 26	Q2 Jul – Sep 26	Q3 Oct – Dec 26
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	1/3 (33%)	1/9 (11%)	-	-
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	0/3 (0%)	1/9 (11%)	-	-
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.	0/3 (0%)	0/9 (0%)	-	-
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	0/3 (0%)	0/9 (0%)	-	-

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FAMILY SERVICES DIVISION

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - MIS Year 8, Safety Action C

National Perinatal Mortality Review Tool (PMRT)

HUTH Quarterly Report (Quarter 1 2026/27)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

Matthew Proctor
Quality and Safety Maternity Matron

July 2026

- **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:

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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**

- **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 are notified as soon as possible.	**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.	**60%**
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 Eight (Appendix A)

There has been a total of **10** incidents reported to MBRRACE-UK via the PMRT that fall within the MIS year 8 period (01 April 2026 – 30 November 2026):

Quarter	Eligible for full CNST Assessment	Eligible for notification only	Not eligible as baby still alive	Not eligible
December 2025	4	1	1	0
Q4 (01 Jan – 31 Mar 26)	16	1	1	0
Q1 (01 Apr – 30 Jun 26)	10	2	0	0
Total	**30**	4	2	0

Within Q4-Q1 26 cases are eligible for notification only or review and full assessment against CNST standards. Of these, 100% were notified to MBRRACE within seven days.

From 1st January 2026, please note there are 2 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 1 2026/27 (Appendix B)

There have been **12** incidents reviewed through the PMRT process in quarter 1; **4** of these were conducted with partner organisations where care was provided prior to an in utero/ ex-utero transfer of care. 1 of these was conducted with the attendance of MNSI.

There have been reports published for **8** of these. 4 are awaiting final report writing and remain within MIS standards. When reviewing these cases, they are broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby. It should be acknowledged that reporting relates to incidents that occurred earlier in the year due to the lag in the review and reporting process.

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

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

<u>Grading of care of the baby from birth up to the death of the baby (HUTH care)</u>

- 2 cases had no issues identified from birth up to the point that the baby died.
- 4 cases had issues identified that would have had no impact on the outcome for the baby.
- 1 cases had issues identified that may have impacted the outcome for the baby.
- 0 cases had issues that have impacted the outcome for the baby.

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

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

3.3 CNST Compliance as per MIS Year 8 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.

- **Saving Babies' Lives (Appendix E)**

To comply with safety action C 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 25	101629	Antenatal stillbirth	22+6	13.12.25	13.12.25	495g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	101730	Early NND	25+0	20.12.25	22.12.25	755g	UHLT	UHLT	HUTH	Yes	No	Yes	Yes	Yes	Yes
	101816	Antenatal stillbirth	35+0	23.12.25	23.12.25	2435g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	101817	Antenatal stillbirth	25+0	23.12.25	23.12.25	597g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
Q4 25-26	102014	Antenatal stillbirth	38+2	13.01.26	13.01.26	3125g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	102078	Antenatal stillbirth	35+3	16.01.26	16.01.26	2490g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	102116	Neonatal Death	Early NND	08.01.26	20.01.26	2800g	HUTH	HUTH	HUTH	Yes	Yes	Yes	Yes	Yes	Yes

Q4 25-26	102257	Antenatal stillbirth	33+1	29.01.26	29.01.26	2065g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	102252	Early Neonatal Death	25+4	10.01.26	29.01.26	540g	Pinders	Pinders	Pinders	Yes	No	Yes	Yes	Yes	Yes
	102356	Neonatal Death	22+6	29.01.26	04.02.26	445	York	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	102365	Neonatal Death	Early NND	02.02.26	06.02.26	2040	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	Yes
	102412	Neonatal Death	23+6	09.02.26	09.02.26	585g	DPoW	HUTH	HUTH	Yes	No	Yes	Yes	On track	Yes
	102422	Neonatal Death	24+5	10.02.26	10.02.26	705g	Pinders	HUTH	HUTH	Yes	No	Yes	Yes	On track	Yes
	102423	Neonatal Death	26+6	24.01.26	10.02.26	946g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	July Planned
	102477	Neonatal Death	24+	22.01.26	15.02.26	650g	ULTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	July Planned
	102539	Antenatal stillbirth	35+3	17.02.26	17.02.26	1690g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	July Planned

	102771	Antenatal stillbirth	25+6	07.03.26	07.03.26	365g	SGH	HUTH	HUTH	Yes	No	Yes	Yes	On track	July Planned
	102836	Late Misc	23+5	14.03.26	14.03.26	575g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	July Planned
	102879	Antenatal stillbirth	32+1	16.03.26	16.03.26	1190g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	August Planned
	103099	Neonatal Death	23+4	20.03.26	21.03.26	650g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	August Planned
	101382	Intrapartum stillbirth	42+5	02.04.26	02.04.26	4245g	Unbooked	HUTH	HUTH	Yes	Yes	Yes	Yes	On track	August Planned
	103272	Early NND	33+5	07.04.26	10.04.26	2000g	DBTH	DBTH	HUTH	Yes	No	Yes	Yes	On track	August Planned
	103310	Early NND	22+0	12.04.26	13.04.26	550g	Unbooked	HUTH	HUTH	Yes	No	Yes	Yes	On track	August Planned
	103278	Antenatal stillbirth	35+6	13.04.26	13.04.26	2410g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	September Planned
	103470	Antenatal stillbirth	35+3	23.04.26	23.04.26	2090g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	September Planned
	103471	Antenatal stillbirth	34+2	26.04.26	26.04.26	1820g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On Track	September Planned

Q1 26/27	103588	Late NND	>28 days	04.02.26	01.05.26	638g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On Track	September Planned
	103686	Late NND	>28 days	20.04.26	10.05.26	1152g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On Track	September Planned
	103769	Early NND	40+2	14.05.26	15.05.26	3960g	HUTH	HUTH	HUTH	Yes	Yes	Yes	Yes	On Track	October Planned
	103896	Late NND	> 28 days	06.04.26	22.05.26	860g	York	York	HUTH	Yes	No	Yes	Yes	On Track	October Planned
	103979	Antenatal stillbirth	38+6	30.05.26	30.05.26	2950	HUTH	Leeds	Leeds	Yes	No	Yes	Yes	On Track	Leeds
	104059	Early NND	<28 days	04.06.26	04.06.26	2030g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On Track	October Planned
	104245	Late NND	<28 days	26.05.26	16.06.26	2775g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On Track	October Planned

Appendix B – Summary of all incidents reviewed through PMRT and reviews completed/moved to report writing in Q1 2026-2027

Case	Cause of Death	Grading of Care	Mother's ethnicity/ IMDD	Issues Identified	Actions	External representative present at MDT PMRT / contributed
101629	Intrapartum still birth following extreme premature labour Breech presentation	C/A	BA/3	• Partogram not utilized fully due to rapid labour • Missed PPC referral (multiple fibroids) and seen in EPAU • Improve rainbow clinic referrals via EPAU	• Communication strategy to be implemented with all obstetric and midwifery staff (extending to EPAU) about the importance of timely referrals	Yes. Grading agreed with and contributed to clinical discussions
101817	Early onset growth restriction mild hypercoiling of the umbilical cord	B/A	WB/4	• The baby had to be transferred elsewhere for the post-mortem	• N/A	Yes. Grading agreed with and contributed to clinical discussions
101816	Tight true knot of the umbilical cord	B/A	WB/7	• The baby had to be transferred elsewhere for the post-mortem • This mother has a psychological/mental health disorder, this was identified in a previous pregnancy, but she did not receive specialist periconceptional counselling/management	• This was declined in pregnancy and pre-conception is not offered locally	Yes. Grading agreed with and contributed to clinical discussions
102014	Placental insufficiency	B/A	Asian/4	• None	• None	Yes. Grading agreed with and contributed to clinical discussions
102078	Acute hypoxic-ischaemic event most likely due to maternal vascular malperfusion and fetoplacental weight ratio.	B/B	WB/7	• This mother had pre-eclampsia/eclampsia during her pregnancy and there was a delay in the diagnosis • This mother had pre-eclampsia/eclampsia during her pregnancy which was not managed according to national or local guidelines • The baby had to be transferred elsewhere for the post-mortem • This mother did not have Kleihauer test despite it being requested	• QI regarding hypertension and PLGF ongoing • Post-mortems are not completed in the organization • Bereavement learning communication	Yes. Grading agreed with and contributed to clinical discussions
102257	Small Fetoplacental weight ratio hypercoiling maternal arterial malperfusion	B/A	WB/4	• This mother has a history of renal disease, this was identified in a previous pregnancy, but she did not receive specialist pre-conceptional counselling/management	• This is not currently offered within the service and has not affected the outcome	Yes. Grading agreed with and contributed to clinical discussions
102116	Severe HIE following cord prolapse at home	A/A/A	BA/6	• This mother had a risk factor(s) for having a growth restricted baby or there were concerns about the growth of the baby but serial scans were not planned • This mother's progress in labour was not monitored on a partogram	• Single growth scan performed in line with local guidance • Attended via 999 ambulance, straight to theatre for CAT EMLSCS	Yes. Grading agreed with and contributed to clinical discussions

102252	Bilateral IVH	B/B/A	Asian/1	• No HUTH issues	• No HUTH Issues	Yes. Grading agreed with and contributed to clinical discussions
102356	1a - Klebsiella sepsis 1b - extreme pre-term gestation	A/B/A	BA/3	• No Issues	• No Issues	Yes. Grading agreed with and contributed to clinical discussions
102365	T18 and complex congenital heart disease	A/A/A	Asian/1	• No Issues	• No Issues	Yes. Grading agreed with and contributed to clinical discussions
102412	Extreme prematurity and BBA	A/A/A	WB/1	• No HUTH Issues	• No HUTH Issues	Yes. Grading agreed with and contributed to clinical discussions
102422	1a - Unsuccessful resuscitation 1b - pre-term gestation 24 weeks 1c - abruption	C/C/C	Asian/2	• This mother had abnormal fetal heart rate monitoring during her pregnancy which was not managed according to national or local guidelines • The confirmed/suspected delay in this mother's labour was not managed appropriately • This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately • The type of fetal monitoring used in established labour was not appropriate • The baby had to be transferred elsewhere for the post-mortem	• The organisation has since identified and shared a position statement with all Obstetric Consultants within HHP regarding CTG <26/40 is not to be performed due to lack of evidence regarding interpretation. This has been agreed and followed local governance process. This has been escalated to the LRP (executive safety team). The decision to perform an ARM has been questioned and holistically it is felt this should not have been performed. If there were concerns with bleeding, fetal heart rate or maternal wellbeing this should have prompted a cesarean section due to the gestation. This has been widely shared and discussed with the Obstetric consultant teams during governance processes. • Neonatal AAR declared regarding resuscitation and the difficult airway	Yes. Grading agreed with and contributed to clinical discussions

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 8 standards (01/04/26 – 30/11/26)

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Q1 Apr – Jun 26	Q2 Jul – Sep 26	Q3 Oct – 30 Nov 26	Total
Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	**100%**	100% (13/13)			
Cases applicable for PMRT review are applicable to the following standards (n=11)					
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%**	91% (10/11) – joint case and ongoing)			
Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death?	**95%**	100% (11/11)			
Multi-disciplinary reviews should be published within six months of the death.	**75%**	Ongoing			
An external member should be present at the multi-disciplinary review panel meeting, and this should be documented within the PMRT.	**60%**	100%			
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	To be submitted Aug 2026			

Appendix D: Learning Points and Key Themes:

Key themes and/or learning identified from **Q1** cases PMRT or continued from previous quarterly reviews are as follows:

- CTG being performed <26/40 and intervention (ARM performed)
- Unsuccessful neonatal resuscitation declared an AAR
- Increased fetal medicine pathways due to congenital abnormalities
- Continued early gestation early or neonatal death
- Unbooked pregnancy occurred in 2 incidents
- PLGF and hypertensive management – improvement noted due to QI project (Completed June)

Parental Feedback

Feedback received and overall positive regarding the kind and compassionate care received on labour ward. There has been 1 feedback that was not positive (believed their care to be influenced negatively by their race and religion) and this has been directly fed back to the senior leadership team and the labour ward management team. All parental feedback is read out in the review meeting and answers are communicated in the debrief.

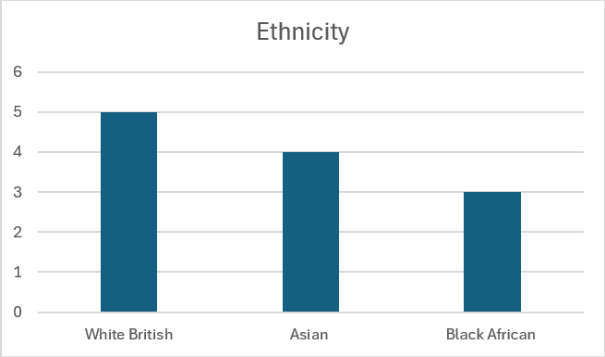
Communication issues / themes identified

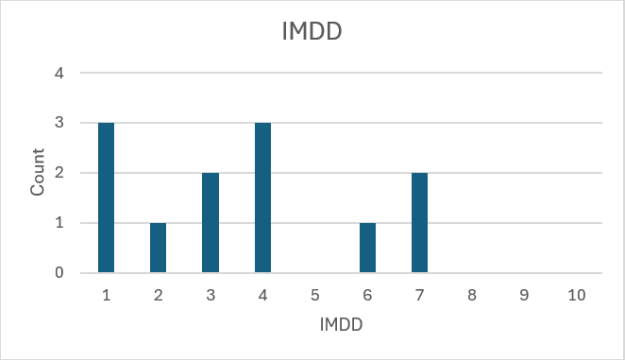
Theme identified:

- It was not clear that a poor outcome was anticipated.
- LMWH and its ingredients were not made clear to a practicing Muslim couple.

Ethnicity/IMDD Breakdown

The tables below show the mother's ethnicity and multiple deprivation index for the 12 cases discussed in PMRT meetings during the quarter. 42% of mother were of White British ethnicity, 33% Asian and 25% Black African. In regard to the IMDD data, 75% were under decile 5 and from deprived areas.





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 26	Q1 Apr– Jun 26	Q2 Oct – Dec 26	Q3 Oct – Dec 26
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	0/6 (0%)	0/12 (0%)	-	-
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	0/6 (0%)	0/12 (0%)	-	-
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	0/6 (0%)	1/12 (8.3%)	-	-
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	1/6 (16.6%)	0/12 (0%)	-	-

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NHS Trust

NHS
Northern Lincolnshire and Goole
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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)194

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	10th September 2026
Director Lead	Jo Ledger, Interim Group Chief Nurse
Contact Officer / Author	Yvonne McGrath, Group Director of Midwifery
Title of Report	Overview of National Maternity and Neonatal Papers
Executive Summary	Recent national maternity and neonatal reviews, including the Nottingham Review (2026), the Amos Review (2026), and NHS England's Maternity and Neonatal 10 Point Plan, reinforce longstanding concerns regarding safety, culture, workforce, leadership, governance and the need to better listen to women and families. The findings mirror themes identified in previous inquiries and highlight the importance of learning from incidents, addressing inequalities, strengthening accountability, and ensuring safe, responsive services. Humber Health Partnership is well positioned to respond, with many of the required actions already incorporated within existing maternity and neonatal improvement programmes, governance arrangements, workforce initiatives and equity workstreams. Immediate priorities include completion of the first NHS England 10 Point Plan return by 25 September 2026, review of board-level accountability arrangements, assurance of maternity triage services, continued focus on workforce and escalation processes, and progression of patient experience and engagement programmes. Given NHS England's direction that local systems should await the publication of the National Maternity and Neonatal Action Plan in December 2026 before developing significant new programmes of work, the immediate focus is on assuring compliance with current requirements, evidencing progress against national expectations, and maintaining oversight through Humber Health Partnership governance arrangements. Further recommendations and actions will be incorporated into the partnership improvement plan once the national implementation framework is published.
Background Information and/or Supporting Document(s) (if applicable)	**Findings, conclusions and essential actions from the independent review of maternity services at Nottingham University Hospitals NHS Trust** **NHS England » Maternity and Neonatal 10 Point Plan assurance process** **NHS England » Publication of Baroness Amos' independent investigation into maternity and neonatal services in England** **NHS England » National maternity triage specification**

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:

V2

Overview of National Maternity and Neonatal Papers

Purpose
• To summarise the recent national maternity and neonatal publications
• Outline immediate actions required by HHP
• Outline approach going forward

Introduction

Since the publication of the Morecambe Bay Report (2015), there has been a succession of maternity reviews highlighting systemic failings in safety, culture and leadership. These include Ockenden Review – Shrewsbury & Telford (2022), Reading the Signals – East Kent (2022), Ockenden Review – Nottingham (2026) and the National Maternity Review (Amos Report, June 2026).

Independent Review of Maternity Services – Nottingham University Hospitals NHS Trust

Largest review of maternity and neonatal care involving over 2,000 families and more than 800 staff. Key findings included 21% of maternity cases and 6% of neonatal cases being graded as potentially avoidable.

Key Themes

• Long-standing issues known but not addressed
• Failure to learn from incidents
• Women and families not consistently listened to
• Poor communication and involvement in decision making
• Inadequate staffing and training
• Weak governance and accountability

Immediate and Essential Actions

1. Listening to Women and Families
2. Workforce Planning and Safe Staffing
3. Training and Multi-Professional Learning
4. Risk Assessment Throughout Pregnancy
5. Incident Investigation and Family Involvement
6. Governance and Board Accountability
7. Culture, Teamwork and Psychological Safety
8. Mothers who have Died and Post-Death Care

Independent Investigation into Maternity and Neonatal Services in England (Amos Review)

Key themes include women not being listened to, inequalities within the maternity system, inconsistent care and fragmented services.

Eight Key Recommendations

1. National Maternity and Neonatal Commissioner
2. Listening to women and families
3. Improving learning from incidents
4. Modern Service Framework
5. Tackling inequalities
6. Improving governance and accountability
7. Improving culture and leadership
8. Delivering fit-for-purpose estates and digital systems

NHS England 10 Point Plan

In response to the Nottingham review and the Amos report NHS England has published a 10 Point Plan. The National Maternity Taskforce will lead on the development of required actions. This is due in December 2026. Clear directive to await this action plan prior to development of new local actions. The first return for the Maternity and Neonatal 10 Point Plan is due for submission on the 25th of September.

- Listening to women and their families by rolling out Martha's Rule
    - There are significant number of other documents expected in Autumn/Winter 2026 related to homebirth, personalised care and induction of labour. There are existing workstreams already in place across HHP related to these areas of practice.
- Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit data that are acted
    - Patient Experience outcomes are already reported in the MNAG Report monthly. Patient Engagement Lead Midwife due to shortly start in post and will review data collections, metrics and audits related to patient experience. MIS Year 8 also requires triangulation of themes from multiple sources.
- Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care
    - Chief Medical Office and Chief Nursing Officer to review current arrangements.
- 'Amos into action' staff listening exercise
    - Listening Events planned reactively at present- plans emerging for proactive Listening Events and Tea Trollies led by the SLT
- Addressing inequalities in maternity and neonatal outcomes
    - Onboarding to the Perinatal Equity and Anti-Discrimination Programme ongoing. Review of data that is collated on the MATNEO dashboard to ensure that relevant metrics are included and to have a single data set that serves improvement, local and regional assurance.
- Ensuring 24/7 safety and responsiveness of maternity and neonatal services
    - Immediate recommendation to review internal escalation strategies (i.e. availability of on-call staff and "Manager-on-Call" MATNEO rota).
- Trusts to review their homebirth services
    - Homebirth PFD- update in MNAG Report
- Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach
    - Trauma- informed care already threaded through our improvement plan
- Deliver safe and effective triage in maternity services (further information later in this paper)

- Post death care- All trusts must implement actions set out in the System letter following the Fuller and NUH reviews, including responding to the board assurance statement by 31 July and to the Human Tissue Authority requirement to review and assure completeness of incident records over the past 10 years.

National Maternity Triage Specification

Aims to improve safety, reduce variation, tackle inequalities and strengthen accountability. A maternity triage specific benchmarking tool has now been provided and will be submitted on the 25th of September as part of the 10 point maternity and neonatal plan reporting requirements

National Principles for Maternity Triage Services

1. Access and integration
2. Recognition as urgent care
3. Assessment and care of women
4. Clear information for women
5. Telephone maternity triage
6. Service user voice and experience
7. Facilities and estates
8. Staffing
9. Equity and equality
10. Data and measurement

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)195

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**10 September 2026**
Director Lead	Alan Downey, Group Chair
Contact Officer / Author	Alan Downey, Group Chair
Title of Report	Group Chair's Report
Executive Summary	Report on Policy, Regulation and wider activities
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Group Chair's Update

Performance

In my last update I commented on the performance challenges we face, many of which are long-standing and date back to the formation of the group and before. Our underperformance as a group has understandably attracted a great deal of public and media attention.

It is therefore gratifying that we are beginning to see measurable results from the improvement initiatives launched in recent months. These include:

- Improved Care Quality Commission (CQC) ratings for many of the services recently inspected, including: Urgent and Emergency Care in Hull Royal Infirmary; Outpatients at Goole and District Hospital; and End of Life care at Diana, Princess of Wales Hospital, Grimsby and at Scunthorpe General Hospital.
- Lifting of the Section 31 notice previously served in respect of our maternity services. This is in recognition of significant improvements.
- A dramatic reduction in the number of Never Events: from 18 in the period April 2024 to December 2025, to a single Never Event in the period from January 2026 to date.
- The elimination of corridor care in inpatient areas.
- Improvements in performance against the cancer faster diagnostic standard and 31-day standard.
- Improvements against the 4- and 12-hour standards for Emergency Department (ED) waits.

None of this would have been possible without the hard work and determination of our Chief Executive, her executive team, and colleagues at all levels and in all disciplines across the group.

In addition to the recent CQC inspections mentioned above, the CQC has also carried out a well-led inspection, looking at the robustness and quality of leadership within the two Trusts at all levels, from board to ward. Despite our recent progress in improving performance, the CQC inspectors identified a number of remaining gaps and weaknesses. This led them to serve two Section 29A notices, one for each trust, requiring us to make urgent improvements in our governance systems, approach to risk management, processes for learning from incidents and complaints, and approach to infection prevention and control. The steps we need to take have been incorporated into our Integrated Improvement Plan (to the extent that they were not already covered), and we will be working very hard to satisfy the CQC that we have addressed their concerns in full. We have been given six months to make the required improvements.

Partnerships

We work as part of an integrated health and care system, which means that partnerships are key to improving performance. I am therefore continuing to meet regularly with partners within and outside the NHS, including MPs, local authority chief executives, voluntary sector leaders, and colleagues in NHS England (NHSE) and the Humber & North Yorkshire Integrated Care Board (ICB).

Governance

The big question which has hung over the group in recent weeks concerns the structure within which our two Trusts, HUTH and NLaG, will operate in future. I am grateful to colleagues in NHSE and to Carnall Farrar for wrestling with this question and for providing the evidence and analysis to support a considered decision. We have an obligation to take the views of interested parties into account. We all know that strong views have been expressed in recent weeks by NLaG Governors and consultants (see below), but we also know that other colleagues take a different view. The decision must be based on what we understand to be in the best interests of our patients, their families and carers, and the wider communities that we serve.

Once the decision is taken and communicated, we will move into a period of planning and implementation which we must manage well, while continuing to focus on stabilising and improving services.

One of my priorities as Chair is to make sure that we have a stable and effective Group Board. Our Chief Executive has continued to make progress in filling gaps in the executive positions. I have been focusing on the Non-Executive Directors (NEDs), and by the time of the September board meeting I hope to be able to announce the appointment (subject to ratification by NHSE and the NLaG Governors) of an additional NED and two associate NEDs.

The NLaG Council of Governors (CoG) remains a key governance forum. The Governors represent the views of patients, local people, staff and partner organisations and they offer a unique perspective on the services we provide, particularly in terms of patient experience. At the most recent CoG meeting, on 20 August, the Governors voted to support the call by a majority of NLaG consultants for the break-up of Humber Health Partnership (HHP).

In addition to the regular CoG meetings, I have continued to meet informally with Ian Reekie and Mike Bateson, respectively the Lead and Deputy Lead Governor. I value their insight and advice. I have also had recent one-to-one meetings with several of the other Governors.

Colleagues

One of my personal objectives as Chair is to get out and about as much as possible. In the last few weeks, as well as paying informal visits to wards and departments, I have had organised walkabouts at most of our sites. In the last few days I have spent several very enjoyable hours with the NLaG Community and Therapies team (unfortunately cut short by other events) and at the Hull Community Diagnostic Centre (CDC). The former enabled me to see at first hand the essential work that helps to keep patients out of hospital and in their own homes. The latter gave me a very encouraging insight into what can be achieved with brand new facilities and, more importantly, strong compassionate local leadership, a positive culture and a can-do attitude.

I have also had recent meetings with our Staff Side colleagues, and it was both a pleasure and an education to attend the annual conference of the LGBTQIA+ staff network.

I also want to mention a number of recent discussions with colleagues who run the two main hospital charities, the Health Tree Foundation (HTF) and WISHH. These charities

have an important role to play, raising money for equipment and improving the environment for patients and staff. They also help to create a sense of community, because active involvement in fundraising is a great way of bringing together members of staff, former patients and family members who want to show their gratitude for the services we provide. I would like to express my thanks, and those of the board, to everyone involved in the running of HTF and WISHH, including (but by no means limited to) Neil Gammon (the Independent Chair of HTF), Lucy Skipworth (the HTF Charity Manager), Jamie Lewis (Chief Executive of HEY Smile Foundation, a local charity which supports HTF), Susan Lockwood (the Independent Chair of WISHH) and her board of independent trustees, and Carl Wheatley (the WISHH Chief Executive).

Patients

I continue to take the opportunity to talk to patients whenever I can. I recently had fascinating conversations with two patients in the intensive rehabilitation unit at Castle Hill Hospital, one recovering from a severe stroke and the other from a serious road traffic accident. I felt privileged to be able to chat to two patients of our district nursing team in their own homes in Scunthorpe. It brought home to me not only the important work our district nurses do for patients, but also the impact that illness has on family members and other carers. They need our support and compassion too. I will say more at the board meeting.

Alan Downey
Group Chair

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Trust Boards-in-Common - Public

Agenda Item No: BIC(26)196

Name of Meeting	**Trust Boards-in-Common - Public**
Date of the Meeting	10 September 2026
Director Lead	Lyn Simpson, Group Chief Executive
Contact Officer / Author	Lyn Simpson, Group Chief Executive
Title of Report	**Group Chief Executive Briefing**
Executive Summary	This report provides the Board with an update on a number of developments across Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust. The report is intended to support public transparency about the work taking place to improve services, patient experience and outcomes across our hospitals and community services.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

PUBLIC BOARD OF DIRECTORS
Thursday 10 September 2026

GROUP CHIEF EXECUTIVE UPDATE

1) Robotic surgery milestone

Our robotic surgery programme at Castle Hill Hospital (CHH) has reached an important milestone, with the 5,000th patient undergoing robotically assisted surgery.

Robotic surgery was first introduced in Hull in 2015, initially within Urology and now six surgical specialties use the technology: Urology, Gynaecological Oncology, Thoracic Surgery, Colorectal, Upper Gastrointestinal and Head and Neck surgery. The programme has continued to develop as clinical experience and capability have grown.

The July Chief Executive (CE) update to Board highlighted the first patient within Humber Health Partnership (HHP) to undergo a robotic prostatectomy as a day-case procedure. The wider programme is also helping suitable patients to spend less time in hospital, while supporting faster recovery and reducing complications and readmissions in a number of surgical pathways.

Reaching 5,000 procedures is a significant achievement and reflects the expertise and commitment not just of our surgeons but of the theatre, anaesthetic, nursing, recovery and ward teams who support patients throughout their care.

2) New Care Co-ordination Centre at Hull Royal Infirmary

Planning permission has been granted for the new £7.5 million purpose-built Care Co-ordination Centre at Hull Royal Infirmary (HRI).

The development will create a new patient discharge lounge on the ground floor, bringing together a modern environment for patients who are medically ready to leave hospital but are awaiting medication, transport, community support or another element of their discharge arrangements. The first floor will bring Care Co-ordination and Discharge teams together, while non-clinical accommodation on the second floor will release additional space within the Tower Block for clinical use.

The development therefore supports two important objectives: improving the experience of patients as they leave hospital and freeing existing hospital space and beds for patients who require acute care. Bringing teams involved in discharge and operational co-ordination together will also support closer working and better management of demand across our services.

Construction is currently planned for completion in autumn 2027.

3) Improved care environments for patients living with dementia

New dementia-friendly facilities have opened on Ward 5 at Scunthorpe General Hospital (SGH).

A bay and side room have been refurbished to provide a calmer, less clinical and more familiar environment for patients living with dementia, including improved flooring and adjustable lighting. A further bay is planned for refurbishment.

The work forms part of a wider programme of dementia-friendly improvements at SGH, which has included specialist signage, improved lighting, refurbished bed spaces and dedicated dementia support. The programme has been made possible through a £326,000 legacy left by former Scunthorpe resident and is being delivered jointly by colleagues, the Health Tree Foundation and our Vulnerabilities Team.

4) Generation Study

More than 1,000 families in Hull and East Yorkshire (HEY) have now joined the Generation Study since it was launched locally by our research team at HRI earlier this year.

The national study, led by Genomics England in partnership with NHS England (NHSE), is exploring whether whole genome sequencing shortly after birth can identify more than 200 rare genetic conditions at an earlier stage. The national programme aims to recruit 100,000 babies.

Early diagnosis can allow families to access monitoring, treatment and specialist support before symptoms develop and, for some conditions, can significantly improve longer-term outcomes. Participation is voluntary and the study does not replace routine newborn blood spot screening.

The response from local families is very encouraging and reaching 1,000 participants so quickly demonstrates both the strength of our research capability and the willingness of local people to contribute to research which could influence the future of genomic medicine in the NHS.

5) National Maternity and Neonatal 10 Point Plan

NHSE published its assurance arrangements for the national Maternity and Neonatal 10 Point Plan on 12 August 2026, following the publication of the independent reviews led by Baroness Amos and Donna Ockenden.

NHSE has made clear that immediate delivery of the 10 Point Plan should be the priority for Trusts while the national Maternity and Neonatal Taskforce develops a more comprehensive action plan later this year. Provider Boards are expected to demonstrate visible ownership and scrutiny, including ensuring that actions are progressing, risks are appropriately managed, and significant concerns are escalated where necessary.

Trusts are required to submit a baseline assessment to NHSE by 25 September, followed by a progress update by 31 December. The assurance process includes specific work on safe and effective maternity triage, including benchmarking against the new national maternity triage specification.

This is particularly relevant to the work already underway locally to strengthen maternity triage, including the development of a dedicated 24-hour maternity triage unit at Diana Princess of Wales (DPoW) Hospital described in my previous update.

6) Patient-Led Assessments of the Care Environment

Our annual PLACE (Patient-Led Assessments of the Care Environment) inspections will take place across HHP during October and November.

Teams made up of colleagues and patient volunteers will visit wards, departments and other clinical areas to assess the quality of the environment in which our patients receive care.

An important feature of PLACE is that it brings the patient perspective directly into the assessment process. The findings help to identify where environments are working well and, where improvements are required.

I would like to thank the patient volunteers who give their time to take part, as well as colleagues who will support the assessments across our sites. The results will inform our ongoing work to improve the experience, dignity and environment of care for patients.

7) Staff flu vaccination programme

Preparations for winter are continuing, and our annual staff flu vaccination programme will begin on 1 October 2026.

Flu can have a significant impact both on vulnerable patients and on the resilience of our services during winter. Vaccination remains an important way in which colleagues can help to protect themselves, their patients and the people around them.

For the first three weeks, drop-in vaccination hubs will operate at HRI, CHH, SGH and West Arch. Occupational Health appointments will also be available and roving vaccination teams will visit all five hospitals.

The programme is open to all colleagues, including clinical and non-clinical staff, students and contractors. Further information about vaccination opportunities will be provided to colleagues each week through Bridget and other staff communications.

8) CE Dashboard

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

CEO DASHBOARD

September 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**
  The group's organisational structure review has focused on establishing arrangements that provide a stronger foundation for safe, high-quality and sustainable patient care.
- **People**
  The review has drawn on evidence across quality, workforce, finance, performance and governance, with input from clinical leaders, colleagues, commissioners and partners.
- **Population**
  The review has considered how future arrangements can provide better support the populations and health systems served by HUTH and NLAG.

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

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

OPERATIONAL PERFORMANCE (JUL 26)

IPR

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

HUTH

A&E 4hr wait (62.6% plan)	62.2%	↑↓	58.6% in June
62-day cancer (53.0% plan)	*54.4.%	↑↓	49.4% in May
28-day FDS (69.0% plan)	*67.3%	↓↓	70.6% in May
18-week RTT (56.0% plan)	56.0%	↓↓	56.8% in June
6 week wait (31.3% plan)	36.6%	↑↑	37.2% in June

*June 2026

NLAG

A&E 4hr wait (74.0% plan)	69.0%	↑↑	68.9% in June
62-day cancer (60.3% plan)	*64.1%	↑↓	54.0% in May
28-day FDS (69.0% plan)	*64.0%	↑↓	58.5% in May
18-week RTT (58.6% plan)	59.8%	↑↓	59.7% in June
6 week wait (29.7% plan)	33.5%	↓↑	32.6% in June

*June 2026

PATIENT AND STAFF EXPERIENCE

PATIENT EXPERIENCE

- Friends and Family results: community 96.9%, inpatient 97.8%, outpatient 97.9%, postnatal community 100% and postnatal 73.3. A&E scored 76.3%, antenatal 81.1%, and birth 95%.
- A central test throughout the organisational review has been which arrangements would best support patients, service sustainability and the delivery of consistently high-quality care.
- The review has considered both closer integration and more separate, locally accountable arrangements; no outcome is pre-empted within this update.

STAFF EXPERIENCE

- Clinical and operational colleagues have been closely involved in the organisational review, alongside commissioners and key partner organisations.
- The Group Chair and Chief Executive will hold staff roadshows across Castle Hill, Hull Royal Infirmary, Goole, Scunthorpe and Grimsby during September and October.
- The roadshows form part of the Partnership's continuing commitment to open engagement with colleagues as the improvement work develops.

PEOPLE (JUL 25)

IPR

Group sickness absence	4.8%	↔	4.8% in June
Appraisal rate (AfC)	81.6%	↓	81.8% in Jun2
Mandatory training	85.3%	↓	87.1% in June
Role specific training	82.9%	↓	81.2% in June
Agency usage	0.6%	↑	0.8% in June
Headcount	19.22k	↑	19.66k

GROUP FINANCIAL POSITION (JUNE)

IPR

Indicator	£M / %
CIP YTD against plan	62.5%
Planned Surplus/Deficit	(63,065)
Variance YTD Financial Plan	(10,207)

DISCHARGE (AUG 26)

MH

HUTH

Bed occupancy classed as clinically ready for discharge (lower is better)	27.4%	↓↑	27.1% in July

NLAG

Bed occupancy classed as clinically ready for discharge (lower is better)	15.3%	↓↑	15.1% in July

THEATRE UTILISATION

IPR

HUTH touch-time capped utilisation (Elective 85% standard)	82.0%	↓↑	82.6% in June
NLAG touch-time capped utilisation (Elective 85% standard)	81.5%	↓↑	84.0% in June

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)197

Name of Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	10 September 2026
Director Lead	Lyn Simpson, Group Chief Executive
Contact Officer / Author	Richard Dickinson, Associate Director of Quality Governance
Title of Report	National Reports and Guidance

Executive Summary	The attached report provides a summary of guidance and national reports and relevant operational lead identified for the period of July and August 2026. The items are published from:
	• NHS England (NHSE)
	  ○ Enhanced therapeutic observations and care (ETOC): workforce deployment models
	  ○ Framework for NHS boards: monitoring research activity
	  ○ Sepsis modern service framework
	• Department of Health and Social Care (DHSC)
	  ○ No items
	• Health Services Safety Investigations Body (HSSIB)
	  ○ Insulin: supporting safe self-administration in vulnerable patient groups in the community
	The Boards-in-Common are asked to note the content of the report.

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

Name	Organisation	Subject	Summary	Published on	Lead officer
Insulin: supporting safe self administration in vulnerable patient groups in the community	Health Services Safety Investigations Body	Insulin: supporting safe self-administration in vulnerable patient groups in the community	Supporting vulnerable patients to be safe in their insulin management, covering mental health, disabilities and learning disability	13/08/2026	Tracy Means, Nurse Director (Community Frailty and Therapies)
Enhanced therapeutic observations and care (ETOC): workforce deployment models	NHS England	Enhanced therapeutic observations and care (ETOC): workforce deployment models	This guidance supports organisations in undertaking ETOC workforce planning within the existing National Quality Board's (NQB's) guidance on safe staffing and Developing workforce safeguards (DWS) guidance.	26/08/2026	Joanne Ledger, Interim Chief Nurse
Framework for NHS boards: monitoring research activity	NHS England	Framework for NHS boards: monitoring research activity	This framework defines what NHS boards need to do to monitor research and describes what a high-performing, research-active organisation looks like.	26/08/2026	Mr Peter Sedman, Deputy Chief Medical Officer
Sepsis modern service framework	NHS England	Sepsis modern service framework	This aligns with the national Quality strategy for NHS Funded care in England and the 10 year Health Plan. This is structured around: • A personalised approach • Supporting people to understand sepsis: our staff and the population • Prevention of severe infection and sepsis where possible • Identification of severe infection and sepsis • Escalation of care • Response that is timely, appropriate and effective	14/07/2026	Hilda Gwilliams, Group Chief Patient Safety Officer

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)198

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	10 September 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	There have been quite extensive developments across all elements of the financial recovery journey of HHP over the summer months with the time being used wisely to get the key elements of the agreed Intensive Recovery Programme (IRP) underway. Conversations continue with NHS England around the status of the plan for 2026/27 which remains non-compliant. The detailed financial performance is outlined in the appended Month 4 financial performance and showed some very small improvements in run rate. Northern Lincolnshire and Goole Foundation Trust were on plan in month and there were small reductions in expenditure at Hull University Teaching Hospitals NHS Trust. The forecast for the year end however remains significantly challenging under each scenario modelled and it is imperative that the Group continues to work together to mobilise and execute opportunities to achieve improved financial performance and in the use of resources by the teams. Month 4 saw the introduction of the Provider Assurance Model (PAM) by the North-East and Yorkshire (NEY) Region of NHS England. Whilst there were some small presentational differences to previous reporting it is reassuring that it naturally built on the work HHP had onboarded as part of the financial recovery work underway already, including weekly variable pay reporting; a more stringent and run rate focus on CIP; and forecasting to include a Best Mid Worse scenarios, to name a few headlines. The senior finance team and I met with regional colleagues and Simon Worthington who helped design and onboard some elements of the framework. The external team were extremely complimentary about the quality of the submissions and the understanding of the financial position by the finance team. As previously reported, despite the ongoing discussions around the plan, the multi-disciplinary teams are really focusing on delivering reductions in expenditure and recovery actions as previously reported. With such a challenging financial plan cash continues to be a key area of focus. Performance Estates and Finance (PEF) CiC met on 1 September 2026 and approved the overall Quarter 3 Revenue

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Trust Boards-in-Common – Public

Agenda Item No: BIC(26)230

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	Thursday 10 September 2026
Director Lead	Lyn Simpson, Group Chief Executive
Contact Officer / Author	Lyn Simpson, Group Chief Executive
Title of Report	**Organisational Structure Review: Board decision and next steps**
Executive Summary	In April 2026, as part of the national Intensive Recovery Programme (IRP), NHS England commissioned an independent review of the Humber Health Partnership (the Partnership) organisational model to establish whether the current arrangements remained the right structure for Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG). The review was undertaken in two phases between April and August 2026, with independent support from Carnall Farrar and oversight from a Steering Group involving NHS England, Humber and North Yorkshire Integrated Care Board (ICB) and the Partnership. The review concluded that a number of the challenges facing HUTH and NLAG are structural as well as operational. It found that the current Partnership arrangements do not provide sufficient clarity of local accountability and organisational focus, while HUTH and NLAG predominantly serve distinct populations and work within different local health and care systems. At its private meeting earlier today, the Trust Boards-in-Common considered the findings and recommendations of the review and agreed that HUTH and NLAG should move away from operating through the current Partnership governance arrangements. The Boards agreed a future model in which HUTH and NLAG operate as two separate, sovereign Trusts, with Goole and District Hospital remaining aligned to NLAG. Each Trust will have its own Board and executive arrangements, with clearer local leadership and accountability for its own patients, workforce, performance and finances. The decision is not a return to the position that existed before the Partnership was established and does not mean an end to collaboration between HUTH and NLAG. The review is clear that arrangements which work well across the two organisations should be retained and strengthened through formal agreements. This includes clinical networks, specialist support, shared learning and patient pathways, as well as clinical

	and non-clinical services where working across both Trusts provides the best service and sustainability. Where specialist or tertiary services need to operate at greater scale to support recruitment, retention and sustainable patient care, formal commissioner-led commissioning and contractual arrangements will be developed by the Integrated Care Board (ICB). The decision does not itself make any changes to clinical services, hospital sites or the way patients access care. Existing governance, clinical and operational arrangements will continue while the transition is carefully planned and implemented. A detailed transition programme will now be mobilised. This will establish the future leadership, governance and operating arrangements for each Trust; identify the clinical and corporate arrangements which should continue across both organisations; and ensure quality, safety and service continuity are protected throughout. Current shared arrangements will continue by default while that work is undertaken rather than ending simply as a consequence of the organisational change. The organisational decision should also be seen alongside, rather than instead of, the wider improvement and recovery work already under way. Delivery within each Trust, together with commissioner and wider system action, will continue to be required to secure sustainable improvement.
Background Information	HUTH and NLAG are two of the five Trusts included in the national IRP. The organisational review forms one part of that work, alongside the separate programme of operational and financial recovery. The review grew from the improvement work commenced across HUTH and NLAG in autumn 2025 and the clinically led Improvement Plan published in January 2026. That work developed a clearer understanding of the long-standing operational, workforce, financial and structural challenges affecting both organisations and prompted consideration of whether the current organisational arrangements provided the strongest foundation for sustained improvement. The review found that many of the challenges the Partnership was intended to address remain. It identified in particular: • The distinct populations, patient flows and local health and care partnerships served by HUTH and NLAG. • The need for clearer local accountability and organisational focus. • Long-standing performance and workforce and which pre-date the Partnership but have not been resolved through the current arrangements. • Financial sustainability issues which cannot be resolved through organisational form alone.

	Based on the review's recommendation, the Boards therefore concluded that the strongest future model is one which combines clearer local accountability within HUTH and NLAG with formal commissioner-led contractual arrangements across the Humber wherever patients and services benefit from working at greater scale. This approach reflects the principle that organisational separation should not result in clinical separation. In particular, the future arrangements will need to retain existing clinical dependencies and provide formal mechanisms for services which need to operate across organisational boundaries. **Next steps** The Boards' decision establishes the future direction rather than bringing about an immediate organisational change. A transition programme will now be established covering leadership and people; the future operating models of each Trust; governance and Board arrangements; clinical and service continuity; shared corporate and enabling functions; communications and engagement; and the financial arrangements required for transition. The implementation plan will ensure these areas are progressed in parallel while recovery and business-as-usual delivery continue. A final date for ending the current Partnership governance arrangements will not be fixed until the necessary conditions have been met and the Boards are assured that the two Trusts can operate safely and effectively under the new arrangements. Patients and colleagues should therefore expect no immediate change as a consequence of today's decision. Patient safety, continuity of care and maintaining the improvement work already under way will remain central throughout the transition.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The equality and health inequalities implications of the proposal were considered by the Boards before reaching their decision. The decision itself does not propose changes to clinical services, hospital sites or the way patients access care and therefore does not create any immediate change for patients, carers or the public. Through the implementation process, any equality impacts will be assessed and considered through at decision-points.
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ✓ Other – please detail below: The emerging findings and direction were considered by the Group Executive Team and by the Trust Boards-in-Common on 2 September 2026. The Trust Boards-in-Common met in private on 10 September 2026 to consider the final evidence and recommendation and to take the

	decision on the future organisational arrangements for HUTH and NLAG. The Boards approved a split-site configuration, with Goole and District Hospital aligned to NLAG, and the dissolution of the Humber Health Partnership governance arrangements, resulting in HUTH and NLAG operating as two sovereign Trusts with formal collaboration arrangements between them. This paper is presented to the subsequent public meeting to formally record that decision and the public on the next steps. No further approval or ratification is sought.

Support PDC cash requirement of £29.6m, (£75.5m Q1-3 cumulative).

National leaders from NHS England, Nicci Briggs (Deputy Chief Financial Officer) and May Li (Director of Efficiency) attended and ran a face-to-face session on Productivity and Efficiency on 30 July 2026 with the Care Group leads including the Chiefs of Service. A follow-up session is going into the diary in 6 months' time, where the Care Groups are being asked to present what has changed because of what they heard.

For completeness outlined below is the detail of the AAA report considered by PEF on 1 September 2026:

Alert

- The Group reported a year-to-date deficit of (£41.8m), (£13.3m) adverse to plan. This position includes (£1.5m) of expenditure relating to Industrial Action cover which will have to be mitigated internally.
- Whilst the Group is formally forecasting a plan compliant position, the forecast includes an unidentified and unmitigated gap of (£36.0m) and this is currently assessed to be the best-case scenario. Mid-case forecast is currently assessed to be a (£116.8m) deficit, a (£53.8m) adverse variance to plan.
- Year to date adverse variance and slippage on identification of CIP is adversely impacting the cash forecast. For H1 (Apr-Sep) the Group has requested Revenue Support PDC of £57.8m, which is £26.92m higher than planned for H1 and will have to be recovered in H2.
- Based on the mid-case forecast, Revenue Support PDC requirement for Q3 is assessed as follows:

Revenue Support PDC	**Q3 (£m)**	**Q1-3 (£m)**
HUTH	18.7	54.0
NLAG	10.9	21.5
Total	29.6	75.5

Q3 value assumes that September request is approved in full, if it is not the Q3 value may need to increase to compensate. Actual cash requirements will be reassessed every month and will be managed within the Q1-3 envelope shown above.

- August cash allocation was lower than requested and this is impacting on the Group's ability to pay suppliers promptly. NHS England finance colleagues have indicated that plan plus any further adverse variance in Creditor values would be considered for funding, and cash forecasts continue to come under significant scrutiny.

	Assure Financial Recovery Plan progress: - Agreed a targeted 30% / £30m reduction in variable pay with associated Care Group targets. - Weekly monitoring of variable pay where data is available - shared weekly with Care Groups. - Introduced vacancy pause – implemented 6 July 2026. - Approved expansion of Locum's Nest digital solution which will facilitate electronic approval for variable pay including Extra Contractual Payments – implemented 1 July 2026. - Full escalation process is to be agreed: Recovery Action Plan's escalated to Performance & Finance Committee for the Care Groups of greatest concern. - Finance training included in LISA programme was developed to support operational managers. - Enhanced communications strategy to support ownership of the finance agenda. - Alignment with clinical priorities through the Integrated Recovery Plan – action plans signed off 30 June 2026. - Strengthened CIP development & support delivery - Appointment of Financial Improvement Director and external support that are directly supporting the 8 most challenged Care Groups to deliver their CIP and financial plans. **Advise** • Request for external cash support for both HUTH and NLAG for September is pending approval. • Underlying deficit position of £127.0m. • Awaiting response to request to reprofile Capital Tower Block expenditure across 2 year programme. • Capital expenditure behind plan at Month 4 with delays in progressing HRI SDEC and Tower Block schemes and the ITU at DPOW. Expecting to recover and spend up to the allocation received.
Background Information and/or Supporting Document(s) (if applicable)	BAF extract PEF AAA Report included of 1 September 2026 Month 4 Financial Position included in the appendices for information section of the agenda
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Financial considerations are an integral element of the update provided so no further updates in this section.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	It is important as we are considering changes and plans for the use of resources these considerations are taken into account through a robust EQIA process.
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)198

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**10 Sept 2026**
Director Lead	**Murray Macdonald, Chair of Performance, Estates and Finance Committees-in-Common**
Contact Officer / Author	**Rebecca Crashley, Deputy Director of Assurance**
Title of Report	**Performance, Estates and Finance Committees-in-Common Highlight / Escalation Report to the Trust Boards**
Executive Summary	This report sets out the items of business considered by the Performance, Estates and Finance Committees-in-Common at their meeting held on 1 September 2026 including those matters which the committees specifically wish to escalate to either or both Trust Boards. **Recommendation/s** The Boards-in-Common are asked to note the contents of the report.
Background Information and/or Supporting Document(s) (if applicable)	**N/A**
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	**All financial implications are included in the report**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**N/A**
Recommended action(s) required	☐ Approval ✓ Information ✓ Assurance ☐ Other – please detail below:

BAF to which the paper relates:	Tick all those appropriate
Our Patients - Access	✓
Our Patients - Safety	☐
Our People	☐
Our Partnerships	☐
Our Pioneers	☐
Our Public Purse	✓

V3

ADVISE, ALERT and ASSURE REPORT	
Meeting	Performance, Estates and Finance Committees-in-Common
Meeting date	01 September 2026
Chair	Murray Macdonald, Non-Executive Director
Quoracy requirements met	Yes

1. **Key items discussed**

TO ALERT (Areas of non-compliance or matters that need addressing urgently)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Digital				
EPR requires organizational focus	EPR oversight, committee governance and capacity to support the pace of improvement was required.		EPR chosen supplier in place, designs being developed and to be approved before build phase. April 27 go live. Being managed through contractual processes.	
Cost Pressures outstripping budgets	Rising digital costs, including both core systems and transformational spend was raised as a concern.		Foundations business case being written in the next 3 months which will outline the baseline on system costs currently. This will be managed at budget planning	

			sessions for 2026/27.	
Digital Oversight clarification	Need for clarity regarding oversight of cyber security, information governance and digital development activity.		Governance team to advise on best split between ARG and PEF.	**Update at Board meeting**
Finance				
Year to date £13.3m adverse to plan	The month 4 financial position was on plan in month for NLAG and saw a very small improvement in run-rate for HUTHT.		The financial recovery programme board was now in place and the minutes would be presented to PEF for review.	Updates to the next CiC September 2026
Year-end position estimated between £26m and 76M adverse to plan	The year-end financial forecast was still being reported as deficit to plan through the Provider Assurance Model including scenarios for Best Mid and Worst cases.		The finance teams were carrying out forecast scenario planning.	
Cash position requires NHS support	There was a material cash risk requiring ongoing NHS E support. The CiC was asked to recommend Board approval of £29.6m cash support for Q3.		The CiC recommended Board approval of the cash support from NHS E.	Update at Board

Performance				
UEC non-compliance with constitutional standards	Whilst the North Bank performance had improved, there were still further actions in progress with the South Bank. The CiC required evidence that improvements could be sustained under winter pressure. Paediatric 4 hour performance remains a risk, due to ED workforce. South Bank performance remains fragile with 12 hour waits being above trajectory (longer than planned wait times) and ambulance handover deterioration. Paediatric flow remains a risk.		UEC Board has executive oversight via the CDO. North Bank Ambulance handover has improved significantly and there have been a reduction in 12 hour waits. Temporary Escalation Spaces in place on the North and South bank with digital support across the wards. Although TES remain outside of the normal ward footprint, it is not classified as corridor care as the spaces have designated facilities for safe patient care. UTC at HRI to open 24/7 in October 2026. This will help ensure right clinical care for type 3 patient cohort away from ED at HRI. Increased grip and control measures are being implemented on the South and North Bank to improve earlier discharges through the SHOP model.	Updates to the next CiC September 2026

			Internal Professional Standards and red lines on safety being implemented to support clinical leadership teams in managing safe patient flows across both the organisations, with impetus in the South in the next 4 weeks	
RTT 52+ non compliance with constitutional standards	Performance remains off trajectory and requires continued attention. Validation remains critical.		GiRFT review of the waiting list management and data quality validation has been signed off by the CDO. Planning for implementing the recommendations is in progress ensuring a clear and streamlined governance structure on assurance and delivery from specialty to Board. There will also be alignment with the Care Group Performance and Accountability meetings ensuring an integrated approach preventing duplication. The process will be based on an earned autonomy basis with final sign off by the CDO through the Planned Care Board. The work on outpatient transformation programme is	

			progressing to include clear deliverables for 2026/27 around pathway and process redesign. Progress update to PEF will be provided in October 26 by the CDO.	
Cancer 28/62 day non compliance with constitutional standards	The 28 day faster diagnostic standard is a critical sustainability measure because any variability and capacity constraints continue to impact the 62 day backlog.		An expert cancer resource supported by NHSE as the recovery director is expected to start soon supporting in-year cancer performance recovery and pathway redesign. This will include implementing best-practice timed pathways at tumour site towards delivering longer-term sustainability in performance. Demand and capacity modelling completed for outpatients. The admitted element is being finalised. The aim is for the tool to be used at specialty level for the management of demand and capacity. This will be a critical shift from a reactive to proactive operational planning with impact assessment on performance as well as	

			workforce outputs linked to productivity.	
ADVISE (Areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Estates and Facilities				
Cleaning Harmonisation	Confirmation that the cleaning tender remained on schedule and the Group was waiting for an update from Capsticks regarding TUPE of staff.		Contract start date was June 2027 The proposed increase in cost was clarified at £497,700 per year. An extension of the programme management (as dedicated resource was required) secondment had been submitted through the vacancy control process and was awaiting a decision.	June 2027
Fire Safety Annual Report	The Fire Safety Annual Report was received.	N/A	There was no material concerns raised as core standards were being monitored and managed.	
Winter Plan	A comprehensive winter plan is in place. There has been significant preparatory work		The CiC gave approval for Board sign off with the caveats that demonstrating	

	on discharge, length of stay, flu vaccination, SDEC pathways and alternatives to ED.		sustainability, testing winter performance and reliance on system partner support were all key to successful implementation. Board sign off 10/09/26 for National sign off 30/09/26	
ASSURE (Areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Committee Business				
Car parking – security Tender	Tendered through the market with one successful bid.	N/A	The CiC required further clarification on the three exclusions and confirmation on affordability. ES suggested that the revised information could be considered virtually ahead of the 29 September PEF due to the award proceeding to the Board.	
Group Performance Report	The CiC identified gaps in the new report, particularly the absence of clear variable pay measures and a stronger finance-workforce-quality triangulation.	N/A	The CiC agreed that the GPR and the BAF should be positioned prominently at the start of the Board agendas to drive discussion.	

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)199

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	10th September 2026
Director Lead	Sam Peate, Group Chief Delivery Officer Emma Sayner, Group Chief Finance Officer
Contact Officer / Author	Chris Fry, Associate Director, Performance & Insights Jackie Railton, Deputy Director, Planning and Performance Louise Topliss, Head of Performance
Title of Report	Group Performance Report
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) • Delivery against the 26/27 Operating Plan trajectories for UEC and RTT are detailed in the paper.
Background Information and/or Supporting Document(s) (if applicable)	Performance, Estates and Finance Committees-in-Common escalation report included within this paper.
Prior Approval Process	
Financial Implication(s) (if applicable)	Report references delivery of activity versus plan with inherent links to income generation via block contract.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Report references delivery of access targets, with inherent links to equity of access across the Group
Recommended action(s) required	☐ Approval ✓ Information ✓ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Integrated Performance Report

Reporting Month:
July 2026

United by Compassion:
Driving for Excellence

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

disability confident EMPLOYER

VETERAN AWARE

CiC Oversight Dashboard

Operational Performance

Metric	Period	Actual	Plan	V	A	Status
A&E - 4 Hour Standard (All - Footprint)	Jul-26	71.4%	≥ 74.2%			Alert
A&E - 4 Hour Standard (All)	Jul-26	66.0%	≥ 68.8%			Alert
A&E - Patients Waiting > 12 hours in Department	Jul-26	11.6%	≤ 13.0%			Assure
Cancer - 28 Day Faster Diagnosis Standard	Jun-26	66.1%	≥ 69.0%			Alert
Cancer - 62 Day All Referral Sources	Jun-26	57.4%	≥ 55.0%			Assure
Diagnostics - 6 Week Standard	Jul-26	35.2%	≤ 30.5%			Alert
RTT - Incomplete 18 Week Standard	Jul-26	57.3%	≥ 56.8%			Assure
RTT - Percentage of 52+ Week Waits	Jul-26	3.7%	≤ 3.4%			Alert

Quality of Care

Metric	Period	Actual	Plan	V	A	Status
CQC Inpatient Survey Satisfaction Mean Score	Jul-26	8.2				
CQC Safe Inspection Score	Jul-26	1.5				
Falls - Serious harm or death	Jul-26	5				
Infections - C.Difficile (Cumulative)	Jun-26	46				
Infections - E.Coli (Cumulative)	Jun-26	120				
Infections - Klebsiella (Cumulative)	Jun-26	37				Assure
Mortality - SHMI	Mar-26	1.0				Advise
Patient Safety Incidents - Moderate harm	Jul-26	97				
Patient Safety Incidents - Severe harm	Jul-26	9				
Pressure Ulcers - Category 3	Jul-26	19				
Pressure Ulcers - Category 4	Jul-26	1				

People (Group)

Metric	Period	Latest	Previous	Change
Staff Appraisal Rate (AfC)	Jun-26	81.8%	80.7%	0
Staff e-Job Planning	Jul-26	94.3%		1
Staff Mandatory Training - Core	Jun-26	87.1%	86.6%	0
Staff Mandatory Training - Role Specific	Jun-26	82.9%	81.7%	0
Staff Sickness Absence Rate	Jun-26	4.8%	4.8%	0
Staff Turnover Annual FTE Rate	Jun-26	12.0%	6.8%	0

Finance and Productivity (Group)

Metric	Period	Latest	Previous	Change
Finance - CIP YTD against Plan	Jun-26	65.3%	62.5%	0
Finance - Planned Surplus/Deficit	Jun-26	(63,065)	(63,065)	0
Finance - Variance YTD to Financial Plan	Jun-26	(10,207)	(5,972)	-4235

Monthly Trend Key

- Improvement on previous reported month
- Deterioration on previous reported month
- No change on previous reported month

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1. Overview

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

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

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

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

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

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

2. Regulation and Compliance

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

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

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

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

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

3. HHP Key Metric Oversight Scorecard

Oversight Group	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Access to Services	Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	55.5%	56.2%	62.2%	70.8%	65.8%	64.1%	55.9%	72.9%	73.0%	68.4%	66.2%	66.1%	
		Cancer - 62 Day All Referral Sources	≥ 80.0%	56.1%	55.9%	52.9%	59.7%	61.0%	57.4%	55.4%	55.3%	61.3%	56.9%	53.6%	57.4%	
	Elective Care	RTT - Incomplete 18 Week Standard	≥ 92.0%	58.5%	57.5%	57.6%	57.6%	57.1%	56.8%	56.0%	56.2%	58.0%	58.0%	58.8%	58.4%	
		RTT - Percentage of 52+ Week Waits	≤ 1.0%	3.2%	3.6%	3.5%	3.5%	3.6%	3.3%	3.4%	3.3%	3.0%	3.1%	3.3%	3.5%	
	Urgent & Emergency Care	A&E - 4 Hour Standard (All - Footprint)		72.5%	73.8%	70.9%	69.9%	68.7%	69.3%	69.6%	72.4%	73.8%	73.7%	70.8%	69.6%	71.4%
		A&E - 4 Hour Standard (All)	≥ 82.0%	67.1%	68.5%	65.0%	63.4%	62.5%	62.9%	62.0%	66.3%	68.1%	67.8%	65.0%	64.2%	66.0%
		A&E - Patients Waiting > 12 hours in Department	≤ 0.0%	13.0%	12.1%	15.3%	17.1%	15.9%	16.0%	20.2%	14.7%	11.7%	11.4%	12.8%	12.9%	11.6%
Effectiveness & Experience	Effectiveness	Inpatient - Days between DRD and Discharge Date		4.4	4.6	4.5	4.1	4.5	4.6	4.3	5.5	5.1	5.2	4.8	5.2	5.4
		Mortality - SHMI	≤ 1.0	1.029	1.025	1.023	1.015	1.015	1.015	1.005	1.012	1.024				
	Experience	CQC Inpatient Survey Satisfaction Mean Score		8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2
Finance & Productivity	Financial Balance	Finance - CIP YTD against Plan		83.0%	85.1%	85.3%	81.5%	77.6%	75.8%	74.9%	71.3%	72.9%	60.8%	62.5%	65.3%	
		Finance - Variance YTD to Financial Plan		(3,030)	(3,035)	(3,276)	(4,779)	(7,922)	(18,306)	(29,300)	(36,357)	(36,521)	(2,244)	(5,972)	(10,207)	
Patient Safety	Patient Safety	CQC Safe Inspection Score		1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
		Infections - C.Difficile (per 1,000 bed days)		0.23	0.20	0.21	0.20	0.18	0.28	0.36	0.25	0.29	0.39	0.25	0.25	
		Infections - E.Coli (per 1,000 bed days)		0.85	0.80	0.91	0.83	0.62	0.58	0.49	0.87	0.50	0.86	0.82	0.66	
		Infections - MRSA (per 1,000 bed days)		0.00	0.02	0.00	0.02	0.00	0.04	0.02	0.02	0.05	0.02	0.06	0.02	
		Staff Survey - Raising Concerns sub-score		6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1
People & Workforce	People & Workforce	Staff Sickness Absence Rate	≤ 4.0%	4.7%	4.7%	4.7%	4.8%	4.8%	4.8%	4.7%	4.8%	4.8%	4.8%	4.8%	4.8%	
		Staff Turnover Annual FTE Rate	≤ 8.0%	7.7%	7.9%	7.2%	7.4%	7.2%	7.0%	6.7%	6.9%	6.9%	6.4%	6.8%	12.0%	
Reducing Inequalities	Primary Prevention	Diagnostics - 6 Week Standard	≤ 1.0%	31.4%	36.2%	33.4%	35.3%	38.5%	43.7%	44.9%	36.6%	31.8%	35.9%	36.8%	35.2%	35.2%

4. HHP Group Executive Summary – Performance

Executive Lead: Sam Peate, Group Chief Delivery Officer

Accountable to: Performance, Estate and Finance Committee

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
A&E - 4 Hour Standard (All - Footprint)	Jul-26	≥ 72.6%	70.6%		
A&E - 4 Hour Standard (All)	Jul-26	≥ 62.6%	62.2%		
A&E - 4 Hour Standard (Type 1)	Jul-26	≥ 48.0%	49.8%		
A&E - 4 Hour Standard (Type 3)	Jul-26	≥ 95.0%	93.0%		
A&E - Ambulance Handovers within 45 minutes	Jul-26	≥ 96.3%	98.3%		
A&E - DTA to Admission > 12 hours	Jul-26	≤ 0.0%	5.5%		
A&E - Patients Waiting > 12 hours in Department	Jul-26	≤ 12.3%	5.6%		
Cancer - 28 Day Faster Diagnosis Standard	Jun-26	≥ 69.0%	67.3%		
Cancer - 31 Day All Stages	Jun-26	≥ 75.0%	77.2%		
Cancer - 62 Day All Referral Sources	Jun-26	≥ 53.0%	54.4%		
Diagnostics - 6 Week Standard	Jul-26	≤ 31.3%	36.6%		
Diagnostics - Total Activity Levels	Jul-26	≥ 21,850	21,652		
Inpatient - Cancelled Operations 28 Day perfomance	25/26 Q4	≤ 5.0%	39.1%		
Inpatient - Days between DRD and Discharge Date	Jul-26	≤ 3.8	5.3		
Outpatient - Total Overdue Backlog (3 months+)	Jul-26		47,753		
RTT - 52+ Week Waits	Jul-26	≤ 3,308	3,331		
RTT - 65+ Week Waits	Jul-26	≤ 0	277		
RTT - Incomplete 18 Week Standard	Jul-26	≥ 56.0%	56.0%		
RTT - Total Incomplete Pathways	Jul-26	≤ 83,196	85,756		
Theatres - Capped Theatre Utilisation	Jul-26	≥ 85.0%	82.0%		

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
A&E - 4 Hour Standard (All - Footprint)	Jul-26	≥ 75.9%	72.2%		
A&E - 4 Hour Standard (All)	Jul-26	≥ 74.0%	69.0%		
A&E - 4 Hour Standard (Type 1)	Jul-26	≥ 53.0%	50.3%		
A&E - 4 Hour Standard (Type 3)	Jul-26	≥ 99.0%	98.6%		
A&E - Ambulance Handovers within 45 minutes	Jul-26	≥ 88.5%	73.6%		
A&E - DTA to Admission > 12 hours	Jul-26	≤ 0.0%	50.3%		
A&E - Patients Waiting > 12 hours in Department	Jul-26	≤ 13.7%	17.3%		
Cancer - 28 Day Faster Diagnosis Standard	Jun-26	≥ 69.0%	64.0%		
Cancer - 31 Day All Stages	Jun-26	≥ 94.9%	94.1%		
Cancer - 62 Day All Referral Sources	Jun-26	≥ 60.3%	64.1%		
Diagnostics - 6 Week Standard	Jul-26	≤ 29.7%	33.5%		
Diagnostics - Total Activity Levels	Jul-26	≥ 28,830	18,971		
Inpatient - Cancelled Operations 28 Day perfomance	25/26 Q4	≤ 5.0%	16.7%		
Inpatient - Days between DRD and Discharge Date	Jul-26	≤ 4.4	5.6		
Outpatient - Total Overdue Backlog (3 months+)	Jul-26		35,902		
RTT - 52+ Week Waits	Jul-26	≤ 887	1,412		
RTT - 65+ Week Waits	Jul-26	≤ 0	98		
RTT - Incomplete 18 Week Standard	Jul-26	≥ 58.6%	59.8%		
RTT - Total Incomplete Pathways	Jul-26	≤ 40,093	42,605		
Theatres - Capped Theatre Utilisation	Jul-26	≥ 85.0%	81.5%		

Chief Delivery Officer Update – Performance Overview (July 2026)

Planned Care performance in July presents a deteriorating risk position despite some areas moving in the intended direction. RTT incomplete performance fell at both Trusts, long waits increased materially, cancer standards deteriorated across the principal measures and diagnostics remain significantly off the national standard and continue to be constrained by Outpatient capacity.

Cancer performance was mixed in June. HUTH improved against the 62-day and 31-day standards, while Faster Diagnosis deteriorated to 67.3%; but improved to 64% at NLAG, with the latest available position remaining below standard. Continued reliance remains on tumour pathway grip, protected diagnostics, pathology, MDT and treatment capacity.

Diagnostics remain a major constraint to elective and cancer recovery. Six-week performance improved at both Trusts, but total waits increased and performance remains materially above the 1% standard, requiring modality- and site-level recovery trajectories for MRI, CT, NOUS and endoscopy, alongside system agreement on capacity, workforce, reporting turnaround and seven-day CDC utilisation.

RTT recovery is fragile. Incomplete performance fell to 56% at HUTH and 59.8% at NLAG, while 65-week waits increased to 277 and 98 respectively and 52-week waits increased to 3,331 and 1,412. Weekly specialty trajectories dated patient-level plans and escalation of outpatient, diagnostic, theatre, workforce and mutual-aid gaps are required to prevent further replenishment of the long-wait cohorts.

Outpatient access and productivity remain key enablers. Time to First Appointment deteriorated at both Trusts, theatre utilisation remains below the 85% benchmark, NLAG follow-up backlog increased and cancelled operations not rebooked within 28 days worsened. Executive focus should remain on specialty-level ownership, booking and SPOA controls, use of PIFU and discharge, theatre session fill and daily cancellation PTL management.

Unplanned Care performance in July remained below plan across both Trusts, with all-type four-hour performance at 62.2% for HUTH against a 62.6% plan and 69.0% for NLAG against a 74.0% plan. The overall position reflects sustained Type 1 demand, adverse pathway mix and continuing downstream flow constraints, with NLAG presenting the greater immediate risk.

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

HUTH maintained Type 1 performance on plan and ambulance handovers remained assured; however, Type 3 performance and whole-pathway flow remain the key gaps. Although mean time to treatment and non-admitted time improved from June, both remain above target and require sustained focus on UTC access, streaming, rapid assessment and alternatives to ED.

NLAG saw Type 1 performance below plan, handovers deteriorate and decision-to-admit waits remain a material risk. Although mean time to treatment improved and non-admitted time remained relatively stable, the combination of handover, admission and front-door delay requires immediate recovery oversight.

Demand mix remains adverse: Type 1 attendances stayed above trajectory while Type 3 attendances remained below plan at both Trusts, increasing pressure on emergency departments and reducing the expected benefit of UTC and redirection pathways.

a. Hull University Teaching Hospitals Performance AAA Summary

Count: 13

Alert

A&E - 4 Hour Standard (All - Footprint)
A&E - 4 Hour Standard (All)
A&E - 4 Hour Standard (Type 3 - Footprint)
A&E - 4 Hour Standard (Type 3)
A&E - DTA to Admission > 12 hours
Cancer - 28 Day Faster Diagnosis Standard
Diagnostics - 6 Week Standard
Diagnostics - Total Activity Levels
Inpatient - Cancelled Operations 28 Day perfomance
Inpatient - Days between DRD and Discharge Date
Outpatient - Total Overdue Backlog (3 months+)
RTT - 65+ Week Waits
RTT - Total Incomplete Pathways

Count: 1

Advise

Theatres - Capped Theatre Utilisation

Count: 7

Assure

A&E - 4 Hour Standard (Type 1)
A&E - Ambulance Handovers within 45 minutes
A&E - Patients Waiting > 12 hours in Department
Cancer - 31 Day All Stages
Cancer - 62 Day All Referral Sources
RTT - 52+ Week Waits
RTT - Incomplete 18 Week Standard

b. Northern Lincolnshire and Goole Hospitals Performance AAA Summary

Count: 16

Alert

A&E - 4 Hour Standard (All - Footprint)
A&E - 4 Hour Standard (All)
A&E - 4 Hour Standard (Type 1)
A&E - 4 Hour Standard (Type 3)
A&E - Ambulance Handovers within 45 minutes
A&E - DTA to Admission > 12 hours
A&E - Patients Waiting > 12 hours in Department
Cancer - 28 Day Faster Diagnosis Standard
Cancer - 31 Day All Stages
Diagnostics - 6 Week Standard
Diagnostics - Total Activity Levels
Inpatient - Cancelled Operations (%)
Inpatient - Days between DRD and Discharge Date
RTT - 52+ Week Waits
RTT - 65+ Week Waits
RTT - Total Incomplete Pathways

Count: 1

Advise

Theatres - Capped Theatre Utilisation

Count: 3

Assure

A&E - 4 Hour Standard (Type 3 - Footprint)
Cancer - 62 Day All Referral Sources
RTT - Incomplete 18 Week Standard

c. Unplanned Care

Four-hour performance was below June plan at HUTH (58.6% against 62.1%) and NLAG (68.7% against 73.8%).

Demand mix remains adverse. HUTH Type 1 was on plan (46.9% against 47.0%); NLAG was below plan (50.3% against 52.0%). Type 3 was below plan at HUTH (87.9% against 95.0%) and NLAG (97.8% against 99.0%).

Admission delay is the principal risk: decision-to-admit waits over 12 hours were 15.7% at HUTH and 41.0% at NLAG. Ambulance handovers were strong at HUTH (98.3%) but below plan at NLAG (80.3%).

Progress

- HUTH Type 1 was on plan; handovers were strong and over-12-hour stays remained within threshold (10.2%).
- NLAG Type 1 improved, but overall performance, handovers and DTA waits remained off plan; over-12-hour stays were within threshold (15.6%).
- Mean time to treatment increased at both Trusts and non-admitted time remained above target.
- HRI frailty, streaming, SDEC and UTC work progressed alongside SHOP and stronger board and ward rounds.
- Golden Patient, EDD, criteria-led discharge and Home First remain the key actions for earlier flow.
- MADE, South Bank escalation and system reviews continued to support flow.

Action

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

Monitor delivery daily against Trust recovery milestones and escalate variance.

- The South bank are taking a flow out model to SLT in 3 weeks for agreement by all CoS and Exec – this was implemented in the North some time ago and is working well, this would improve Ambulance handovers, 4 and 12 hour performance within ED and give better patient experience, there may be a deterioration of TES spaces initially until the discharge AM profile improves accordingly.
- Continue work on Criteria to admit and ensure embedding once working well.
- Commencement of LoS rounds with GIRFT SGH 7th September, DPOW 14th September and HUTH 27th September, 3 wards each site and commencing with >21 days and working down to 7 days.
- Embed seven-day senior decision-making and criteria-led admission and discharge.
- Reduce long stays through weekly review of patients exceeding 21 days and escalate NCTR barriers.
- Actions to inform Winter Planning which is due for Board approval in September

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Effective	Urgent & Emergency Care	A&E - 4 Hour Standard (All - Footprint)		68.8%	71.6%	68.5%	67.3%	67.4%	69.5%	69.8%	70.4%	73.2%	74.6%	70.0%	67.5%	70.6%
		A&E - 4 Hour Standard (Type 1 - Admitted)		24.5%	25.8%	21.5%	21.4%	24.9%	26.3%	23.4%	24.2%	26.5%	31.0%	26.0%	26.2%	31.2%
		A&E - 4 Hour Standard (Type 1 - NonAdmitted)		52.5%	55.5%	51.0%	49.5%	50.5%	56.7%	50.9%	56.4%	61.5%	64.4%	56.7%	55.2%	57.5%
		A&E - 4 Hour Standard (Type 1)		44.1%	46.3%	42.1%	40.9%	42.6%	47.1%	42.6%	46.3%	50.7%	54.1%	47.7%	46.9%	49.8%
		A&E - Ambulance Average Handover Time		22.8	20.8	23.1	23.8	23.9	23.8	26.6	20.4	19.2	18.6	19.5	20.1	19.1
		A&E - Ambulance Handovers within 45 minutes		95.4%	96.8%	95.3%	94.6%	92.8%	93.2%	91.1%	90.4%	98.2%	96.3%	97.8%	98.3%	98.3%
		A&E - Assessed within 60 minutes		90.2%	91.4%	84.6%	80.4%	84.3%	88.0%	87.0%	92.5%	94.1%	93.3%	91.6%	92.1%	92.1%
		A&E - Corridor Care in Dept		37	34	48	41	30	33	44	26	22	17	23	29	12
		A&E - DTA to Admission > 12 hours	≤ 0.0%	12.6%	10.5%	19.8%	21.5%	16.3%	19.7%	28.0%	14.7%	11.7%	9.2%	15.0%	14.7%	5.5%
		A&E - DTA to Admission > 24 hours	≤ 0.0%	1.6%	1.4%	3.1%	5.2%	3.4%	4.8%	10.4%	1.0%	0.6%	0.8%	0.3%	0.8%	0.0%
		A&E - Patients Waiting > 12 hours in Department	≤ 0.0%	12.3%	10.1%	15.0%	17.4%	14.2%	14.0%	18.3%	11.8%	9.0%	6.9%	10.5%	10.2%	5.6%
		A&E - Specialty Referral to Departure within 30 minutes		11.7%	11.8%	10.8%	11.0%	11.0%	11.6%	11.1%	13.3%	13.1%	12.0%	10.6%	12.3%	12.4%
		A&E - Time to Initial Assessment	≤ 15	22	20	30	34	29	24	25	19	17	18	20	21	20
		A&E - Total Time in A&E (Admitted)	≤ 180	576	532	668	733	622	638	801	579	509	465	545	543	415
	Effectiveness	Inpatient - Corridor Care on Wards		56.2	51.8	65.2	60.7	57.4	64.9	70.9	68.8	49.3	40.0	46.7	45.9	41.1
		Inpatient - Discharge Lounge Utilisation		13.9%	13.5%	14.3%	12.2%	11.6%	7.3%	11.2%	14.9%	15.5%	14.7%	14.5%	15.0%	16.3%
		Inpatient - Discharge to Assess (D2A) over 14 days		1.5%	2.7%	2.6%	1.7%	1.7%	2.3%	2.4%	3.2%	2.9%	3.0%	2.9%	2.4%	3.1%
		Inpatient - Discharges by 5pm		64.2%	61.7%	63.8%	62.2%	63.9%	65.2%	61.0%	64.7%	64.7%	62.2%	61.6%	63.4%	64.0%
		Inpatient - Long Stay Occupancy (21+ days)		186.5	196.8	211.8	190.7	183.3	183.3	210.5	208.3	199.2	203.8	192.3	194.6	178.3

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

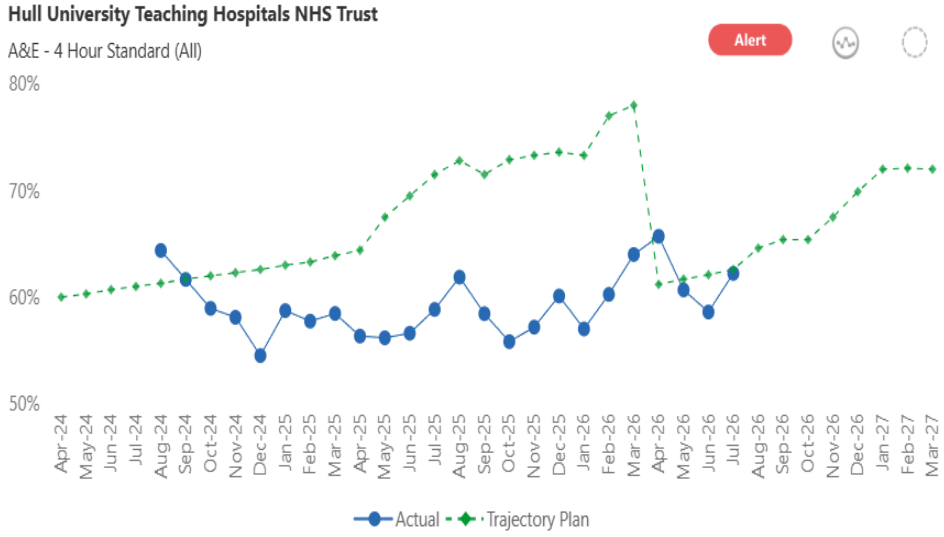
Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Effective	Urgent & Emergency Care	A&E - 4 Hour Standard (All - Footprint)		76.6%	76.1%	73.4%	72.7%	70.1%	68.9%	69.4%	74.6%	74.4%	72.8%	71.7%	71.7%	72.2%
		A&E - 4 Hour Standard (Type 1 - Admitted)		14.4%	17.9%	10.1%	11.1%	9.6%	11.2%	7.7%	8.8%	10.8%	8.3%	10.3%	8.7%	8.3%
		A&E - 4 Hour Standard (Type 1 - NonAdmitted)		64.3%	64.5%	57.9%	57.1%	51.9%	50.8%	50.5%	64.0%	64.7%	60.2%	58.3%	58.9%	58.3%
		A&E - 4 Hour Standard (Type 1)		54.5%	55.4%	48.9%	48.0%	43.7%	42.3%	41.8%	54.5%	54.9%	51.2%	49.9%	50.6%	50.3%
		A&E - Ambulance Average Handover Time		30.0	31.0	29.0	26.0	37.0	51.0	61.0	45.0	32.0	36.0	31.0	32.0	38.0
		A&E - Ambulance Handovers within 45 minutes		83.6%	82.4%	83.3%	86.5%	75.6%	65.6%	57.0%	71.5%	81.7%	77.2%	82.5%	80.3%	73.6%
		A&E - Assessed within 60 minutes		72.9%	77.8%	76.2%	73.7%	69.3%	66.8%	68.4%	79.0%	79.1%	80.9%	80.4%	78.2%	76.7%
		A&E - Corridor Care in Dept		7	7	9	9	10	11	10	11	9	11	10	11	8
		A&E - DTA to Admission > 12 hours	≤ 0.0%	27.0%	27.4%	33.0%	33.3%	38.0%	37.8%	52.5%	48.9%	32.9%	39.2%	38.5%	41.0%	50.3%
		A&E - DTA to Admission > 24 hours	≤ 0.0%	5.1%	7.5%	7.6%	7.9%	11.0%	11.6%	16.9%	14.7%	6.5%	9.7%	8.1%	10.3%	10.5%
		A&E - Patients Waiting > 12 hours in Department	≤ 0.0%	13.7%	14.2%	15.7%	16.8%	17.6%	18.1%	22.2%	17.5%	14.1%	15.8%	15.0%	15.6%	17.3%
		A&E - Specialty Referral to Departure within 30 minutes		5.6%	6.0%	5.2%	5.0%	4.1%	4.2%	4.5%	4.2%	5.0%	4.0%	3.7%	4.1%	5.0%
		A&E - Time to Initial Assessment	≤ 15	47	43	46	48	53	56	52	43	42	41	41	43	45
		A&E - Total Time in A&E (Admitted)	≤ 180	603	581	670	667	687	667	776	730	667	701	697	710	767
	Effectiveness	Inpatient - Corridor Care on Wards		2.0	2.1	2.9	2.5	1.8	3.8	3.8	3.8	4.0	7.0	3.4	3.7	1.9
		Inpatient - Discharge Lounge Utilisation		19.6%	19.8%	17.1%	20.9%	16.4%	17.7%	19.5%	19.4%	20.0%	21.2%	19.2%	18.0%	16.0%
		Inpatient - Discharge to Assess (D2A) over 14 days		1.3%	2.3%	1.9%	2.4%	2.4%	3.2%	3.2%	5.0%	4.0%	1.6%	4.5%	3.2%	0.6%
		Inpatient - Discharges by 5pm		74.8%	74.1%	74.7%	72.5%	75.5%	73.6%	71.3%	72.0%	73.1%	71.4%	71.8%	73.7%	71.2%
		Inpatient - Long Stay Occupancy (21+ days)		71.5	76.7	77.0	78.6	83.1	84.9	85.5	97.3	87.0	81.8	84.8	88.1	87.8

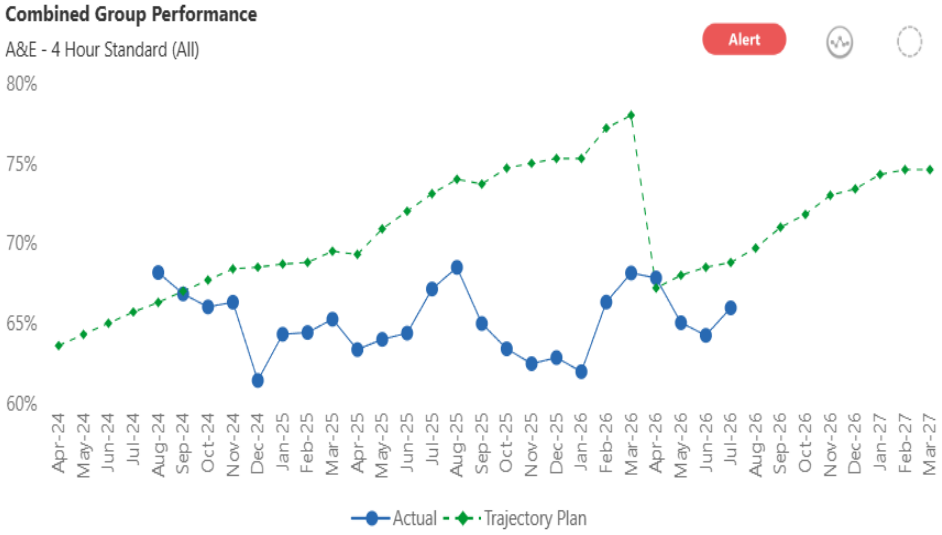
i. Emergency Care Standards – 4-hour Performance

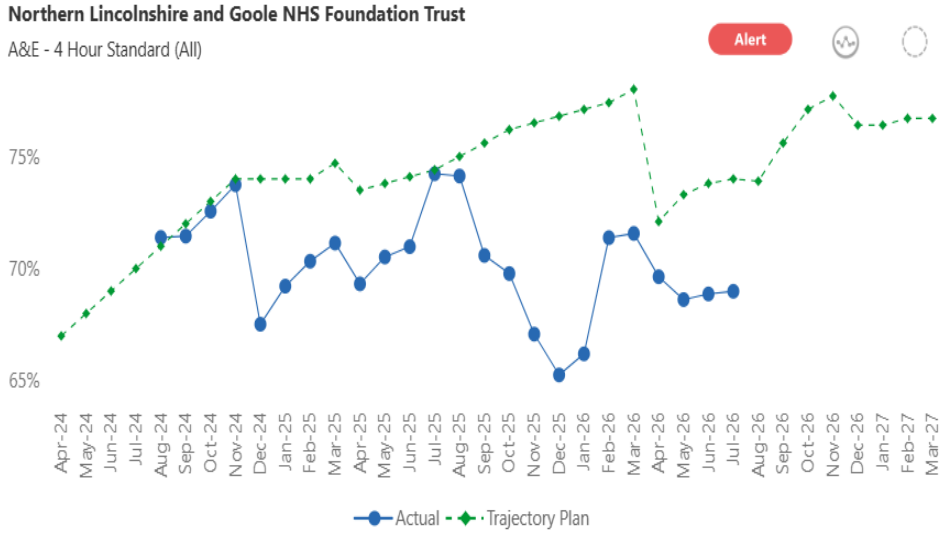
A&E - 4 Hour Standard (All)

Progress:
- All-type performance was below July plan at HUTH (62.2% vs 62.6%) and NLAG (69.0% vs 74.0%).
- HUTH Type 1 was on plan and handovers were assured; despite improvement, Type 3 and whole-pathway flow remain the gaps.
- NLAG Type 1 slipped by 0.3%, with handovers and decision-to-admit waits deteriorated.
- Frailty, UTC, streaming, MADE and NCTR work progressed during July.

Action:
- Recover HUTH UTC and Type 3 performance with CHCP; strengthen frailty, streaming and SDEC.
- Maintain flow through the HRI ED Majors decant and flooring works.
- Deliver South Bank actions to recover NLAG handovers and DTA performance.
- Escalate demand, NCTR and discharge constraints with partners; track named milestones daily. : FSDEC continues on the ward but working through plans for implementation at the front door.







ii. Enabler Metric 1: Mean Time to Treatment

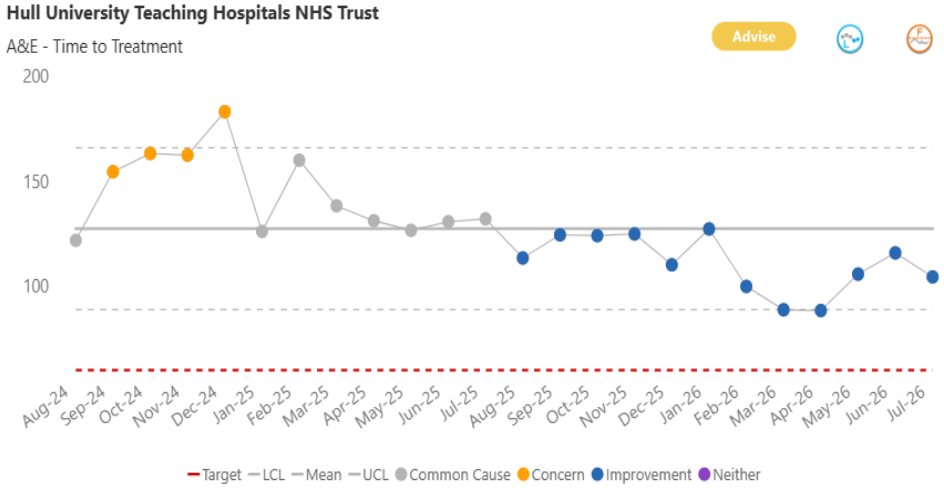
A&E - Time to Treatment

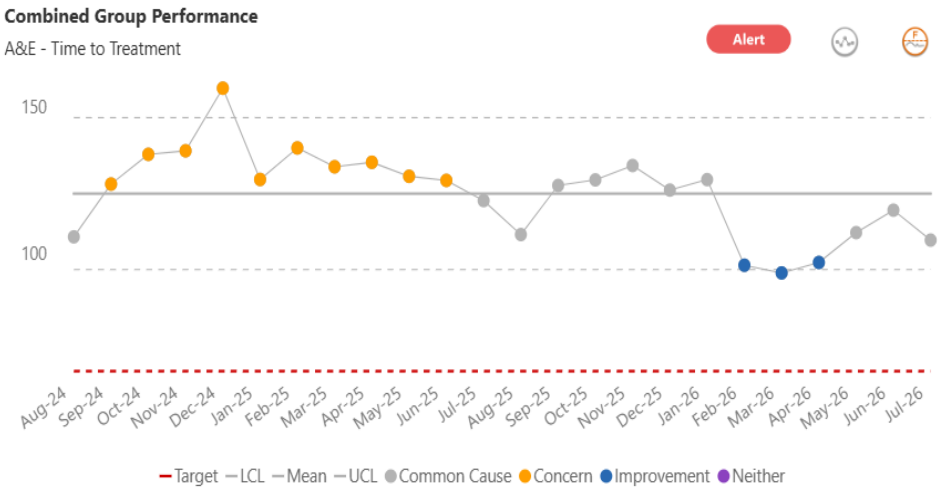
HUTH:

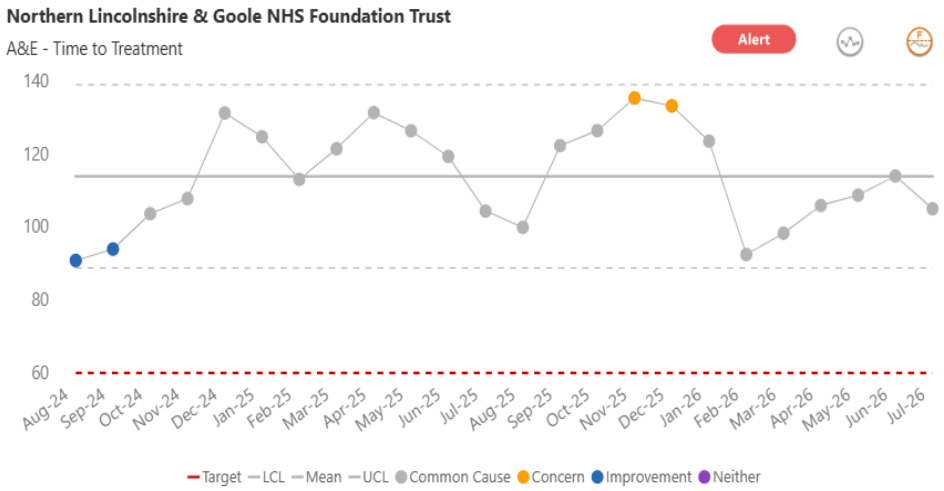
Mean time to treatment decreased in July following deterioration in May and June but remains above 100minutes. It remains below the historical mean but above the operational target, so early clinical assessment, streaming and rapid decision-making must be sustained during peak demand.

NLAG:

Mean time to treatment also improved in July but remains materially above target. This continues to reflect Type 1 demand and flow constraints; recovery requires rapid assessment, effective streaming, escalation of delays and senior clinical decision-making at the front door.







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

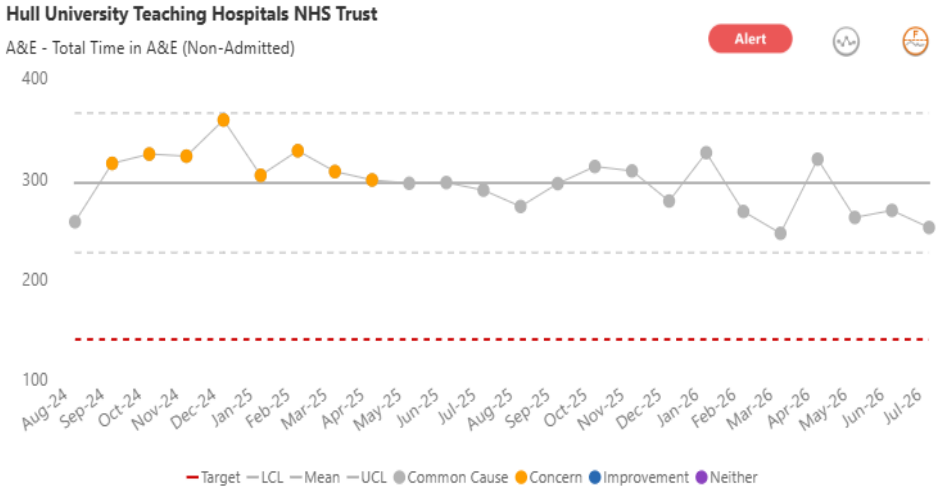
A&E - Total Time in A&E (Non-Admitted)

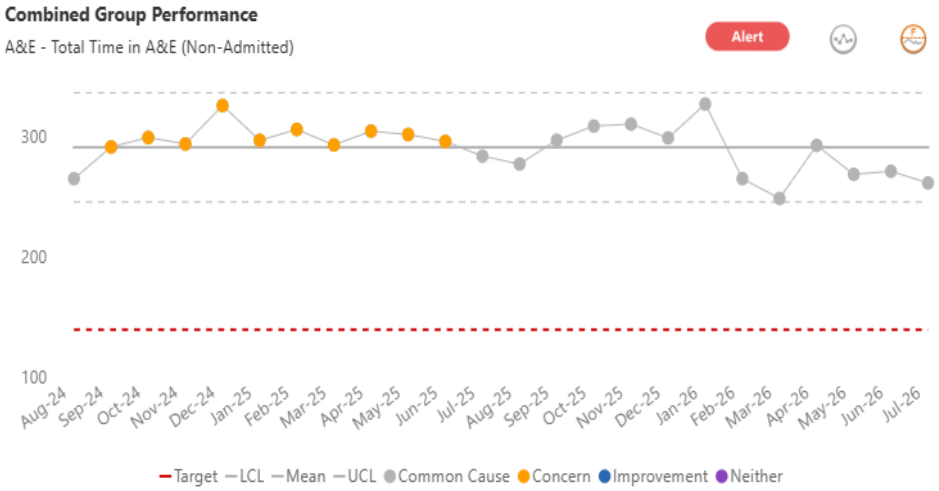
HUTH:

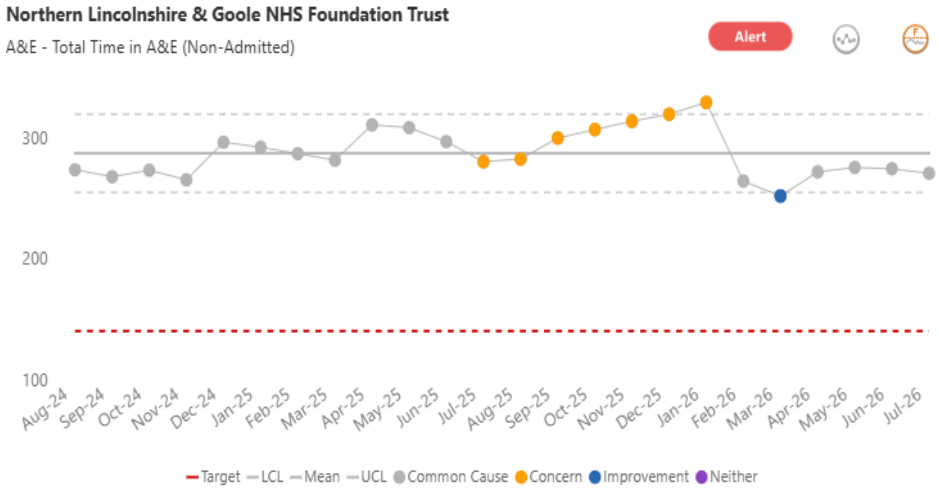
Non-admitted time reduced slightly in July following deterioration in June but remains substantially above target. The response is to strengthen early streaming, rapid assessment and discharge from ED pathways, with daily review of avoidable waits for patients who do not require admission.

NLAG:

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







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

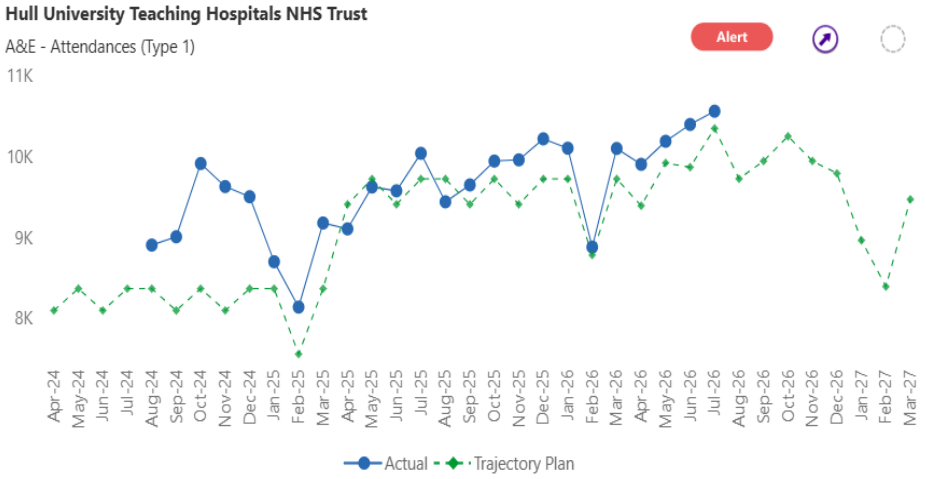
A&E - Attendances (Type 1)

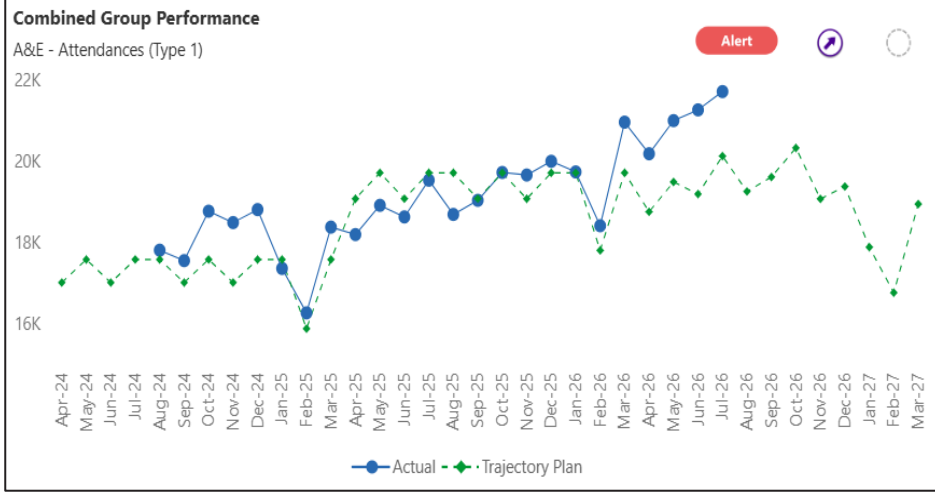
HUTH:

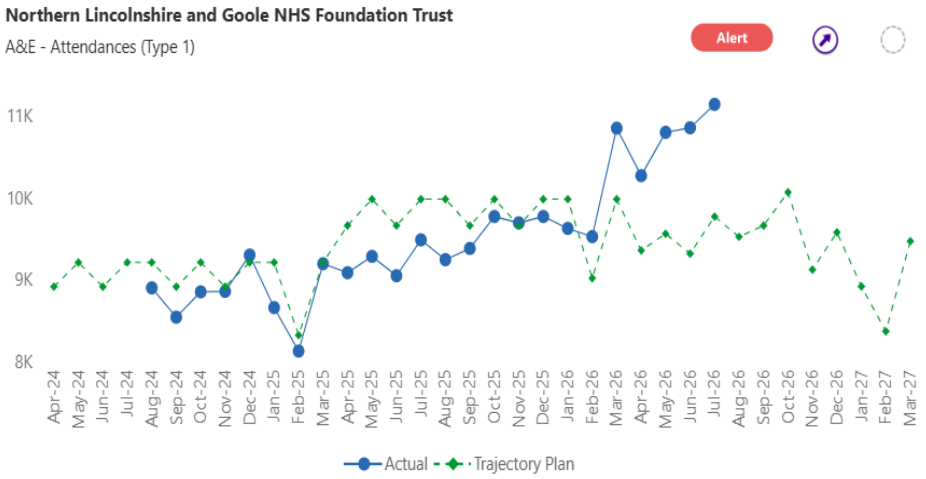
Type 1 attendances remained above trajectory in July (+213) and continue to show sustained upward pressure. This was not planned and is contributing to the four-hour performance gap; action is focused on streaming, alternatives to ED, SDEC and demand management with system partners.

NLAG:

Type 1 attendances remained materially above trajectory in July (+1,273), with recent months indicating a sustained shift in demand. Recovery requires stronger UTC streaming, alternatives to ED, site-level demand management and system action to reduce avoidable Type 1 conveyance and attendance.







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

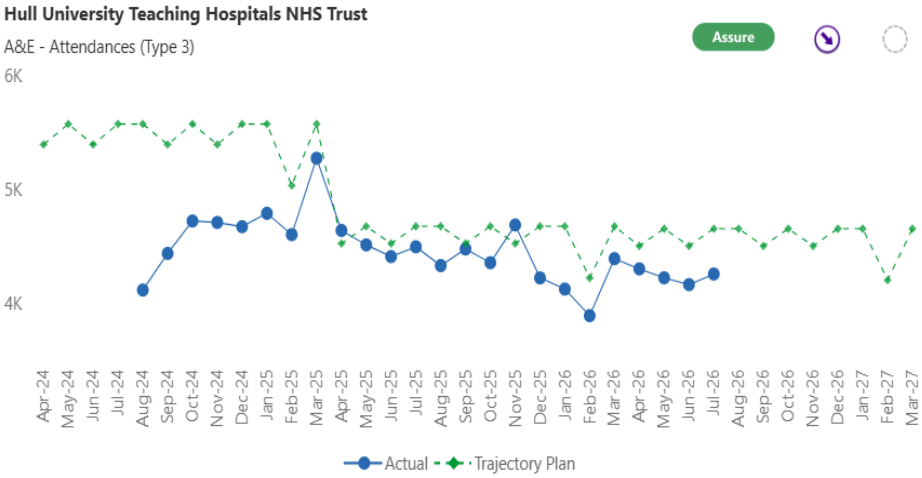
A&E - Attendances (Type 3)

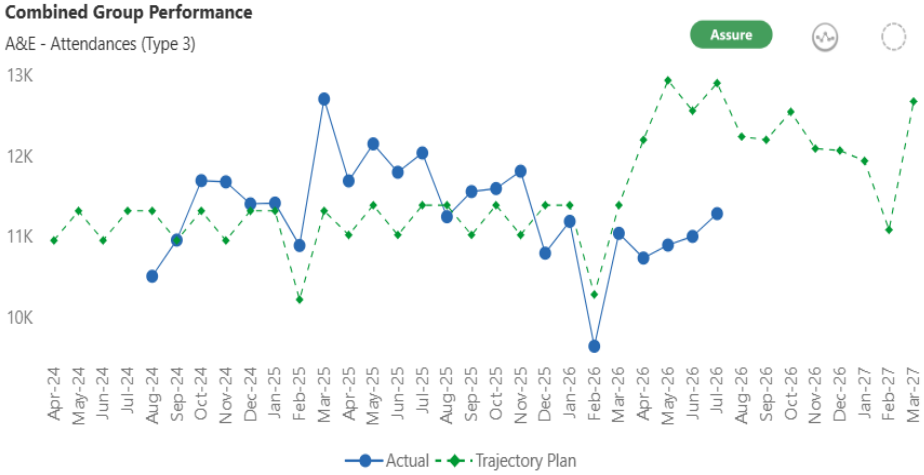
HUTH:

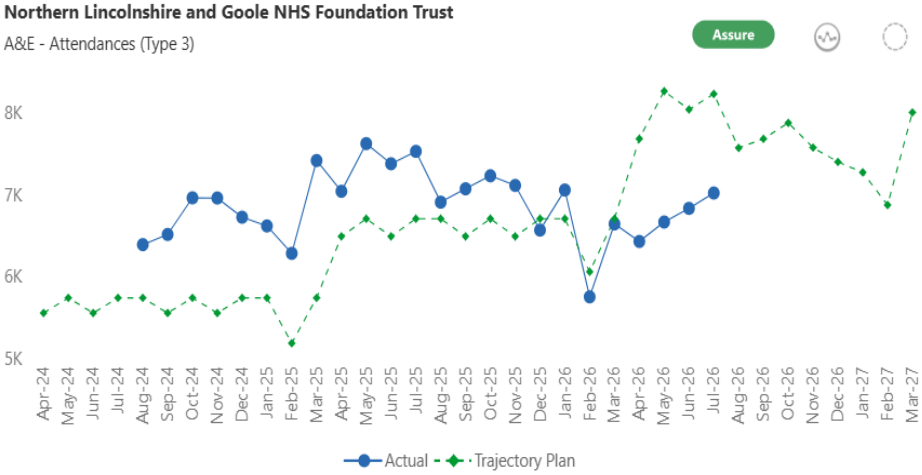
Type 3 attendances remained below trajectory in July (-398) while Type 1 demand was above plan. Although the statistical classification is Assure, the demand shift is operationally adverse and increases pressure on ED flow; UTC access, streaming and redirection pathways require review with system partners.

NLAG:

Type 3 attendances remained below trajectory (-1,213), while Type 1 activity was materially above plan. The Assure classification reflects the statistical direction, but the pathway mix is adverse; actions are to strengthen UTC utilisation, streaming, redirection and public access to alternatives to ED.







d. Planned Care

The national extended submission timetable for July RTT saw validation improve the HUTH 18wk position to 56%, which alongside NLAG at 59.8% maintains us on trajectory, however both PTL's are c2.5k higher than plan indicating that performance is inflated by growth.

Long waits remain the principal risk. 65-week waits were 277 at HUTH and 98 at NLAG, increases of 53 and 20 from June. The 52-week position increased by 143 at HUTH to 3,331 (+23 to plan) and by 94 at NLAG to 1,412 (+525 to plan).

Progress

Validation improved to 95.0% at HUTH but fell to 87.5% at NLAG. Time to First Appointment deteriorated to 62.6% and 69.6%, showing continuing pressure on first outpatient access and non-admitted clock stops.

Diagnostic six-week waits improved by 0.6 points at HUTH to 36.6% but worsened by 0.9 points at NLAG to 33.5%. Activity increased and total waits reduced slightly at both Trusts, but performance remains materially outside the 1% standard.

Cancer was mixed at HUTH: 62-day and 31-day performance improved to 54.4% and 81.4%, while Faster Diagnosis fell to 67.3%. July cancer data was not populated for NLAG; the latest available position remains below standard.

Theatre utilisation fell to 82.0% at HUTH and 81.5% at NLAG. Follow-up backlogs increased to 47,753 and 35,902 respectively, so current productivity and pathway actions are not yet producing the required reduction.

Action

Use weekly specialty trajectories for 52-, 65- and 78-week cohorts, with dated patients, named owners and immediate escalation where capacity is not secured.

- Recover first outpatient access through booking controls, validation, referral management and SPOA/GIRFT pathway redesign.
- Deliver MRI, CT, NOUS and endoscopy recovery by modality and site. Support required: agreement on additional capacity, workforce, reporting and funding.
- Reset tumour-site milestones against Best Practice Timed Pathways. Support required: protected diagnostics, pathology, MDT and treatment capacity.
- Improve theatre session fill, starts, finishes and cancellation recovery, with Care Group ownership and rapid resolution of workforce gaps.
- Reduce follow-up backlogs through clinical validation, PIFU and discharge, with funded capacity where demand exceeds supply.
- Report weekly through Planned Care governance, distinguishing published metrics from management information and showing trajectory, action impact, owner and delivery date.

HUTH

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Effective	Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	50.8%	52.1%	59.8%	70.7%	60.2%	58.7%	52.9%	74.6%	76.6%	71.2%	70.6%	67.3%	
		Cancer - 31 Day All Stages	≥ 94.0%	76.7%	74.0%	69.1%	75.5%	74.0%	76.7%	67.5%	76.2%	78.4%	73.5%	75.2%	77.2%	
		Cancer - 31 Day First Treatment	≥ 94.0%	80.1%	76.1%	73.7%	81.1%	80.3%	78.3%	72.3%	77.4%	80.0%	81.2%	79.7%	81.4%	
		Cancer - 62 Day All Referral Sources	≥ 80.0%	54.9%	48.8%	50.2%	55.5%	57.4%	53.7%	52.0%	51.6%	56.0%	52.9%	49.4%	54.4%	
		Cancer - 62 Day GP Referral	≥ 80.0%	52.2%	33.2%	44.3%	49.9%	49.7%	43.6%	39.7%	44.5%	55.8%	49.4%	41.2%	44.1%	
		Cancer - PTL Waits 104+ days		311	304	298	336	241	236	222	232	237	232	226	235	
	Elective Care	Outpatient - Clinic Slot Utilisation		95.8%	96.6%	95.4%	94.5%	94.4%	93.3%	95.1%	96.4%	95.6%	95.9%	95.5%	94.6%	95.0%
		Outpatient - DNA Rate	≤ 8.5%	7.2%	6.8%	5.8%	5.8%	5.9%	6.0%	5.9%	5.4%	5.6%	5.7%	5.8%	5.8%	5.9%
		Outpatient - Hospital cancellations < 6 weeks	≤ 5.0%	7.3%	7.2%	7.0%	7.1%	7.4%	7.0%	6.9%	6.9%	7.0%	6.4%	6.9%	7.1%	7.0%
		Outpatient - Total Overdue Backlog (3 months+)		44,856	46,268	46,343	46,284	47,461	48,561	47,880	46,880	47,001	46,354	46,905	46,821	47,753
		RTT - 52+ Week Waits		2,954	3,261	3,216	3,221	3,291	3,072	3,157	3,110	2,796	2,888	3,069	3,188	3,331
		RTT - 65+ Week Waits	≤ 0	63	62	85	96	134	112	131	109	65	89	141	224	277
		RTT - 78+ Week Waits	≤ 0	0	0	2	0	0	0	0	2	0	1	3	5	7
		RTT - Incomplete 18 Week Standard	≥ 92.0%	57.9%	56.7%	56.7%	56.5%	56.0%	55.6%	54.9%	54.6%	56.3%	56.3%	57.3%	56.8%	56.0%
		RTT - Pathways Validated within 12 weeks	≥ 90.0%	95.7%	90.2%	94.9%	93.5%	95.5%	95.6%	96.9%	95.5%	93.9%	92.0%	92.0%	92.5%	95.0%
		RTT - Patients waiting <= 18 weeks for 1st appointment		66.3%	65.1%	64.5%	64.3%	64.4%	62.6%	62.9%	62.9%	64.6%	65.1%	65.4%	64.3%	62.6%
		RTT - Total Incomplete Pathways		79,776	80,655	80,583	81,279	80,790	81,643	81,337	81,319	80,999	83,615	84,208	84,186	85,756
	Productivity	Theatres - Capped Theatre Utilisation	≥ 85.0%	79.8%	81.1%	79.6%	80.0%	81.3%	81.0%	80.0%	80.6%	82.1%	81.9%	82.2%	82.6%	82.0%
		Theatres - Early Finishes		64.5%	68.4%	65.6%	66.9%	64.2%	66.0%	69.7%	67.6%	67.2%	63.3%	64.8%	62.4%	65.9%
		Theatres - Late Starts		67.3%	65.4%	68.6%	69.9%	68.7%	66.0%	69.0%	65.4%	61.7%	64.7%	65.5%	66.4%	68.7%
Responsive	Primary Prevention	Diagnostics - 6 Week Standard	≤ 1.0%	26.2%	32.4%	30.0%	31.3%	34.5%	40.2%	42.8%	35.9%	33.8%	38.1%	38.6%	37.2%	36.6%
		Diagnostics - Total Activity Levels		20,598	18,463	20,488	20,788	19,009	18,875	20,662	20,542	21,934	18,996	19,337	20,386	21,652
		Diagnostics - Total Waits		16,742	15,668	17,424	18,458	19,247	20,037	21,431	21,518	23,025	22,796	22,456	23,901	23,885

NLAG

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Effective	Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	65.0%	64.3%	66.7%	70.8%	75.6%	73.8%	62.2%	69.9%	66.4%	63.0%	58.5%	64.0%	
		Cancer - 31 Day All Stages	≥ 94.0%	93.7%	95.1%	94.9%	95.5%	97.3%	98.7%	90.8%	96.0%	98.1%	97.1%	92.2%	94.1%	
		Cancer - 31 Day First Treatment	≥ 94.0%	93.2%	95.1%	96.5%	94.8%	97.3%	98.0%	92.1%	95.8%	98.1%	98.0%	93.8%	93.6%	
		Cancer - 62 Day All Referral Sources	≥ 80.0%	58.8%	71.7%	59.1%	67.2%	70.4%	66.1%	62.1%	63.3%	74.2%	65.0%	64.0%	64.1%	
		Cancer - 62 Day GP Referral	≥ 80.0%	46.6%	66.4%	45.1%	54.8%	58.5%	61.1%	57.1%	58.5%	66.8%	60.1%	61.0%	54.9%	
		Cancer - PTL Waits 104+ days		46	45	42	41	39	34	42	32	40	40	46	35	
	Elective Care	Outpatient - Clinic Slot Utilisation		94.5%	94.9%	95.7%	92.9%	91.9%	92.0%	92.8%	92.3%	92.9%	92.1%	92.3%	93.1%	79.0%
		Outpatient - DNA Rate	≤ 8.5%	7.4%	7.5%	7.6%	7.4%	7.3%	7.6%	7.2%	6.8%	7.0%	7.1%	6.7%	6.8%	6.8%
		Outpatient - Hospital cancellations < 6 weeks	≤ 5.0%	7.9%	8.3%	8.2%	8.0%	9.1%	8.0%	7.6%	7.5%	8.4%	8.3%	8.8%	7.8%	8.0%
		Outpatient - Total Overdue Backlog (3 months+)		33,445	34,506	33,862	33,993	33,696	34,055	33,275	33,183	33,951	34,735	35,405	35,729	35,902
		RTT - 52+ Week Waits		895	1,025	1,045	994	988	915	930	873	820	915	1,038	1,218	1,412
		RTT - 65+ Week Waits	≤ 0	40	54	64	27	29	42	26	38	32	41	50	78	98
		RTT - 78+ Week Waits	≤ 0	1	2	3	1	0	0	1	2	2	0	1	2	2
		RTT - Incomplete 18 Week Standard	≥ 92.0%	59.9%	59.1%	59.3%	59.7%	59.5%	59.2%	58.3%	59.5%	61.4%	61.4%	62.0%	61.6%	59.8%
		RTT - Pathways Validated within 12 weeks	≥ 90.0%	89.4%	90.6%	90.2%	89.1%	87.8%	90.0%	85.0%	91.2%	93.0%	86.1%	89.5%	90.4%	87.5%
		RTT - Patients waiting <= 18 weeks for 1st appointment		68.8%	68.4%	67.6%	67.3%	68.0%	67.2%	66.5%	69.7%	71.3%	72.2%	72.4%	71.6%	69.6%
		RTT - Total Incomplete Pathways		39,114	39,698	40,146	40,156	39,296	39,294	39,644	39,443	39,652	40,793	41,548	42,012	42,605
	Productivity	Theatres - Capped Theatre Utilisation	≥ 85.0%	79.7%	80.8%	81.9%	79.9%	81.1%	82.9%	81.3%	81.5%	81.8%	83.7%	83.9%	84.0%	81.5%
		Theatres - Early Finishes		58.2%	49.7%	50.3%	61.4%	57.1%	52.4%	53.9%	57.4%	53.2%	58.4%	52.7%	47.4%	58.5%
		Theatres - Late Starts		100.0%	98.0%	100.0%	98.4%	99.0%	99.4%	98.5%	98.2%	98.3%	100.0%	98.7%	98.8%	98.8%
Responsive	Primary Prevention	Diagnostics - 6 Week Standard	≤ 1.0%	35.1%	38.8%	35.9%	38.4%	41.6%	46.5%	46.5%	37.2%	29.9%	33.0%	34.4%	32.6%	33.5%
		Diagnostics - Total Activity Levels		27,347	26,367	25,259	25,578	24,155	23,942	25,902	25,258	30,874	17,662	16,752	17,219	18,971
		Diagnostics - Total Waits		24,103	22,803	23,942	24,162	25,675	26,004	26,804	27,270	24,997	17,062	16,998	18,789	18,447

a. Cancer 62 Day First Definitive Treatment

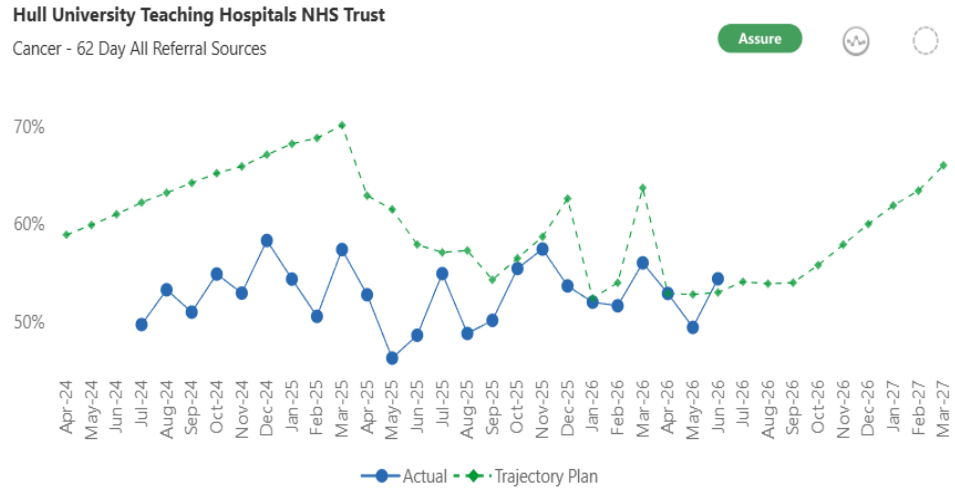
Cancer - 62 Day All Referral Sources

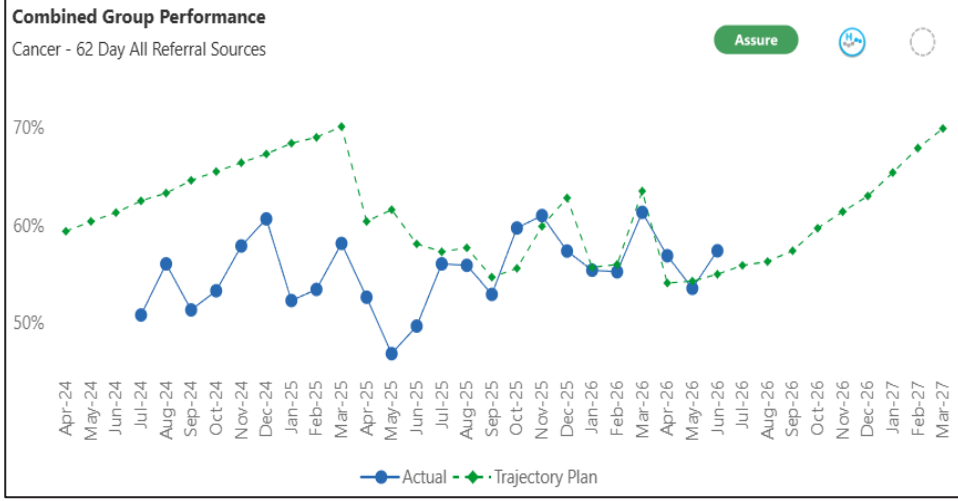
Summary:

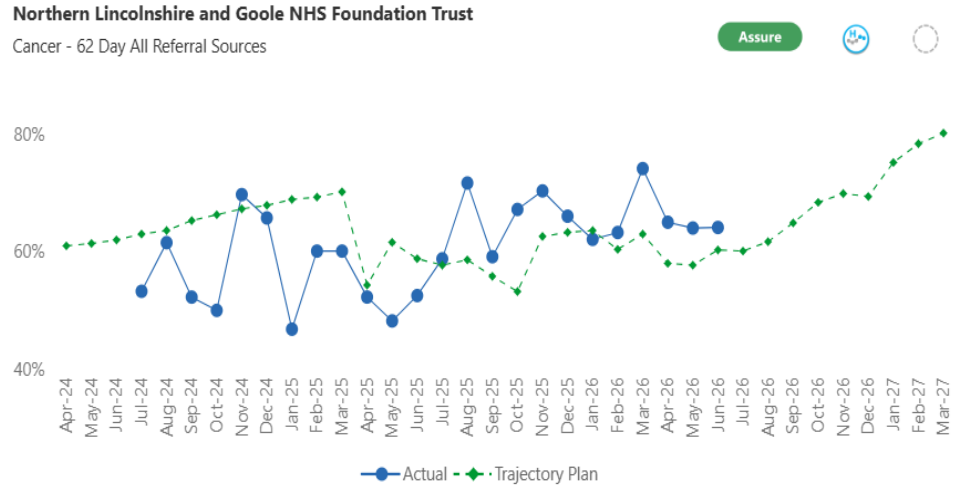
Performance improved by 5 points at HUTH to 54.4% and by 0.1 at NLAG at 64.1%. Both Trusts are above local trajectory, but below the 80% standard.

Progress: Radiotherapy, scheduling, histology cross-cover and urology recruitment were intended to improve delivery; the June change shows benefits have not yet translated into performance.

Action: Complete tumour-level breach analysis and BPTP review. Support required: protected diagnostics, pathology, MDT, theatre/robotic capacity and rapid Care Group escalation of gaps.







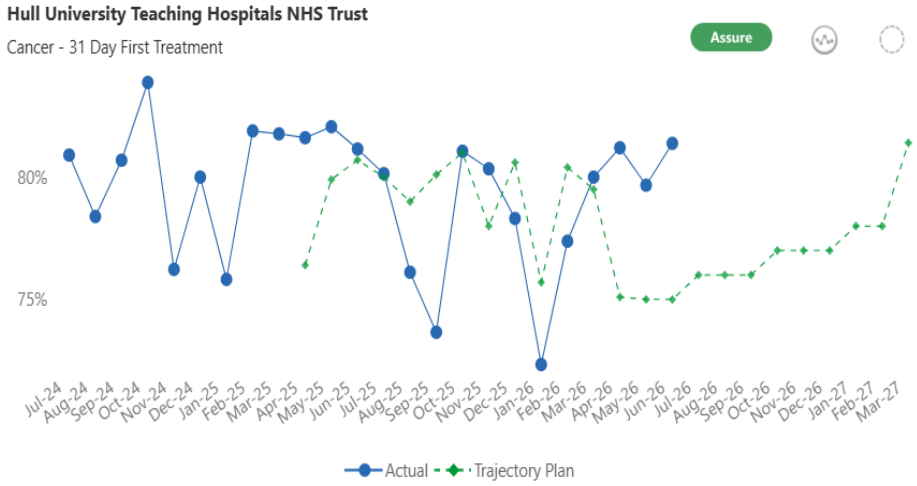
ii. Cancer 31-day First Treatment

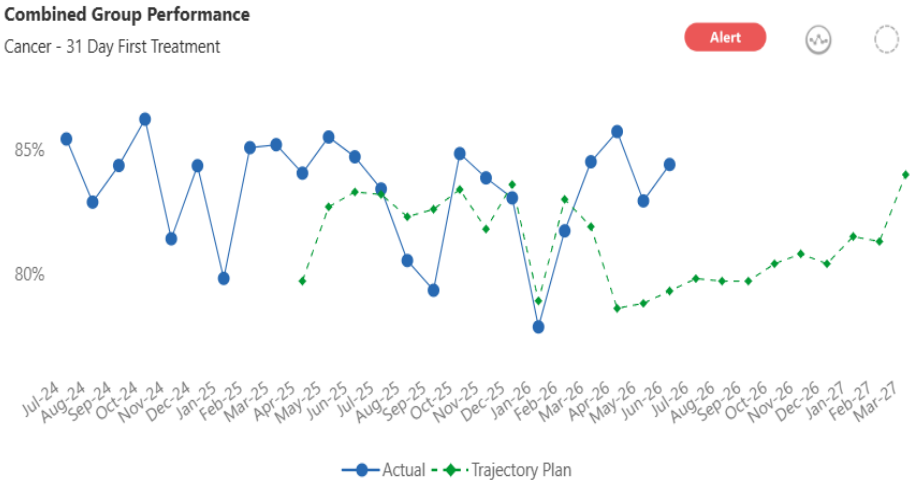
Cancer - 31 Day First Treatment

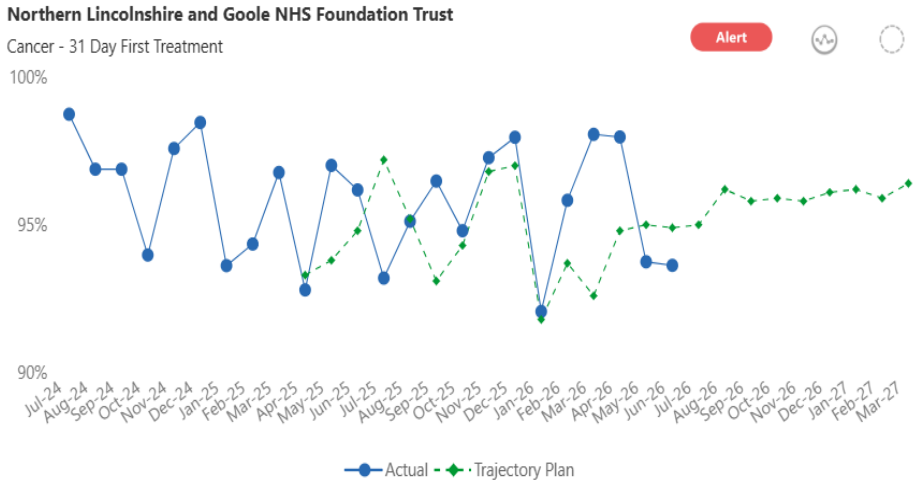
Summary:
Performance improved by 1.7 points at HUTH to 81.4% but deteriorated further at NLAG to 93.6%. The deterioration was not expected and both Trusts are below the 94% standard.

Progress:
Tumour pathway, radiotherapy, scheduling, histology and urology actions were planned to improve flow; the June result indicates inconsistent benefit.

Action:
Review every 31-day breach and reset tumour-level trajectories. Support required: timely diagnostics/MDT decisions, protected treatment slots and executive resolution of capacity gaps.







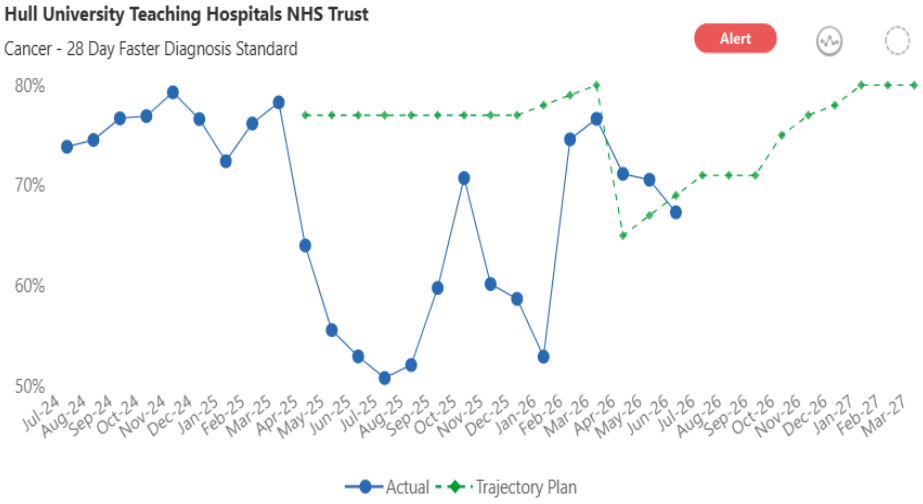
iii. Cancer 28-day Faster Diagnosis Performance

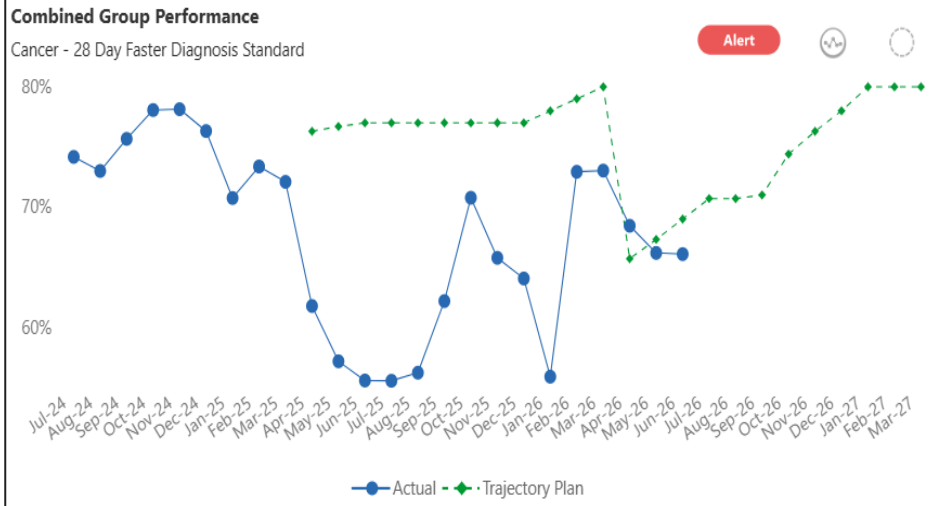
Cancer - 28 Day Faster Diagnosis Standard

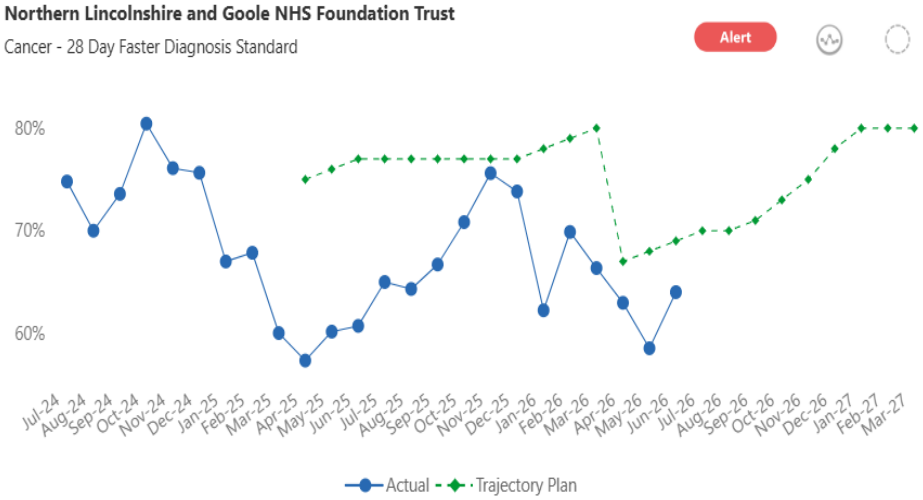
Summary:
Performance fell below trajectory to 67.3% at HUTH reflecting the deterioration in Outpatient capacity and NLAG improved to 64% but remains below trajectory.

Progress:
Urology, Lower GI and nurse-endoscopy work was intended to stabilise performance, but the improvement has not been sustained across pathways.

Action:
Complete BPTP reviews and weekly tumour-site diagnostics tracking. Support required: Breast Radiologist and fellow recruitment, increased nurse endoscopy and reporting capacity.







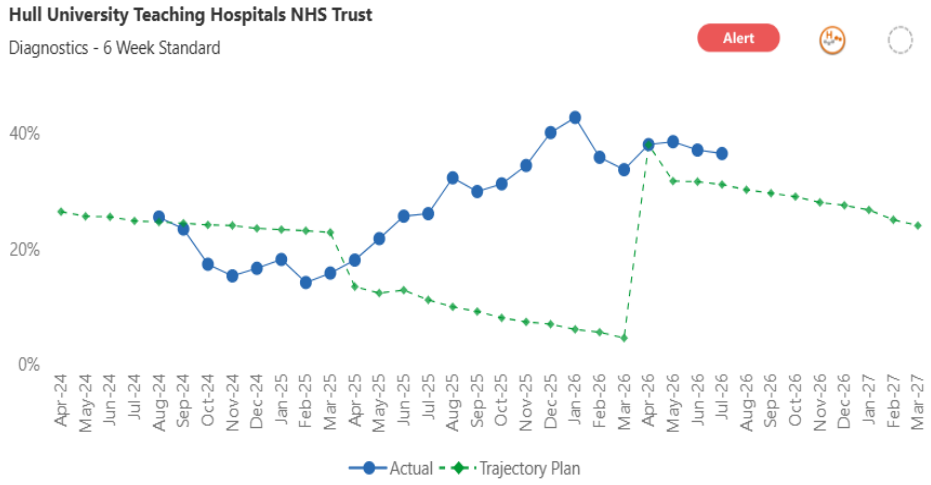
iv. Diagnostic 6-Week Standard

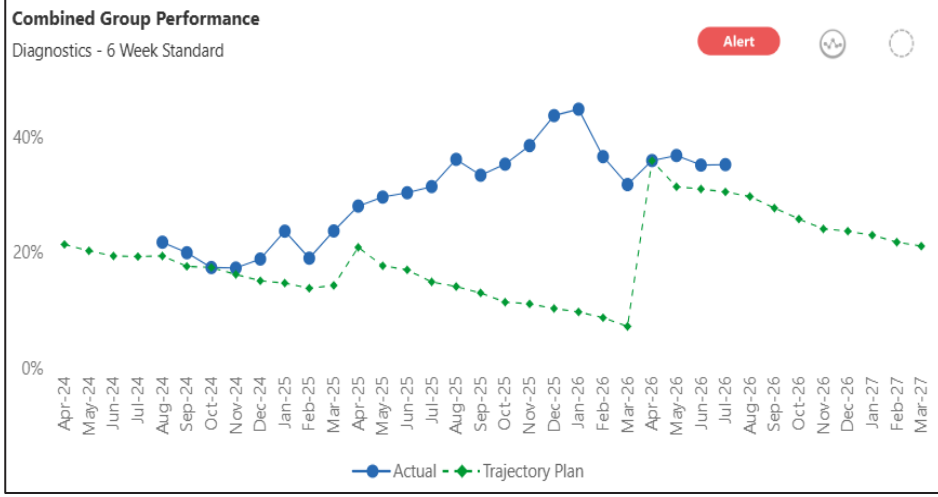
Diagnostics - 6 Week Standard

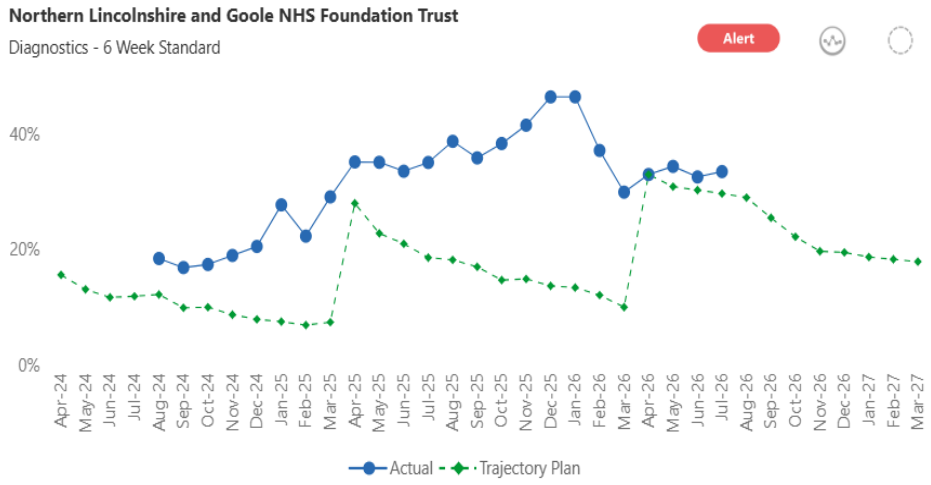
Summary:
Six-week waits improved by 0.6 points at HUTH to 36.6% and deteriorated by 0.9 points at NLAG to 33.5%. The direction is expected as recovery actions take traction however waiting list growth at HUTH is a factor.

Progress:
CDC, NOUS, non-recurrent investment and Scunthorpe MRI actions are generating some improvement, but demand continues to exceed delivered capacity.

Action:
Set modality/site recovery trajectories. Support required: system agreement on MRI/CT capacity, workforce, reporting turnaround, funding and seven-day CDC utilisation.







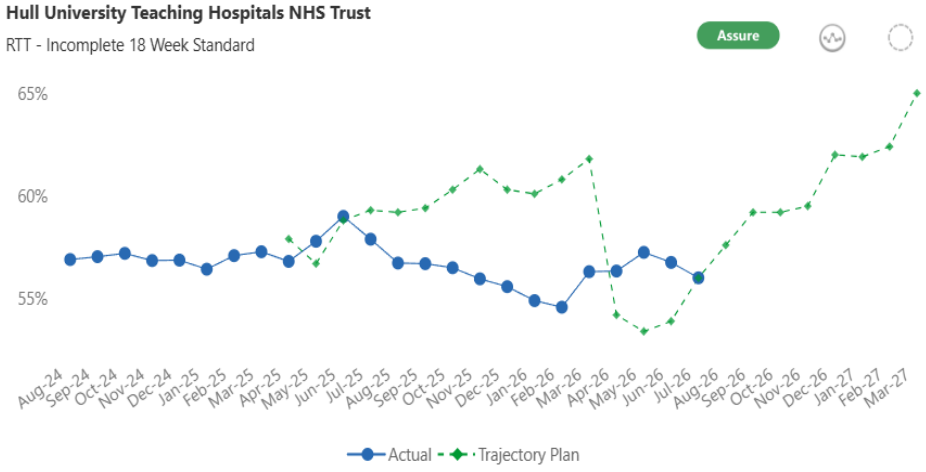
v. RTT Incomplete Performance

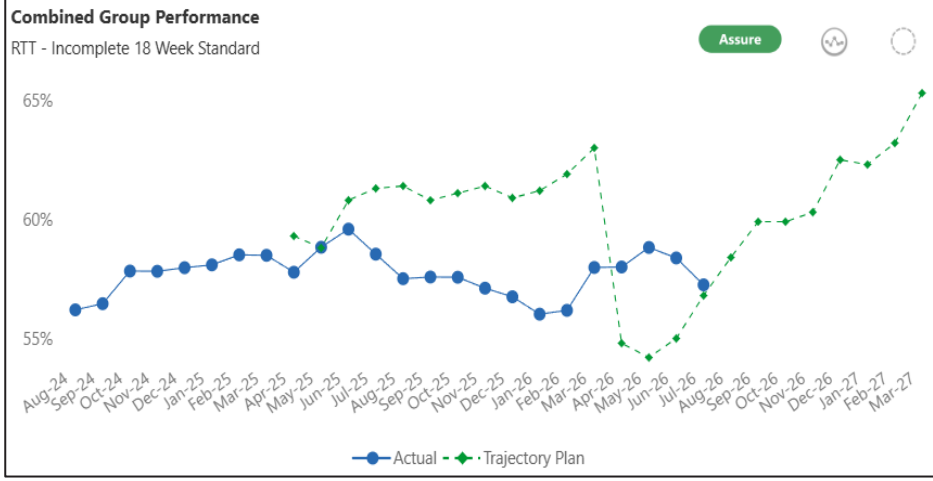
RTT - Incomplete 18 Week Standard

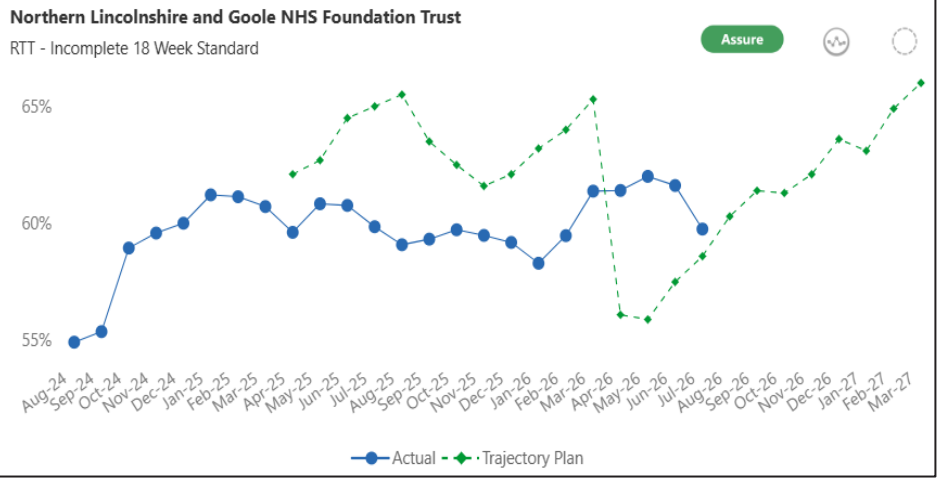
Summary:
RTT fell by 0.8 points at HUTH to 56% and by 1.8 points at NLAG to 59.8% as start of year PTL growth and reduced Outpatient activity begin to tip into > 18wks. PTL size is now >2.5k at each Trust.

Progress:
Outpatient transformation, demand-and-capacity and scheduler work was planned to improve flow; June shows that improvement has not yet been sustained.

Action:
Complete Care Group demand-and-capacity reviews and SPOA/GIRFT changes. Support required: accountable specialty plans, validated data and executive action on capacity gaps.







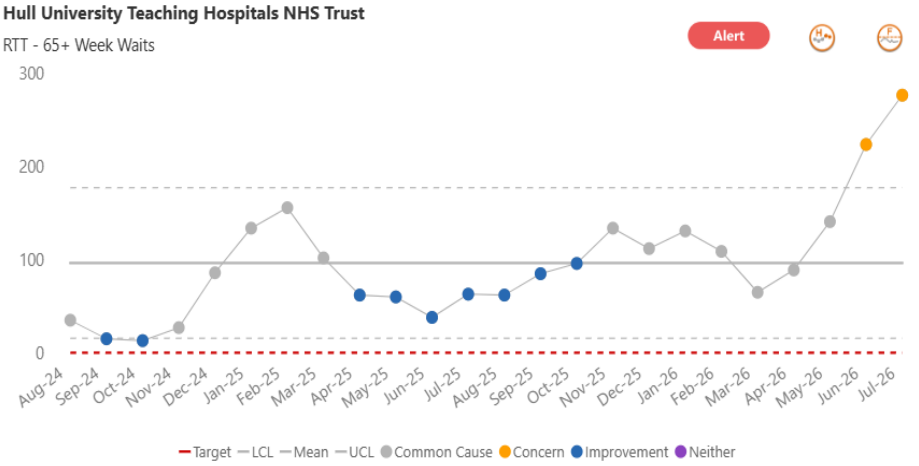
vi. RTT 65 week waits

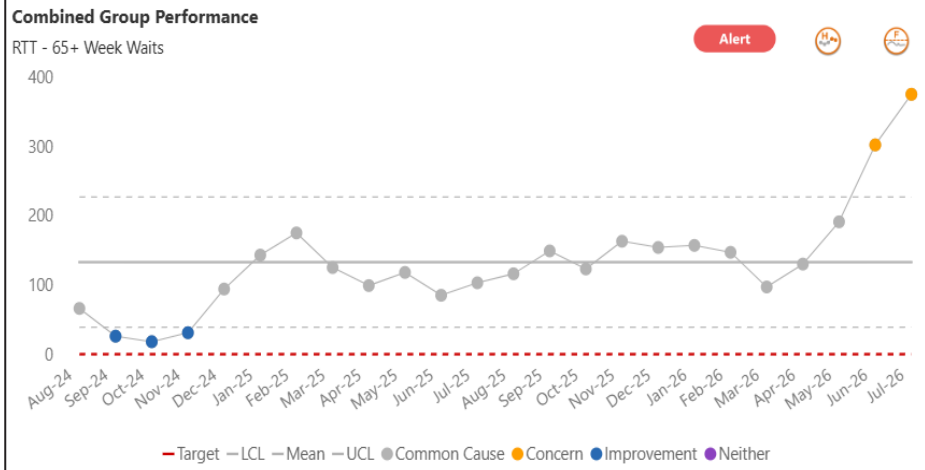
RTT - 65+ Week Waits

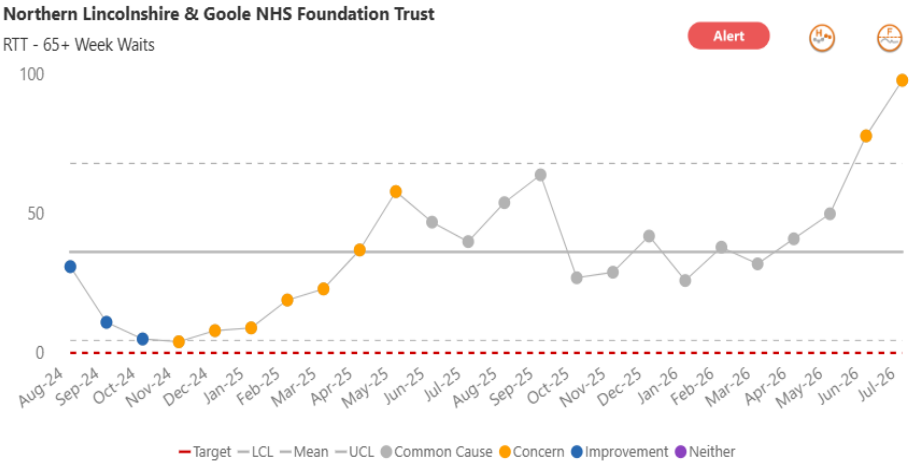
Summary:
65-week waits increased to 277 at HUTH and 98 at NLAG. This sharp deterioration reflects the underlying long wait volumes and capacity restraints.

Progress:
Validation and specialty oversight are established, but replenishment from the 52-week cohort is outstripping treatment capacity.

Action:
Maintain weekly dated-patient plans and protect capacity. Support required: executive escalation of unresolved outpatient, diagnostic, theatre, workforce and mutual-aid gaps.







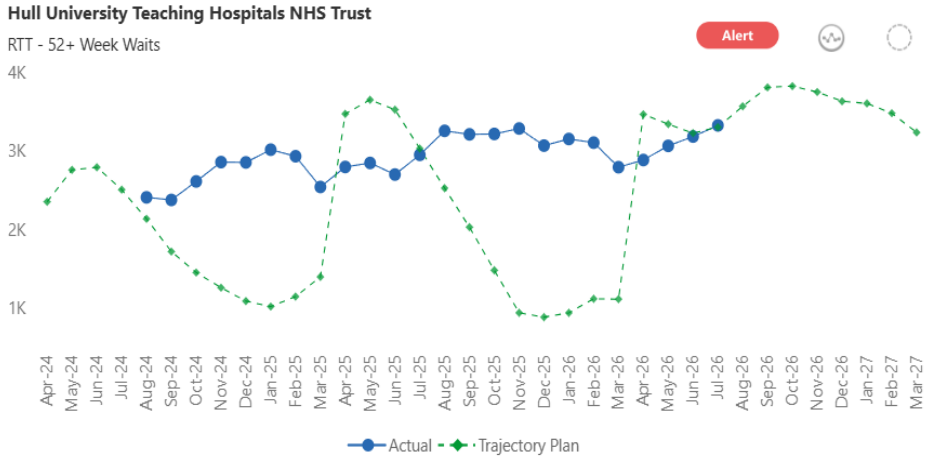
vii. RTT 52 week waits

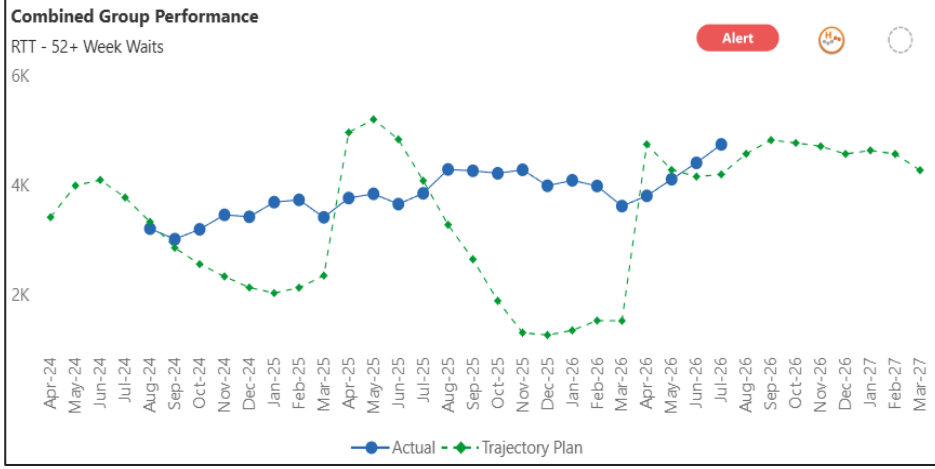
RTT - 52+ Week Waits

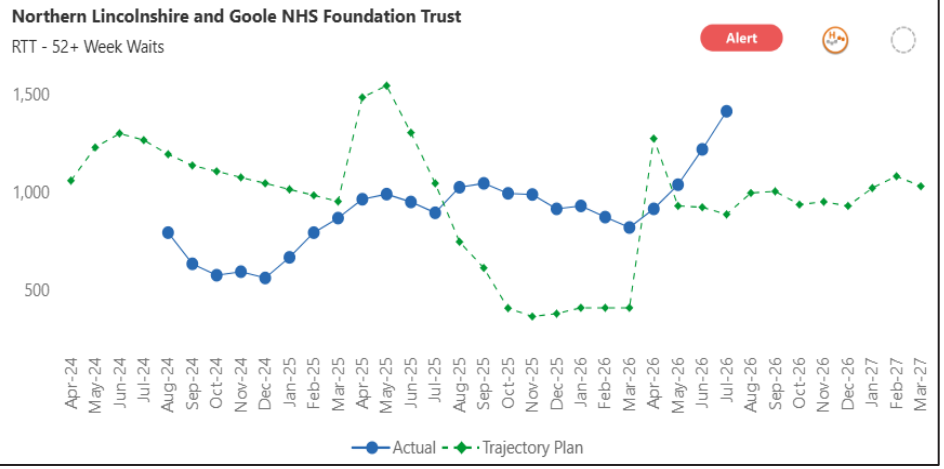
Summary:
52-week waits increased by 141 at HUTH to 3,331 and by 94 at NLAG to 1,412. Growth was not expected; HUTH remains on its plan line, while NLAG is above trajectory.

Progress:
Validation and specialty oversight are in place, but planned recovery has not prevented replenishment of the 65-week cohort.

Action:
Set weekly specialty trajectories and date highest-risk patients. Support required: Care Group ownership and aligned outpatient, diagnostic and treatment capacity.







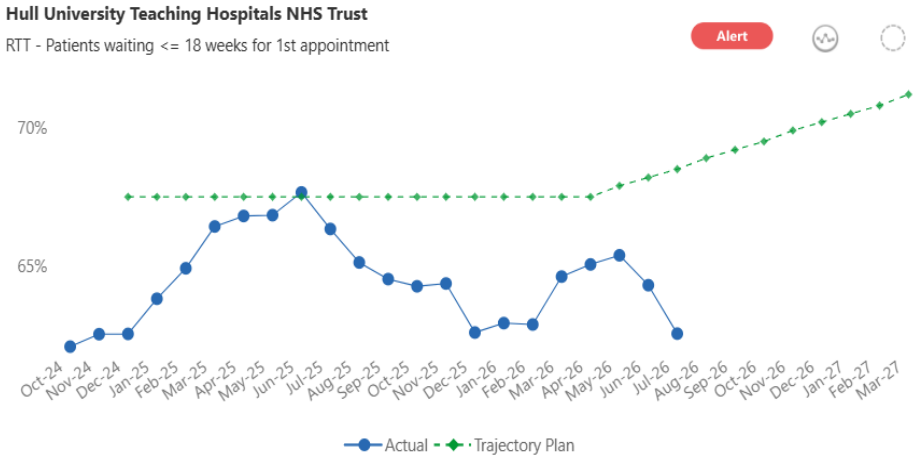
viii. Enabler Metric 1: Time to First Appointment (%)

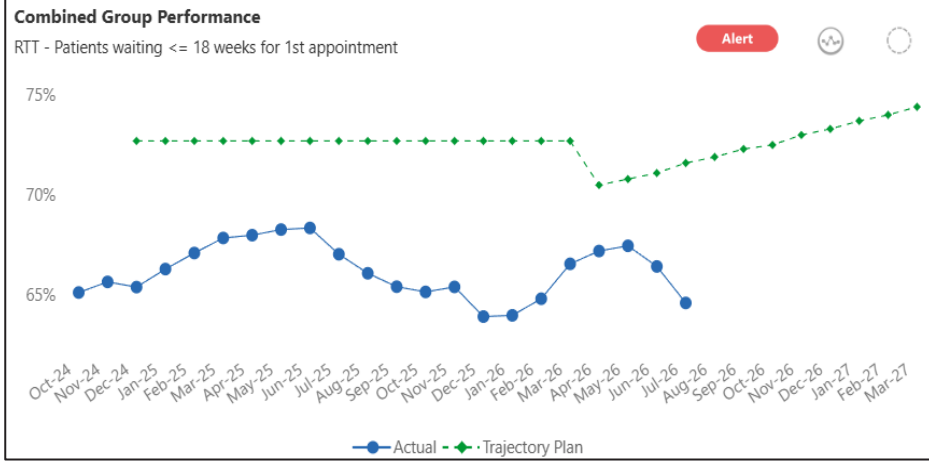
RTT - Patients waiting <= 18 weeks for 1st appointment

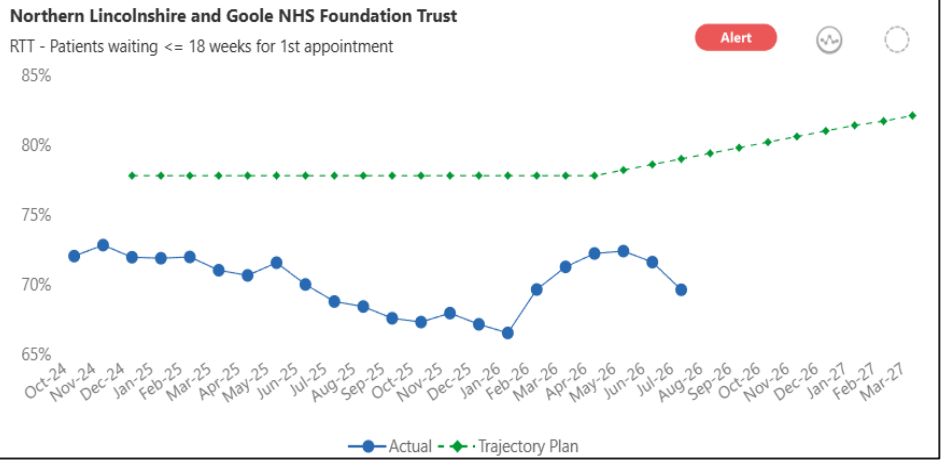
Summary:
Time to First Appointment fell for the second month at HUTH to 62.6% and by 2 points at NLAG to 69.6%.

Progress:
Outpatient transformation and demand-and-capacity reviews were expected to improve access but have not yet generated the required change.

Action:
Improve slot fill, booking and SPOA pathways. Support required: specialty capacity plans, referral-demand controls and executive resolution of workforce gaps.







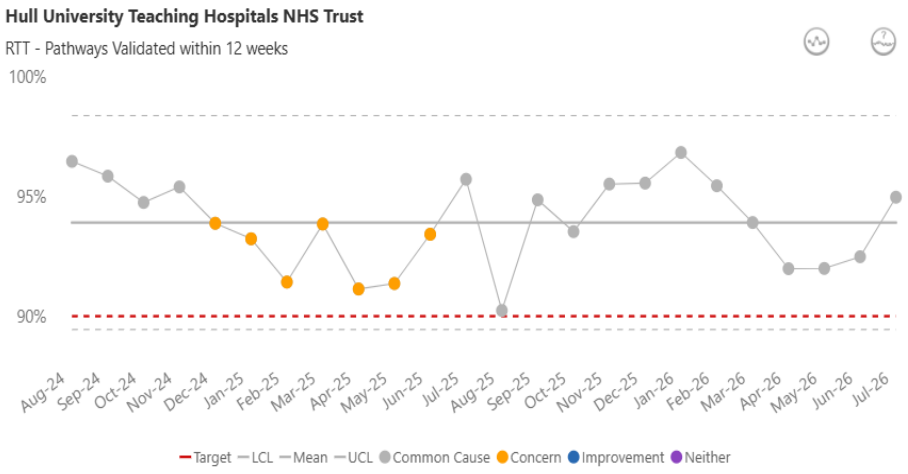
ix. Enabler Metric 2: RTT Data Quality

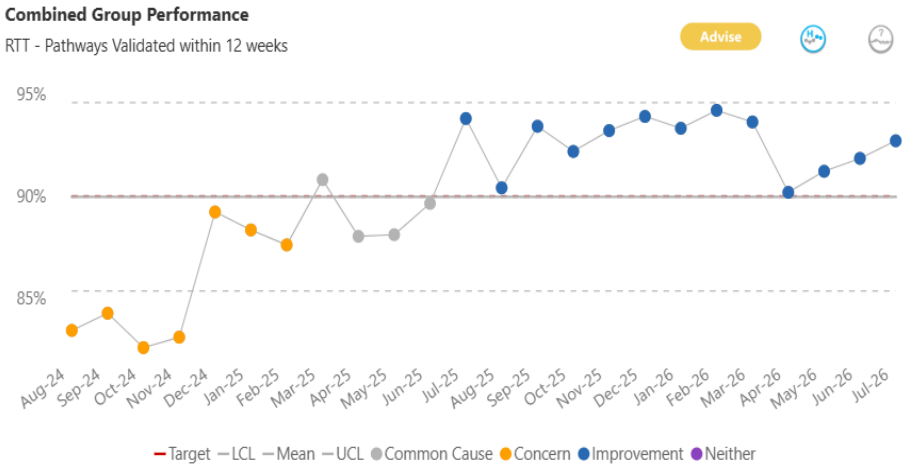
RTT - Pathways Validated within 12 weeks

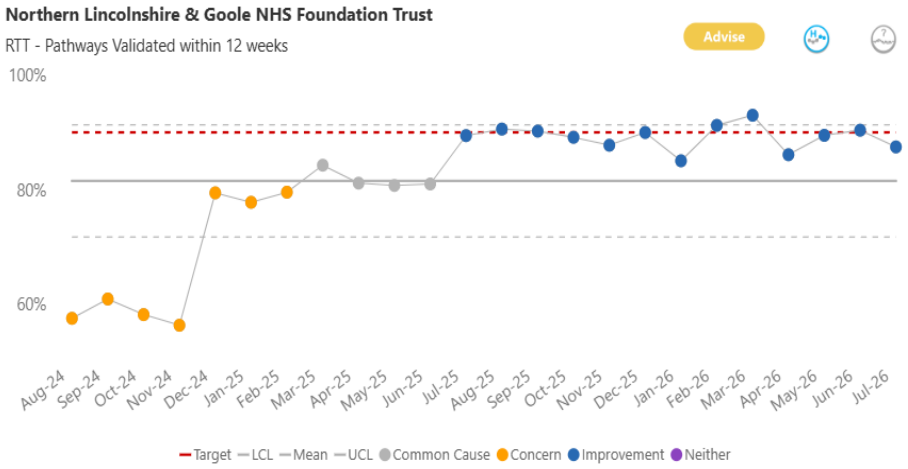
Summary:
Validation improved at HUTH to 95% but fell to 87.4% for NLAG.

Progress:
Communication-partner, completeness and GIRFT work is generating the intended direction of change.

Action:
Sustain weekly validation and confirm methodology. Support required: reliable patient-contact capacity, consistent pathway recording and rapid correction of data-quality exceptions.







x. Enabler Metric 3: Capped Theatre Utilisation

Theatres - Capped Theatre Utilisation

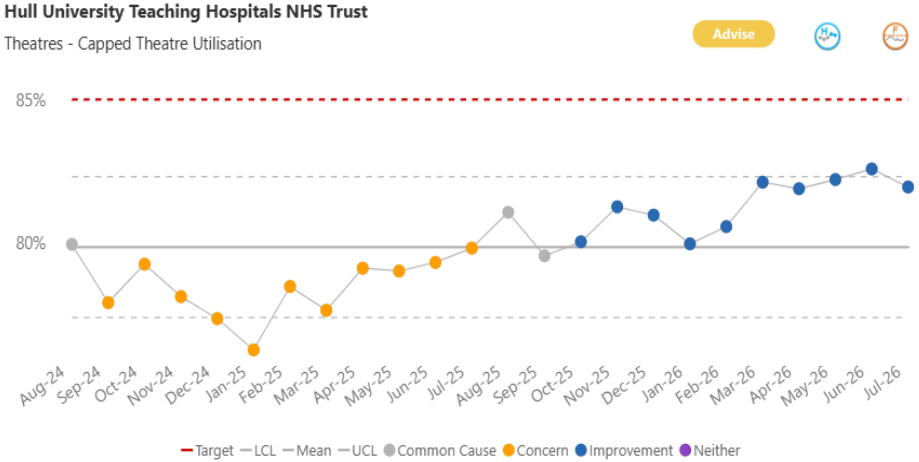
Summary:
Utilisation dropped at HUTH at 82% and 81.5% at NLAG, compounded Non Admitted delays with reduced Elective Admitted throughput.

Progress:
Scheduler access and productivity oversight are sustaining performance above 80%, but have not yet generated sufficient improvement. Theatre improvement works and prioritisation of emergencies continued to impact delivery.

Action:
Improve session fill, starts, finishes and cancellations. Support required: Care Group grip, workforce availability and allocation of capacity to long waits.

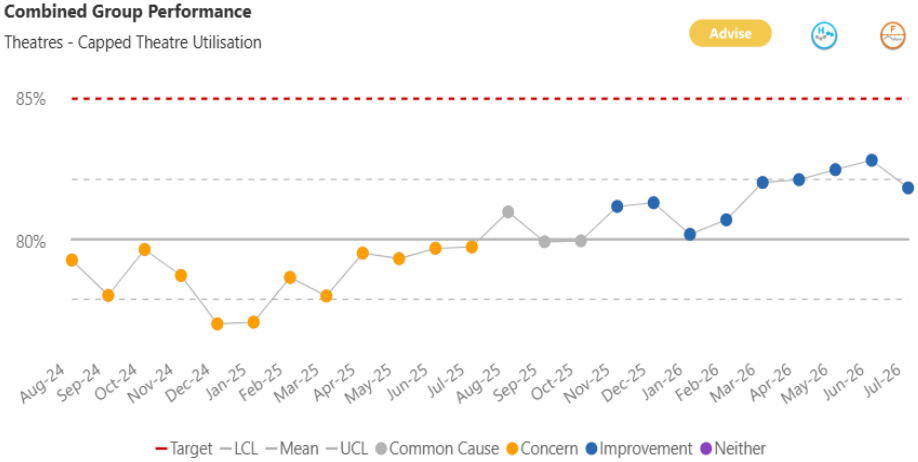
Hull University Teaching Hospitals NHS Trust

Theatres - Capped Theatre Utilisation



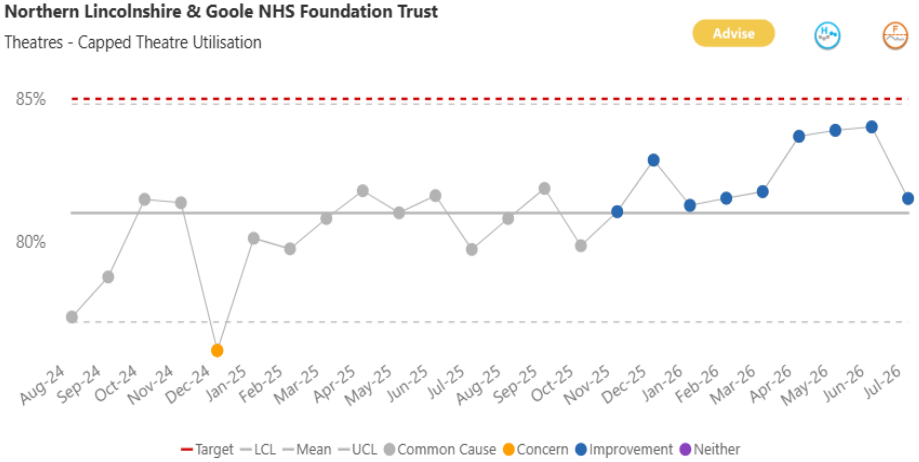
Combined Group Performance

Theatres - Capped Theatre Utilisation



Northern Lincolnshire & Goole NHS Foundation Trust

Theatres - Capped Theatre Utilisation



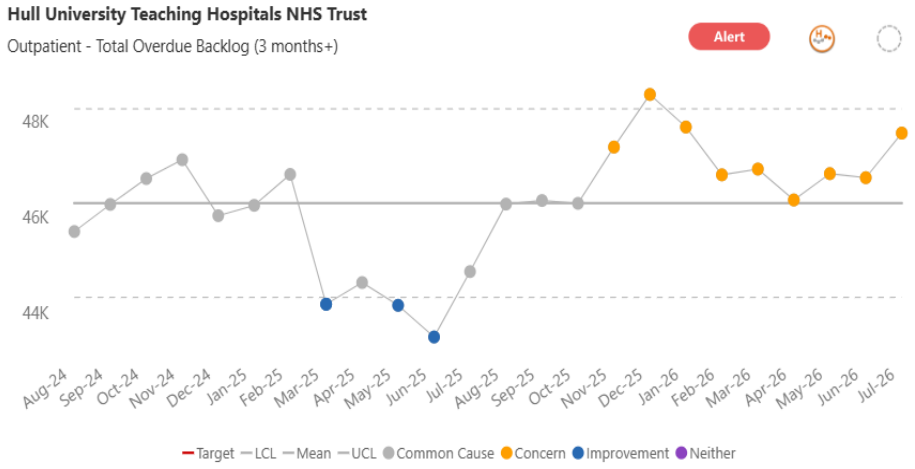
xi. Enabler Metric 4: Outpatient Follow Up Backlog

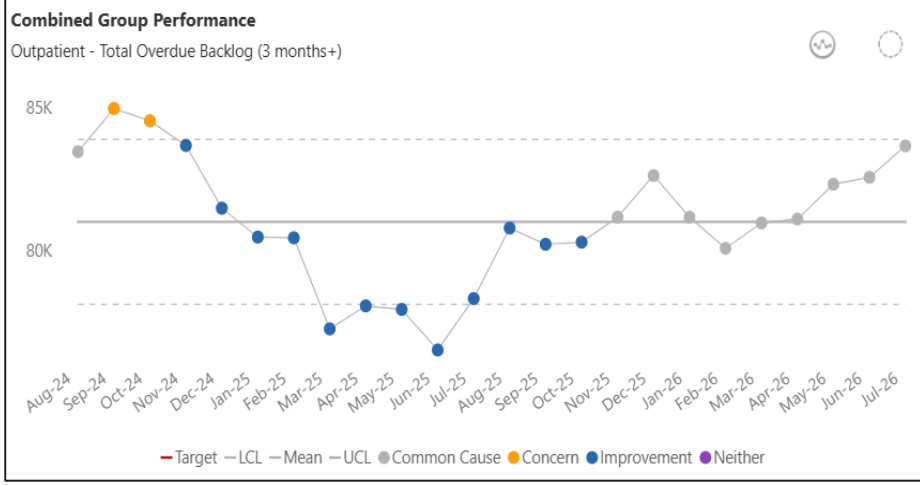
Outpatient - Total Overdue Backlog (3 months+)

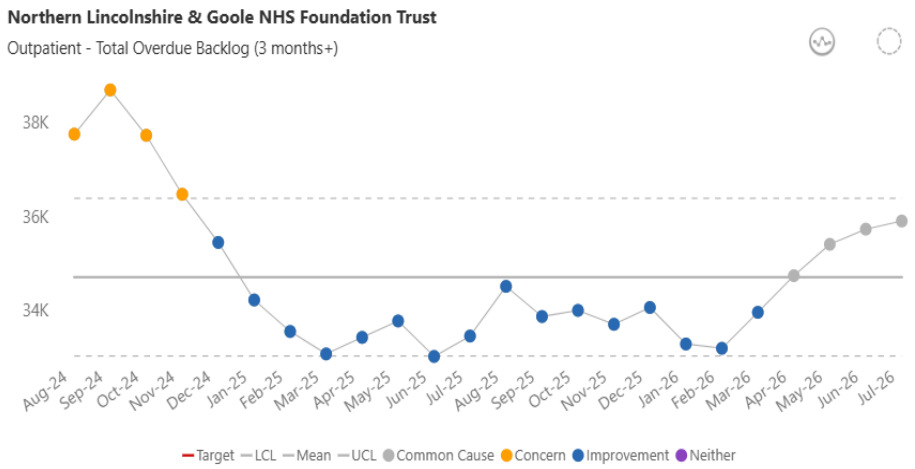
Summary:
The backlog has grown by 1,100 across the Partnership, with HUTH to 47,753 and NLAG to 35,902.

Progress:
Validation and pathway changes are beginning to stabilise HUTH,but have not generated a Group-wide reduction.

Action:
Risk-stratify and assign specialty owners. Support required: clinical validation time, PIFU/discharge adoption and funded capacity where demand exceeds supply.







xii. Enabler Metric 5: Cancelled Operations – 28-day Breaches

Inpatient - Cancelled Operations 28 Day perfomance

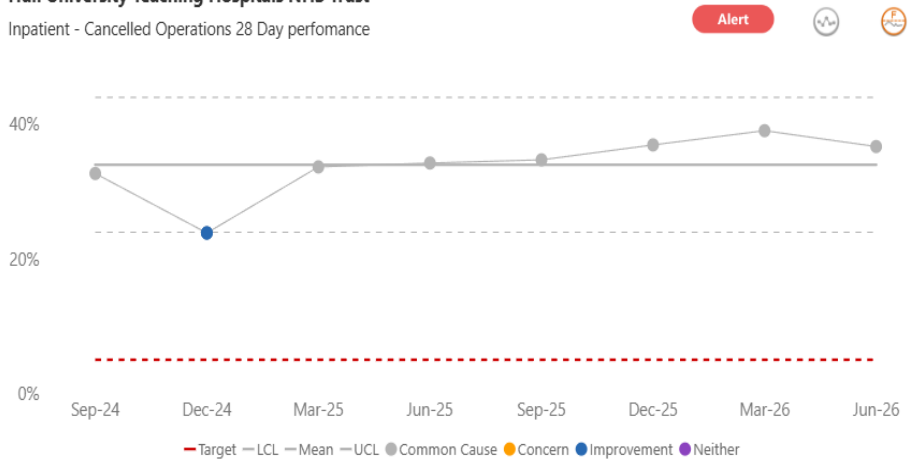
Summary:
The latest quarterly position deteriorated: HUTH rose to 39.1% and NLAG to 16.7% of cancelled patients not rebooked within 28 days. The increase was not expected and is contrary to the recovery aim.

Progress:
Scheduler and productivity oversight should improve identification but has not yet generated reliable rebooking within the guarantee.

Action:
Maintain a daily cancellation PTL. Support required: named specialty owners, protected rebooking capacity and executive escalation before the 28-day deadline.

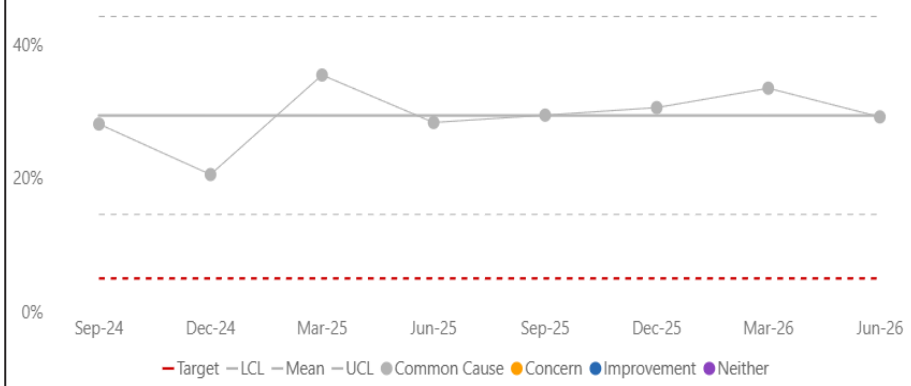
Hull University Teaching Hospitals NHS Trust

Inpatient - Cancelled Operations 28 Day perfomance



Combined Group Performance

Inpatient - Cancelled Operations 28 Day perfomance



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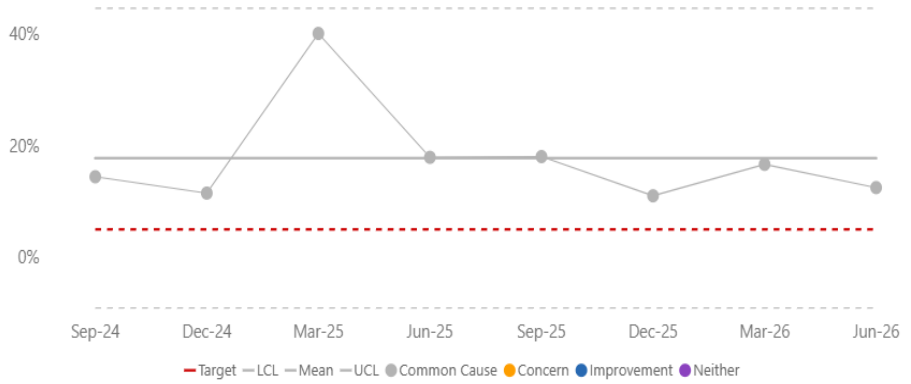
Inpatient - Cancelled Operations 28 Day perfomance



Sample pages only – awaiting further Lead review

5. HHP Group Executive Summary – Quality

Executive Lead: Hilda Gwilliams, Group Chief Patient Safety Officer

Accountable to: Quality Safety Committee

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
Care Hours per Patient Day - Overall	Apr-26	≥ 9.0	7.6		
Complaints - 60 day compliance	Jul-26	≥ 85.0%	64.4%		
Falls - per 1,000 bed days	Jul-26		7.88		
Falls - Serious harm or death	Jul-26		2		
Friends & Family - A&E Score	Jun-26	≥ 85.0%	100.0%		
Friends & Family - Antenatal Score	Jun-26	≥ 95.0%	82.4%		
Friends & Family - Inpatient Score	Jun-26	≥ 95.0%	96.9%		
Friends & Family - Outpatient Score	Jun-26	≥ 95.0%	97.9%		
Infections - C.Difficile (Cumulative)	Jun-26		34		
Infections - E.Coli (Cumulative)	Jun-26		53		
Infections - Klebsiella (Cumulative)	Jun-26		19		
Infections - MRSA (Cumulative)	Jun-26		0		
Inpatient - Corridor Care on Wards	Jul-26		41.1		
Inpatient - Emergency Readmissions within 30 days	Jun-26		10.0%		
Mortality - SHMI	Mar-26	≤ 1.0	1.047		
Never Events	Jul-26		0		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Jul-26		1.84		
Pressure Ulcers - Category 3	Jul-26		3		
Pressure Ulcers - Category 4	Jul-26		0		
Pressure Ulcers - Hospital acquired	Jul-26		135		
VTE Risk Assessment 14 Hour Standard	Jun-26	≥ 95.0%	92.2%		

Northern Lincolnshire and Goole NHS Foundation Trust

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

Metric	Month	Target	Result	Var	Asr
Care Hours per Patient Day - Overall	Apr-26	≥ 9.0	9.5		
Complaints - 60 day compliance	Jul-26	≥ 85.0%	62.1%		
Falls - per 1,000 bed days	Jul-26		6.29		
Falls - Serious harm or death	Jul-26		3		
Friends & Family - A&E Score	Jun-26	≥ 85.0%	76.0%		
Friends & Family - Antenatal Score	Jun-26	≥ 95.0%	66.7%		
Friends & Family - Inpatient Score	Jun-26	≥ 95.0%	98.6%		
Friends & Family - Outpatient Score	Jun-26	≥ 95.0%	97.9%		
Infections - C.Difficile (Cumulative)	Jun-26		12		
Infections - E.Coli (Cumulative)	Jun-26		67		
Infections - Klebsiella (Cumulative)	Jun-26		18		
Infections - MRSA (Cumulative)	Jun-26		5		
Inpatient - Corridor Care on Wards	Jul-26		1.9		
Inpatient - Emergency Readmissions within 30 days	Jun-26		11.0%		
Mortality - SHMI	Mar-26	≤ 1.0	0.993		
Never Events	Jul-26		0		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Jul-26		2.70		
Pressure Ulcers - Category 3	Jul-26		16		
Pressure Ulcers - Category 4	Jul-26		1		
Pressure Ulcers - Hospital acquired	Jul-26		207		
VTE Risk Assessment 14 Hour Standard	Jun-26	≥ 95.0%	94.5%		

Group Chief Patient Safety Officer Update – Quality Overview (July 2026)

Quality performance presents a mixed position across HUTH and NLAG, with the most material oversight risks sitting within patient safety and infection prevention, alongside continuing variation in patient experience and effectiveness indicators. The NOF Quality briefing confirms Patient Safety as a distinct provider oversight domain, combining scored metrics for clinical audit outliers, MRSA, E. coli, C. difficile and the staff survey raising-concerns sub-score with contextual indicators for falls causing harm, pressure ulcers and incidents causing harm.

Patient Experience shows improving grip on 60-day complaint response compliance since October 2025, but complaints received and PALS activity remain variable, indicating that earlier resolution, responsiveness and thematic learning are not yet consistently reducing patient concern activity across services.

Safety remains the principal quality risk area. Care Hours per Patient Day requires continued triangulation with acuity, staffing fill and ward-level risk. Infection prevention indicators are particularly important because MRSA, E. coli and C. difficile are NOF scoring metrics. The latest FYTD position records C. difficile at HUTH 26 and NLAG 12, MRSA at HUTH 0 and NLAG 5, and E. coli at HUTH 17 and NLAG 67, requiring sustained IPC grip, case review, antimicrobial stewardship and targeted improvement where recurrence or adverse variation is identified.

Effectiveness is broadly stable but requires continued governance oversight. VTE assessment compliance remains variable and will be affected by the national change to emergency admission timing from DTA in Quarter 3. SHMI should continue to be handled as a statistical indicator through established clinical governance and coding assurance, while emergency readmissions within 30 days appear broadly stable but should remain subject to specialty-level review of discharge quality, follow-up arrangements and avoidable readmission themes.

Executive focus should be on creating a unified Quality Foundation Scorecard that brings together scored and contextual NOF measures with local quality indicators, providing clear targets, trajectories and accountability. This should enable consistent oversight from Board to care group and ward level, with escalation focused on infection prevention, safe staffing, complaint responsiveness, VTE compliance, SHMI assurance and avoidable readmissions.

a. Hull University Teaching Hospital Quality AAA Summary

Count: 12

Alert

- Care Hours per Patient Day - Overall
- Care Hours per Patient Day - Unregistered
- Complaints - 60 day compliance
- Duty of Candour - Verbal apology
- PALS - Complaints
- Pressure Ulcers - Category 2
- Pressure Ulcers - Community acquired
- Pressure Ulcers - Hospital acquired
- Pressure Ulcers - Hospital acquired (per 1,000 bed days)
- Pressure Ulcers - Unstageable
- VTE Risk Assessment
- VTE Risk Assessment 14 Hour Standard

Count: 6

Advise

- Complaints - Average response time
- Duty of Candour - Written apology within 10 working days
- Friends & Family - A&E Score
- Friends & Family - Birth Score
- Mortality - HSMR
- Mortality - SHMI

Count: 3

Assure

- Infections - E.Coli (Cumulative)
- Infections - Pseudomonas aeruginosa (Cumulative)
- Patient Safety Incidents - Low harm

b. Northern Lincolnshire & Goole Hospitals Quality AAA Summary

Count: 6

Alert

- Care Hours per Patient Day - Unregistered
- Duty of Candour - Written apology
- Friends & Family - A&E Score
- Infections - MRSA
- Infections - MRSA (per 1,000 bed days)
- PALS - Complaints

Count: 1

Advise

- Friends & Family - Postnatal Community Score

Count: 5

Assure

- Care Hours per Patient Day - Registered
- Friends & Family - Community Score
- Friends & Family - Inpatient Score
- Infections - Klebsiella (Cumulative)
- Mortality - HSMR

Experience

Experience narrative updated for June 2026.

Summary

Patient Experience performance remains variable across HUTH and NLAG. The scorecards scope complaints 60-day compliance, complaints received and PALS complaints as the core measures of responsiveness to patient concerns. The strongest improvement signal is complaints 60-day compliance, which has trended positively since October 2025, although performance remains below the stated compliance level. Complaints received and PALS complaints continue to show variation, indicating the need for ongoing review of themes, hotspots and early resolution.

Progress

Since October 2025, both Trusts have shown improved grip on 60-day complaint response timeliness, but further consistency is required to meet the standard reliably. Complaints received remain variable with no clear sustained reduction, and PALS complaints also remain variable across the period. The pattern suggests that while response timeliness is improving, earlier resolution and thematic learning are not yet consistently reducing formal complaint or PALS activity.

Action

Sustain the improvement in 60-day complaint compliance through divisional ownership, overdue case escalation and routine review of response quality. Strengthen early resolution of concerns to reduce avoidable escalation from PALS to formal complaints, with service-level hotspot review, repeat-theme analysis and evidence of learning embedded through patient experience governance.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Caring	Experience	Friends & Family - A&E Score	≥ 85.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	72.4%	70.8%	90.0%	71.4%	66.7%	100.0%	
		Friends & Family - Antenatal Score	≥ 95.0%	100.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	81.8%	50.0%	93.8%	100.0%	82.4%	
		Friends & Family - Birth Score	≥ 95.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
		Friends & Family - Inpatient Score	≥ 95.0%	98.8%	94.8%	97.8%	98.8%	97.2%	96.2%	96.5%	97.1%	96.1%	96.9%	89.0%	96.9%	
		Friends & Family - Outpatient Score	≥ 95.0%	98.8%	98.8%	96.7%	97.8%	96.7%	94.1%	98.6%	97.1%	96.1%	96.2%	96.2%	97.9%	
		Friends & Family - Postnatal Score	≥ 95.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	66.7%	85.7%	100.0%	100.0%	75.0%	
Responsive	Experience	Complaints - 60 day compliance	≥ 85.0%	66.7%	68.2%	71.0%	24.6%	35.4%	51.9%	40.0%	53.5%	50.0%	64.5%	48.8%	57.6%	64.4%
		Complaints - Average response time	≤ 40.0	141.4	164.4	122.8	116.6	112.1	76.6	77.5	65.2	69.9	47.5	65.8	60.6	48.7
		Complaints - Received		42	36	47	51	56	36	31	35	26	18	49	29	28
		Complaints - Received (per 1,000 bed days)		1.19	1.04	1.37	1.32	1.63	1.11	0.99	1.22	0.69	0.51	1.60	0.93	0.90
		Complaints - Reopened		2	3	3	2	1	4	2	2	4	3	1	0	1
		PALS - Complaints	≤ 1	320	280	250	397	272	241	254	216	140	64	219	159	130
		PALS - Complaints compliance within 5 working days		55.5%	49.6%	46.9%	52.5%	42.9%	42.0%	38.3%	47.4%	41.1%	46.6%	55.3%	33.0%	36.4%

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

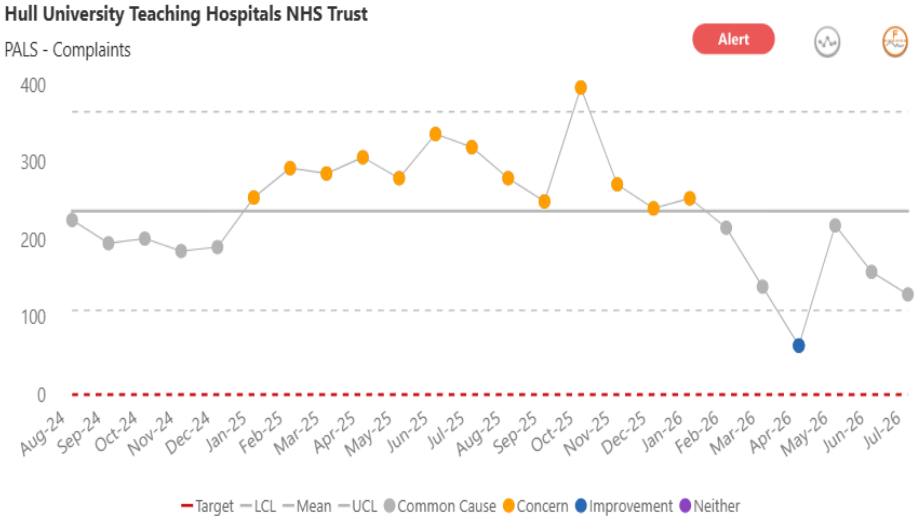
Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Caring	Experience	Friends & Family - A&E Score	≥ 85.0%	81.9%	82.0%	75.6%	75.6%	75.6%	75.0%	76.8%	76.8%	76.4%	79.4%	74.3%	76.0%	
		Friends & Family - Antenatal Score	≥ 95.0%	80.7%	82.8%	65.6%	65.6%	76.2%	75.8%	68.0%	96.3%	87.0%	100.0%	66.7%	66.7%	
		Friends & Family - Birth Score	≥ 95.0%	100.0%	91.7%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	
		Friends & Family - Inpatient Score	≥ 95.0%	98.7%	95.8%	97.4%	97.4%	97.5%	97.2%	97.5%	98.2%	98.7%	98.5%	98.4%	98.6%	
		Friends & Family - Outpatient Score	≥ 95.0%	95.5%	95.1%	96.9%	96.9%	95.9%	97.7%	95.1%	96.9%	95.5%	97.9%	96.3%	97.9%	
		Friends & Family - Postnatal Score	≥ 95.0%	100.0%	92.9%	100.0%	100.0%	92.9%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	66.7%	
Responsive	Experience	Complaints - 60 day compliance	≥ 85.0%	73.3%	36.6%	50.0%	37.1%	53.1%	67.9%	48.3%	63.9%	71.8%	78.6%	59.2%	72.2%	62.1%
		Complaints - Average response time	≤ 40.0	47.3	69.3	59.5	74.2	67.2	43.8	63.3	55.3	40.8	45.8	48.6	42.4	48.8
		Complaints - Received		29	28	27	20	26	19	47	45	43	46	34	26	45
		Complaints - Received (per 1,000 bed days)		1.45	1.44	1.39	0.97	1.29	0.91	2.22	2.33	2.12	2.30	1.63	1.29	2.21
		Complaints - Reopened		5	3	1	1	7	0	5	4	2	6	1	0	0
		PALS - Complaints	≤ 1	259	221	247	278	228	240	262	208	233	253	226	248	263
		PALS - Complaints compliance within 5 working days		65.2%	59.6%	60.9%	59.0%	56.1%	57.3%	61.4%	63.4%	64.8%	66.9%	63.3%	54.0%	59.9%

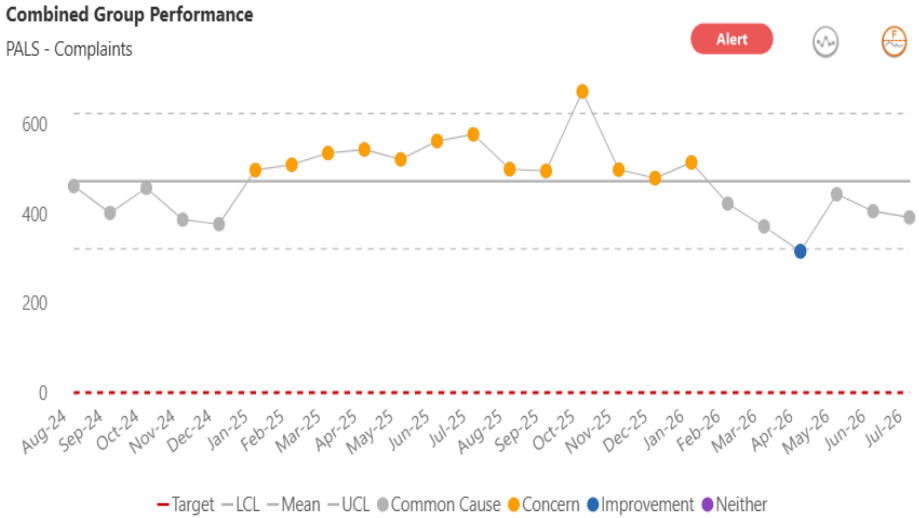
i. PALS Concerns

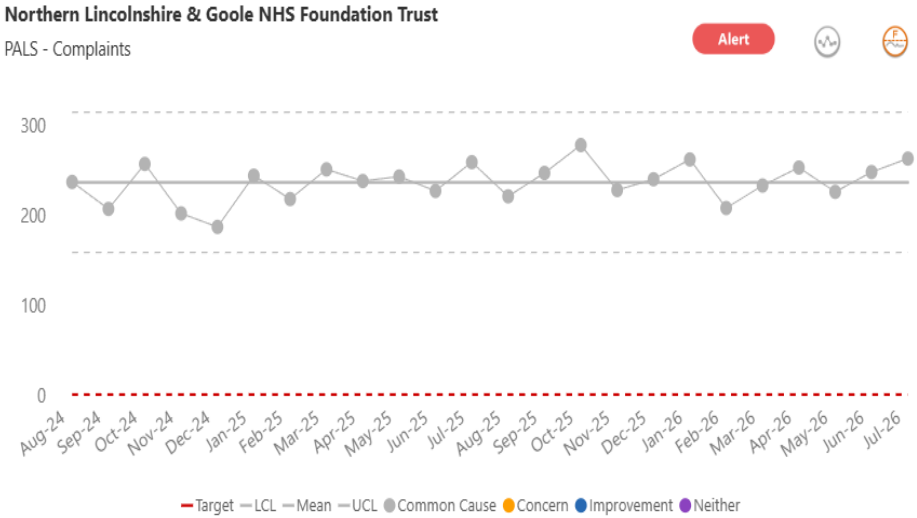
PALS - Complaints

HUTH:
PALS complaints show continued variation across the period, with the latest position requiring ongoing review of themes and service-level hotspots. The trend should be interpreted alongside formal complaints received and complaints 60-day compliance to understand whether concerns are being resolved early or escalating into formal complaint routes.

NLAG:
NLAG also shows variation in PALS complaints, with no clear sustained improvement evident from the chart. Continued focus is required on early resolution, responsiveness to patient concerns and thematic learning, particularly where repeat issues are identified across services.







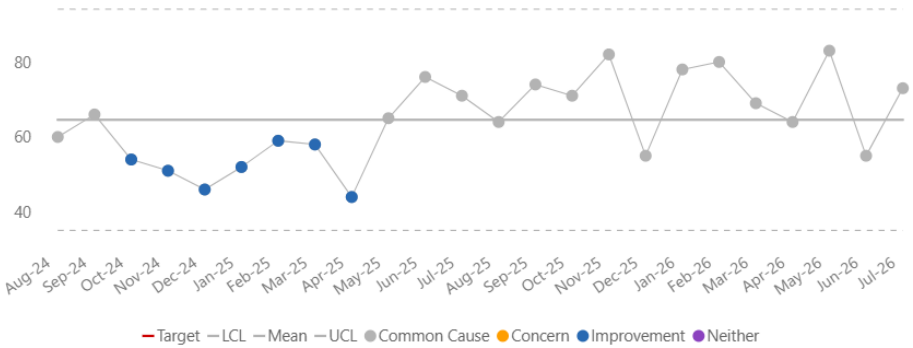
Sample pages only – awaiting further Lead review

ii. Complaints Received

Complaints - Received

Complaints received show variation across the period, with the latest trend not clearly demonstrating sustained improvement.

Continued focus is required on complaint themes, service-level hotspots and early resolution, particularly where repeated issues are driving formal complaints.



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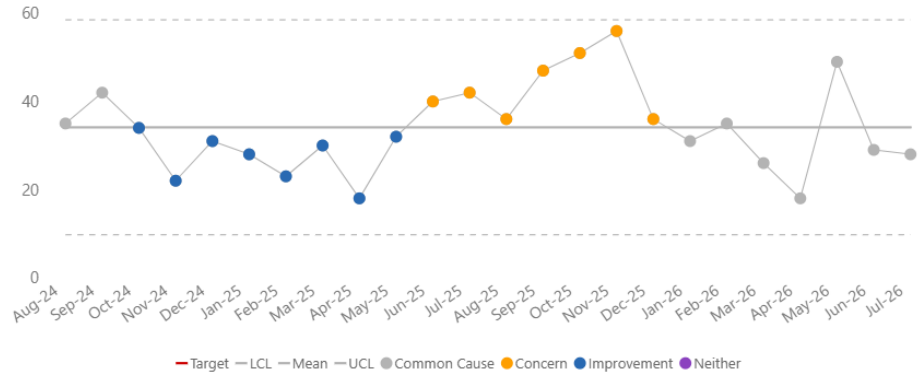
Complaints - Received



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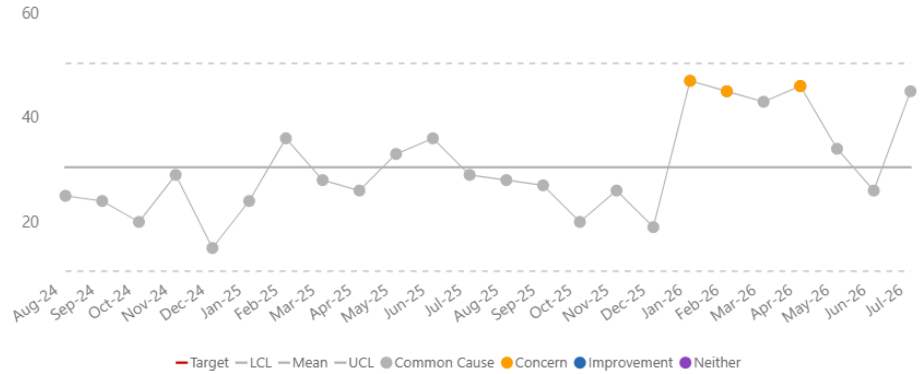
Complaints - Received



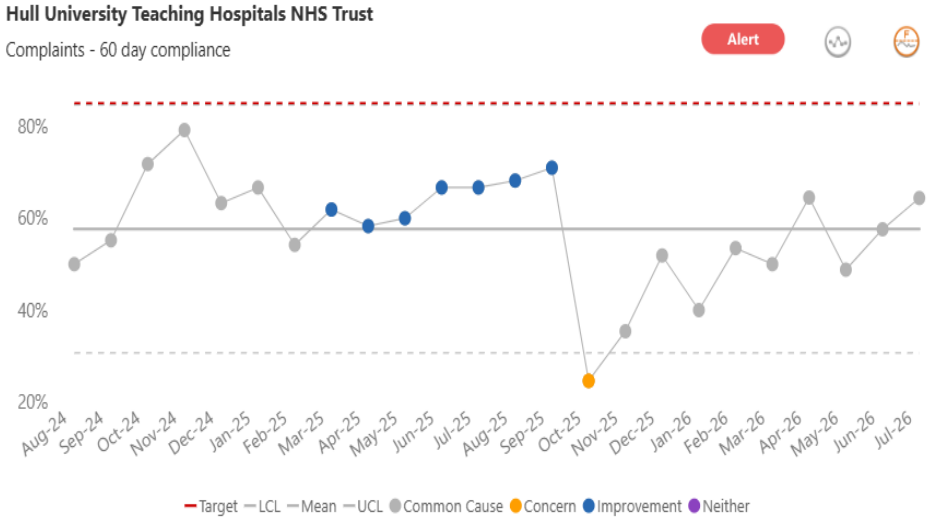
Sample pages only – awaiting further Lead review

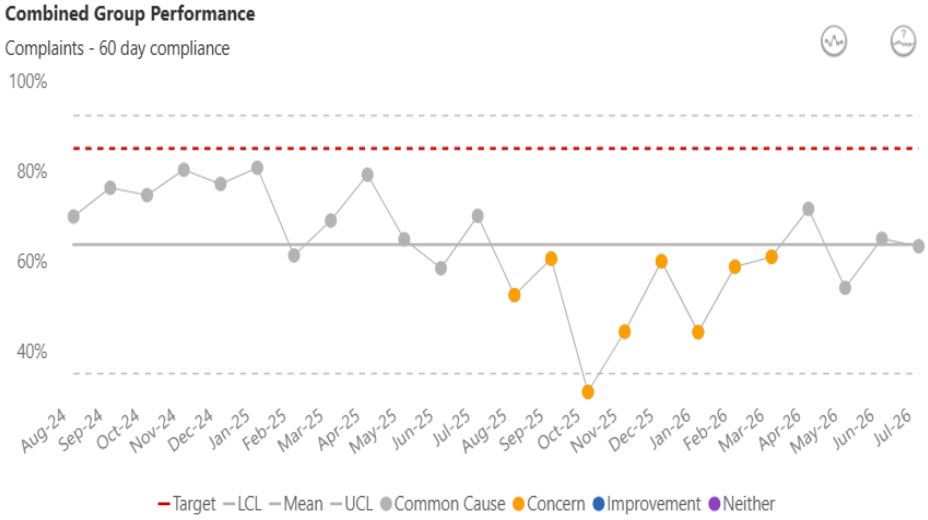
iii. Complaints 60 Day Compliance

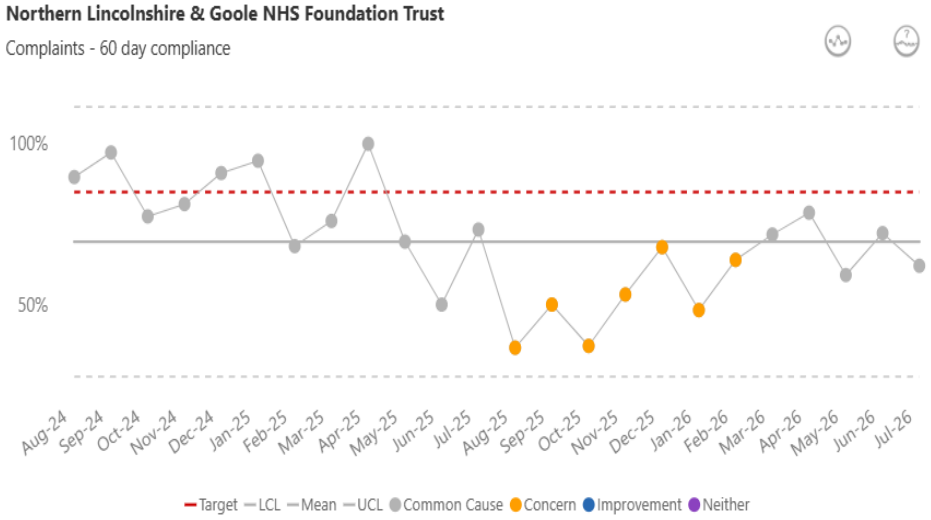
Complaints - 60 day compliance

Overall improving trend since October 2025, with recent performance indicating better grip on complaint response timeliness but ultimately underneath stated compliance levels.

Continued focus is required to sustain this improvement, reduce variation and ensure responses remain within the 60-day standard.







c. Safety

Summary

Safety performance remains mixed. HUTH's overall Care Hours per Patient Day remains under target at 7.6, driven by the unregistered staff group. NLAG also has pressure in unregistered staffing, but stronger registered staffing keeps the overall CHPPD position above target. Infection prevention remains a key safety risk, with C. difficile, MRSA and E. coli requiring continued oversight.

Progress

For infection indicators, the latest FYTD position is C. difficile: HUTH 26 and NLAG 12, with the latest reported month showing HUTH 10 and NLAG 3. MRSA is HUTH 0 YTD and 0 latest month, while NLAG is 5 YTD with 3 in the latest reporting period. E. coli is HUTH 17 FYTD and NLAG 67 FYTD, showing a materially greater burden at NLAG.

Action

Maintain ward-level safe staffing review, with specific focus on HUTH unregistered fill and NLAG skill-mix balance. Continue systematic IPC case review, thematic learning, antimicrobial stewardship and targeted improvement plans for C. difficile, MRSA and E. coli, with particular executive focus on NLAG MRSA and E. coli and HUTH C. difficile latest-month activity.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

Oversight | CQC

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

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Safe	Patient Safety	Care Hours per Patient Day - Overall	≥ 9.0	7.4	7.3	7.2	7.6	7.6	7.5	7.4	7.3	7.4	7.6			
		Care Hours per Patient Day - Registered	≥ 5.0	5.0	4.9	4.9	5.0	5.2	5.2	5.1	5.0	5.1	5.2			
		Care Hours per Patient Day - Unregistered	≥ 4.0	2.4	2.4	2.3	2.6	2.4	2.3	2.3	2.3	2.3	2.4			
		Falls - Serious harm or death		5	3	4	1	0	5	4	4	3	1	2	2	2
		Falls - Total incidents		262	260	279	286	258	271	308	262	284	222	235	214	244
		Infections - C.Difficile		11	6	8	6	6	8	16	9	11	16	10	8	
		Infections - E.Coli		22	20	19	17	14	13	12	16	14	23	17	13	
		Infections - Klebsiella		16	0	3	7	10	5	7	3	10	6	5	8	
		Infections - MRSA		0	0	0	0	0	1	0	0	1	0	0	0	
		Infections - MSSA		7	6	8	12	7	5	8	11	8	11	3	5	
		Infections - Pseudomonas aeruginosa		4	0	3	6	1	4	1	1	2	2	3	1	
		Medication Incidents		117	148	148	103	120	127	94	109	115	100	117	105	102
		Patient Safety Incidents - % Harmful		2.0%	2.3%	3.2%	3.8%	2.7%	3.2%	2.6%	2.1%	2.4%	1.5%	2.0%	1.8%	2.6%
		Patient Safety Incidents - Fatal		2	1	7	4	2	8	3	4	7	2	5	3	4
		Patient Safety Incidents - Moderate harm		35	37	49	63	44	51	43	32	44	29	34	28	50
		Patient Safety Incidents - Severe harm		5	7	9	12	5	5	8	6	5	2	2	5	3
		Pressure Ulcers - Category 3		0	0	0	4	1	2	2	1	1	0	1	1	3
		Pressure Ulcers - Category 4		0	0	0	0	0	0	0	1	0	0	1	0	0
		Pressure Ulcers - Community acquired		314	310	310	390	346	353	406	371	458	416	388	376	397
		Pressure Ulcers - Hospital acquired		63	43	59	109	110	132	129	114	129	146	148	116	135
		Pressure Ulcers - Suspected deep tissue injury		25	16	16	19	26	34	29	22	26	32	27	29	24

Sample pages only – awaiting further Lead review

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Safe	Patient Safety	Care Hours per Patient Day - Overall	≥ 9.0	9.4	10.0	9.5	9.2	9.3	9.0	9.2	9.1	9.7	9.5			
		Care Hours per Patient Day - Registered	≥ 5.0	5.7	6.0	5.7	5.5	5.7	5.6	5.6	5.6	6.0	5.8			
		Care Hours per Patient Day - Unregistered	≥ 4.0	3.7	4.0	3.8	3.7	3.7	3.4	3.6	3.5	3.8	3.7			
		Falls - Serious harm or death		2	1	0	2	0	3	2	0	0	0	0	2	3
		Falls - Total incidents		115	108	107	149	119	136	139	107	108	125	116	122	128
		Infections - C.Difficile		2	4	3	6	4	7	3	3	6	4	3	5	
		Infections - E.Coli		27	20	28	32	20	18	14	26	15	21	25	21	
		Infections - Klebsiella		16	9	6	12	8	10	6	13	9	7	5	6	
		Infections - MRSA		0	1	0	1	0	1	1	1	2	1	3	1	
		Infections - MSSA		3	6	6	9	6	10	6	3	4	3	10	7	
		Infections - Pseudomonas aeruginosa		6	5	3	3	4	4	1	2	2	0	4	3	
		Medication Incidents		79	65	58	69	89	76	82	78	76	65	71	76	79
		Patient Safety Incidents - % Harmful		3.2%	2.7%	3.2%	3.9%	3.9%	3.2%	2.9%	2.6%	3.2%	2.8%	2.7%	2.8%	3.4%
		Patient Safety Incidents - Fatal		3	2	0	1	1	3	1	3	0	0	0	1	2
		Patient Safety Incidents - Moderate harm		46	37	44	60	55	41	46	36	48	46	43	44	47
		Patient Safety Incidents - Severe harm		3	1	3	6	5	4	2	0	0	0	1	2	6
		Pressure Ulcers - Category 3		9	7	11	6	5	10	13	10	6	5	16	8	16
		Pressure Ulcers - Category 4		0	0	2	4	1	1	0	1	2	0	0	1	1
		Pressure Ulcers - Community acquired		392	341	298	382	368	359	390	364	357	405	399	398	377
		Pressure Ulcers - Hospital acquired		222	198	200	244	222	210	267	213	231	210	240	245	207
		Pressure Ulcers - Suspected deep tissue injury		47	34	43	42	40	45	59	54	48	35	51	46	34

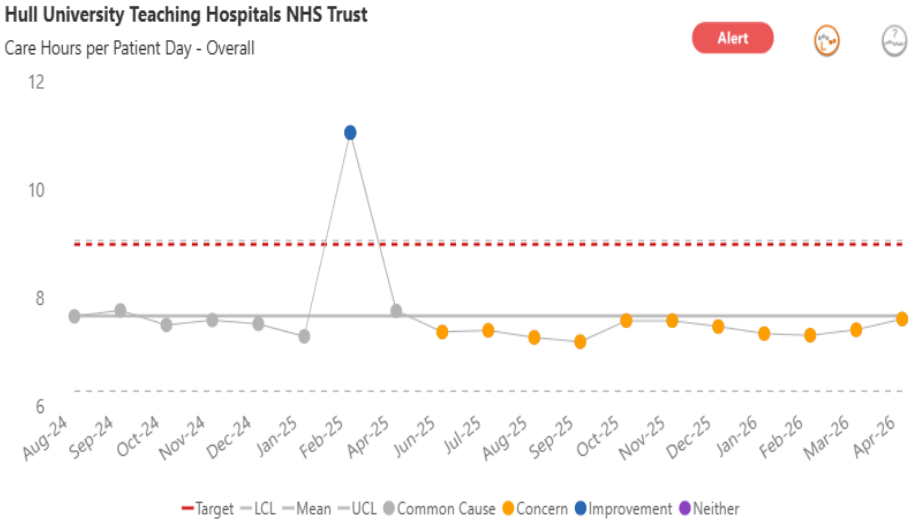
Sample pages only – awaiting further Lead review

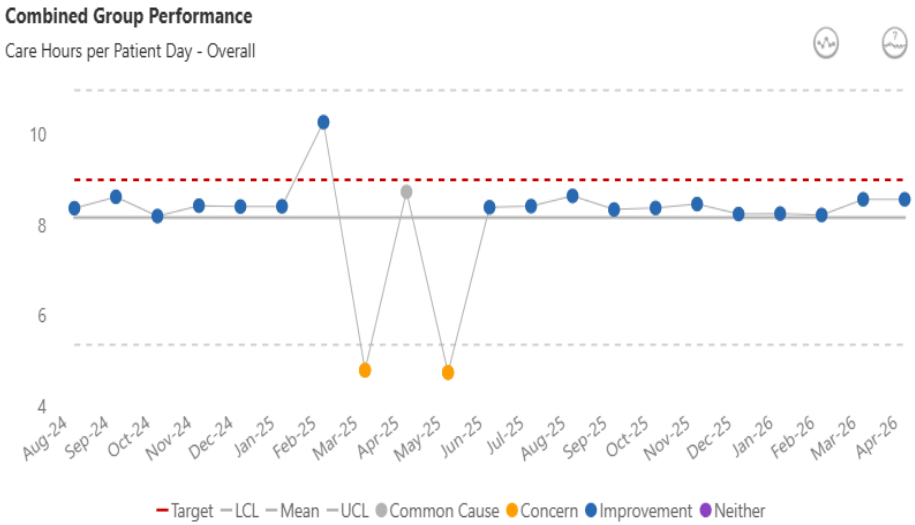
i. Care Hours per Patient Day

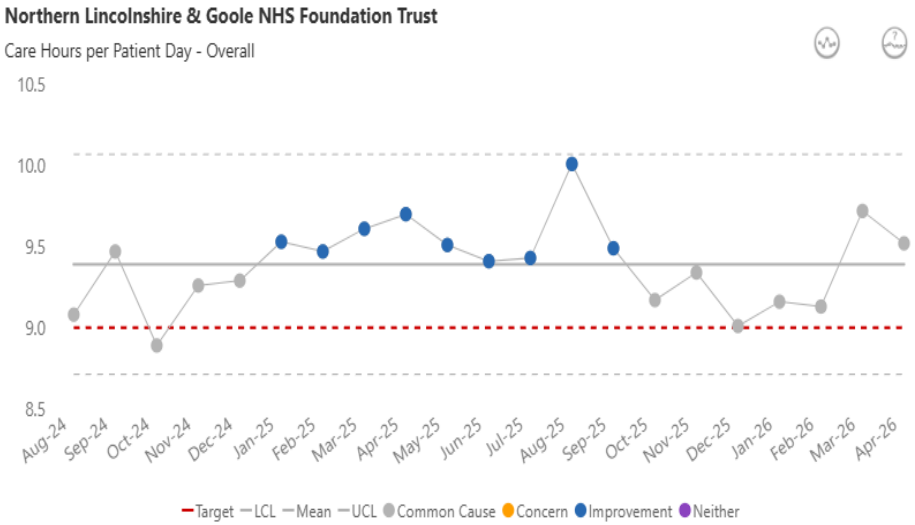
Care Hours per Patient Day - Overall

HUTH:
HUTH's overall Care Hours per Patient Day remains under target at 7.6, with the shortfall driven by the unregistered staff group. This indicates that the overall staffing position is being constrained by support workforce capacity, requiring continued ward-level review of roster fill, deployment and escalation where unregistered hours are below planned levels.

NLAG:
NLAG also shows pressure within the unregistered staff group, but this is offset by stronger registered staff performance, keeping the overall Care Hours per Patient Day position above target.







Sample pages only – awaiting further Lead review

ii. C.Difficile Cases

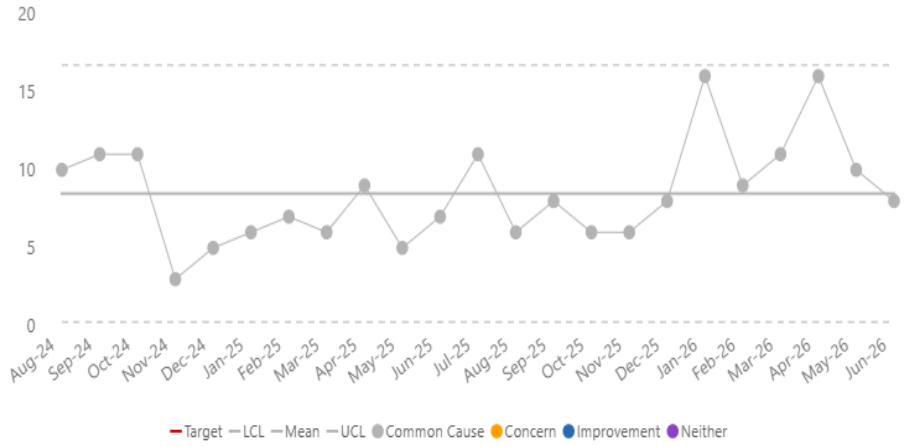
Infections - C.Difficile

HUTH:
C. difficile cases are 26 YTD with 10 confirmed in May

NLAG:
C. difficile cases are 12 YTD with 3 reported for May.

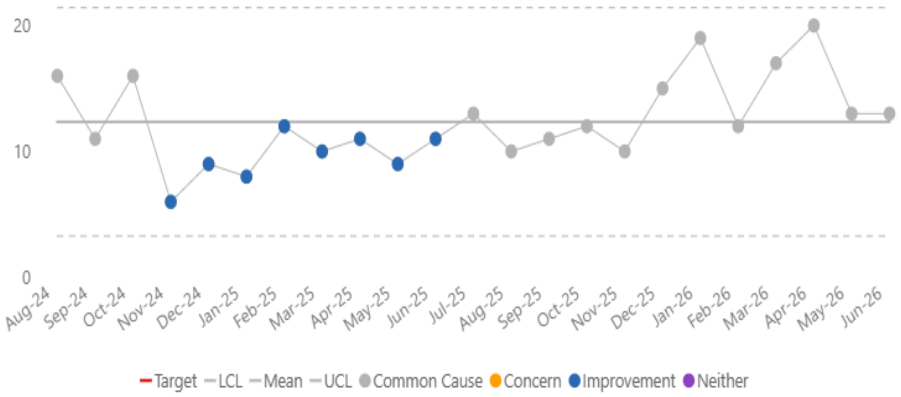
Hull University Teaching Hospitals NHS Trust

Infections - C.Difficile



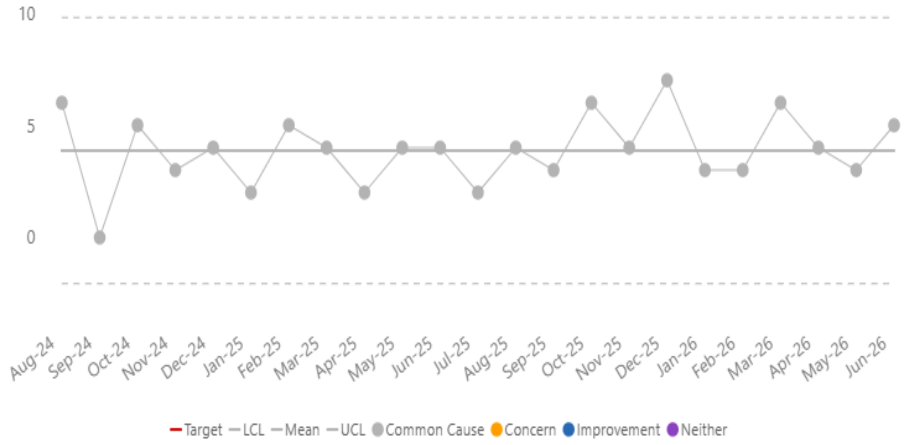
Combined Group Performance

Infections - C.Difficile



Northern Lincolnshire & Goole NHS Foundation Trust

Infections - C.Difficile

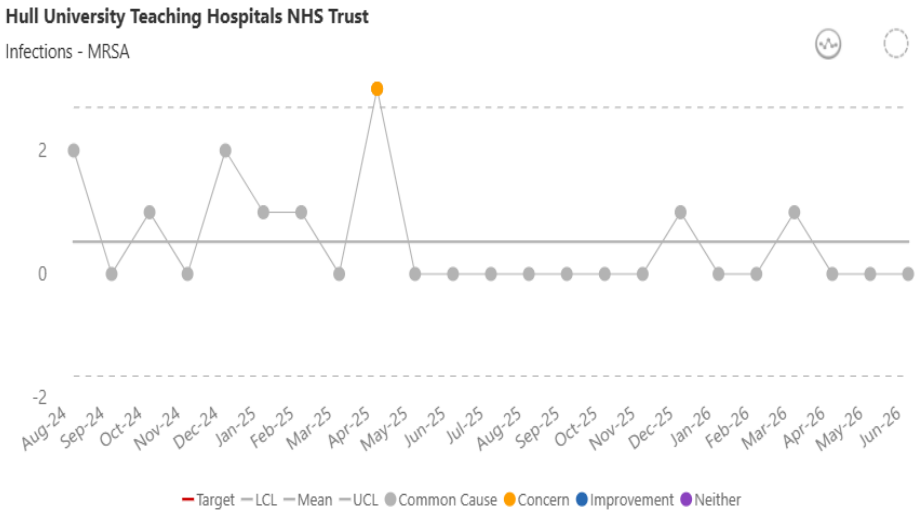


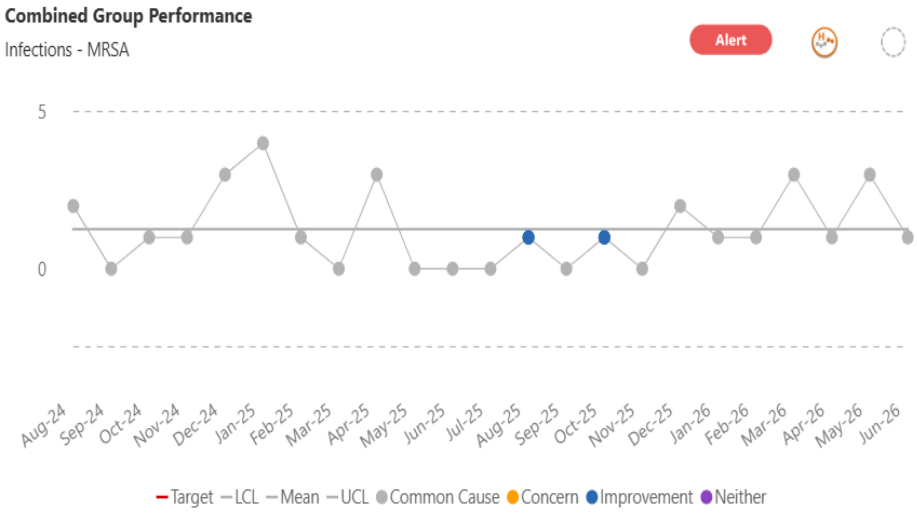
iii. MRSA Cases

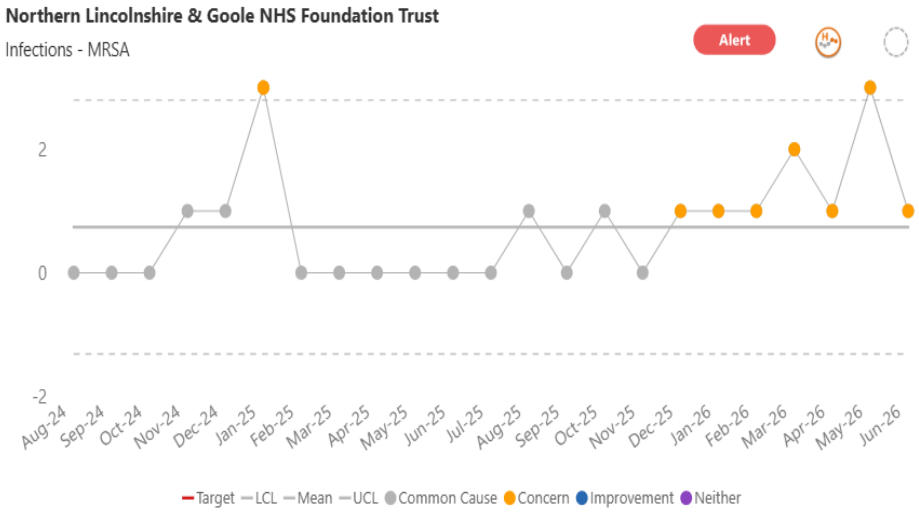
Infections - MRSA

HUTH:
MRSA cases are 0 YTD, with 0 cases in the latest month.

NLAG:
MRSA cases are 5 YTD, with 3 cases in the latest reporting period.



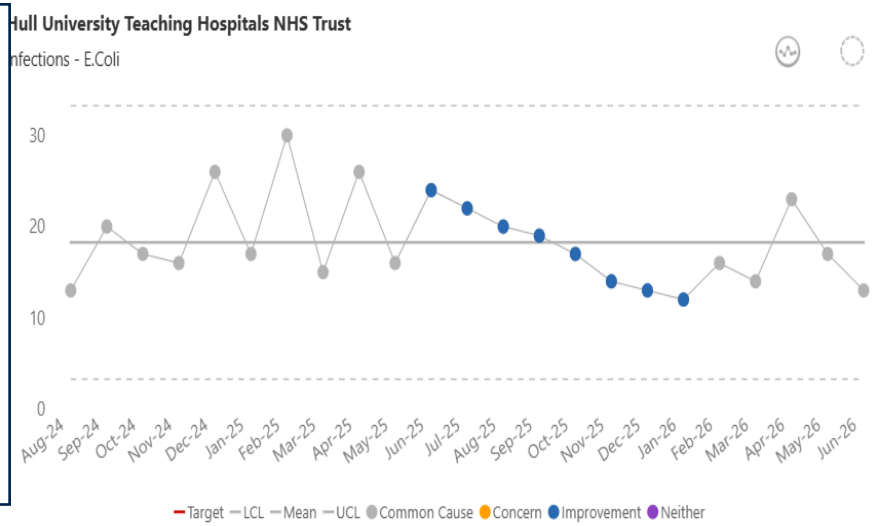


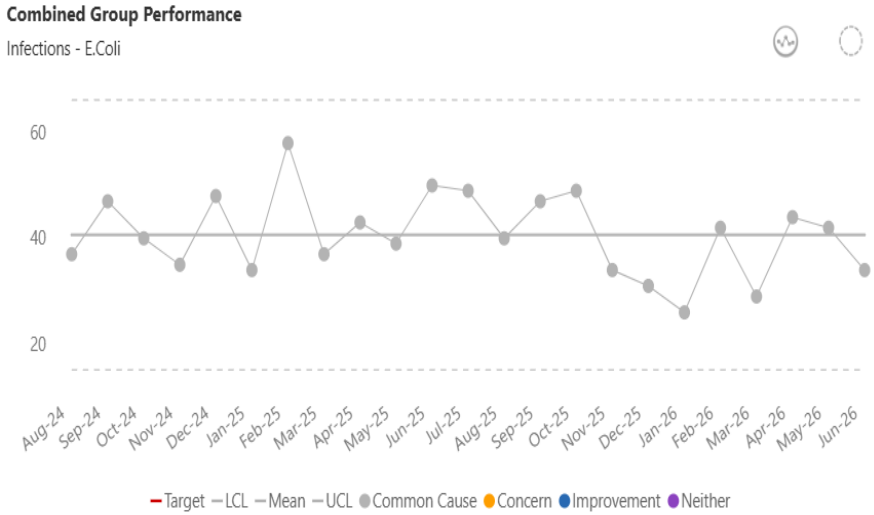


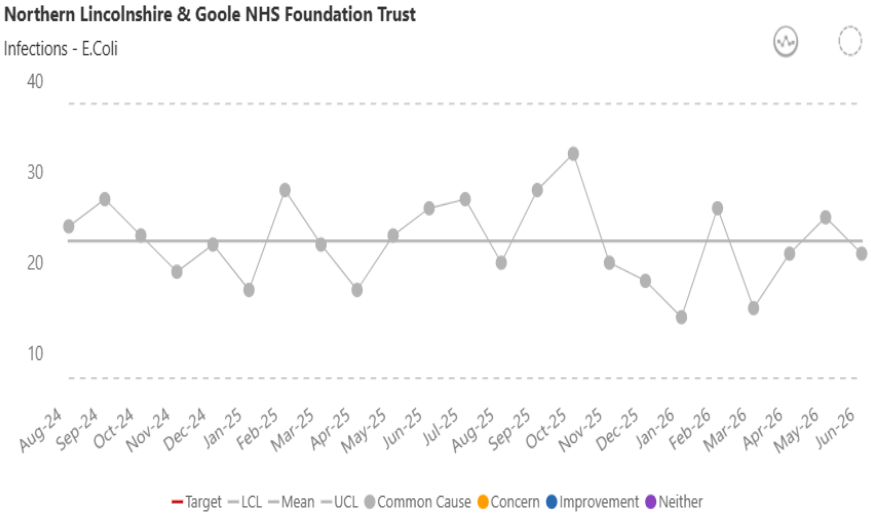
iv. E.Coli Case

HUTH:
E. coli cases are reported at 17 FYTD. The chart should be read as showing ongoing monthly variation, with the latest position materially lower than NLAG.

NLAG:
E. coli cases are reported at 67 FYTD. The chart indicates continued variation over time, but the overall FYTD position shows NLAG carries the greater E. coli burden across the Group and remains the primary focus for infection prevention oversight.







d. Effectiveness

Summary

Effectiveness performance is broadly stable overall, with continued monitoring required across VTE assessment, SHMI and emergency readmissions. VTE assessment compliance remains variable and requires consistent completion within the 14-hour standard. SHMI should be interpreted factually as a statistical indicator, with review focused on whether reported values remain within expected limits. Emergency readmissions within 30 days appear broadly stable at both Trusts, with no clear sustained deterioration indicated.

Progress

HUTH and NLAG both require continued operational grip on timely VTE assessment, particularly as national changes to emergency admission VTE assessment timing from DTA are expected to affect Quarter 3 performance. SHMI reporting continues through separate detailed releases to clinical leads, with clinical coding quality remaining an important factor in interpretation. Readmissions remain an effectiveness indicator for both Trusts and should continue to be reviewed alongside discharge quality, follow-up arrangements, frailty pathways and avoidable readmission themes.

Action

Maintain ward- and specialty-level oversight of VTE assessment compliance, with escalation where completion within 14 hours is inconsistent. Continue factual SHMI review through established clinical governance and coding assurance routes. For readmissions, strengthen specialty-level review of themes, discharge planning, post-discharge support and community interface actions where variation emerges.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Effective	Effectiveness	Inpatient - Emergency Readmissions within 30 days		10.6%	10.8%	10.3%	10.5%	10.1%	10.5%	10.2%	10.4%	10.4%	10.1%	10.2%	10.0%	
		Mortality - Crude Mortality (non-elective)		2.0%	2.5%	2.5%	2.8%	3.2%	3.2%	3.2%	3.2%	2.9%	2.6%	2.8%	2.4%	2.3%
		Mortality - HSMR	≤ 100.0	103.5	101.9	101.0	99.9	100.1	100.1	98.6	98.7	98.9	98.9			
		Mortality - SHMI	≤ 1.0	1.032	1.020	1.025	1.018	1.023	1.027	1.024	1.038	1.047				
		Mortality - Still Births (per 1,000 births)		7.833	2.625	2.439	7.979	2.632	5.115	7.444	2.890	7.853	10.526	0.000	0.000	11.655
Safe	Patient Safety	Clinical Harm Reviews - Cancer 104 day wait		55	83	71					0	0	0	0	0	0
		Clinical Harm Reviews - RTT 78 week wait		0	2	0									0	0
		VTE Risk Assessment	≥ 95.0%	94.2%	93.6%	93.5%	92.4%	92.1%	92.5%	91.8%	91.8%	92.0%	92.3%	92.6%	92.9%	91.8%
		VTE Risk Assessment 14 Hour Standard	≥ 95.0%	93.1%	92.0%	91.7%	90.5%	90.7%	90.9%	90.1%	90.8%	91.2%	91.8%	92.0%	92.2%	

Sample pages only – awaiting further Lead review

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Effective	Effectiveness	Inpatient - Emergency Readmissions within 30 days		11.1%	10.9%	11.7%	11.5%	10.9%	11.3%	11.2%	11.6%	11.0%	11.3%	11.0%	11.0%	
		Mortality - Crude Mortality (non-elective)		1.4%	1.6%	1.6%	1.6%	1.8%	2.4%	1.8%	1.9%	1.9%	1.9%	2.3%	1.9%	1.6%
		Mortality - HSMR	≤ 100.0	93.3	93.5	92.3	90.6	89.8	88.5	85.4	85.3	84.8	84.8			
		Mortality - SHMI	≤ 1.0	1.024	1.030	1.021	1.009	1.001	0.999	0.976	0.977	0.993				
		Mortality - Still Births (per 1,000 births)		0.000	6.135	0.000	9.804	6.024	0.000	3.413	6.645	6.452	3.401	0.000	0.000	0.000
Safe	Patient Safety	Clinical Harm Reviews - Cancer 104 day wait													0	
		Clinical Harm Reviews - RTT 78 week wait													0	
		VTE Risk Assessment	≥ 95.0%	96.0%	96.2%	96.5%	95.5%	92.2%	95.6%	96.1%	95.8%	95.7%	96.9%	96.8%	96.7%	96.6%
		VTE Risk Assessment 14 Hour Standard	≥ 95.0%	93.0%	93.0%	93.7%	93.1%	88.1%	92.6%	93.6%	93.2%	93.3%	94.8%	94.8%	94.5%	

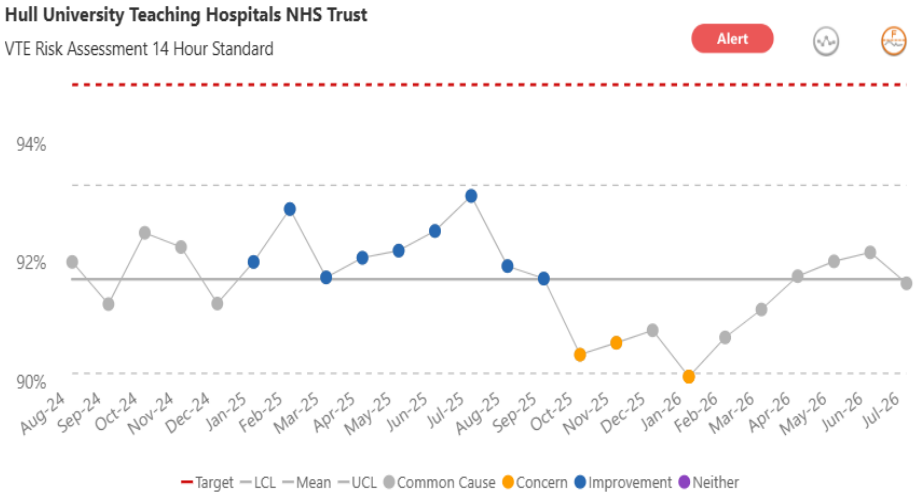
i. VTE Assessment within 14hrs

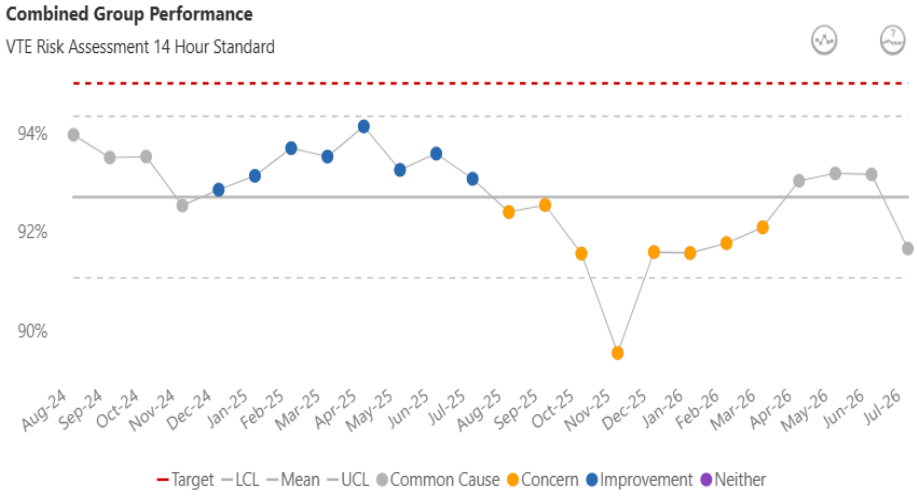
VTE Risk Assessment 14 Hour Standard

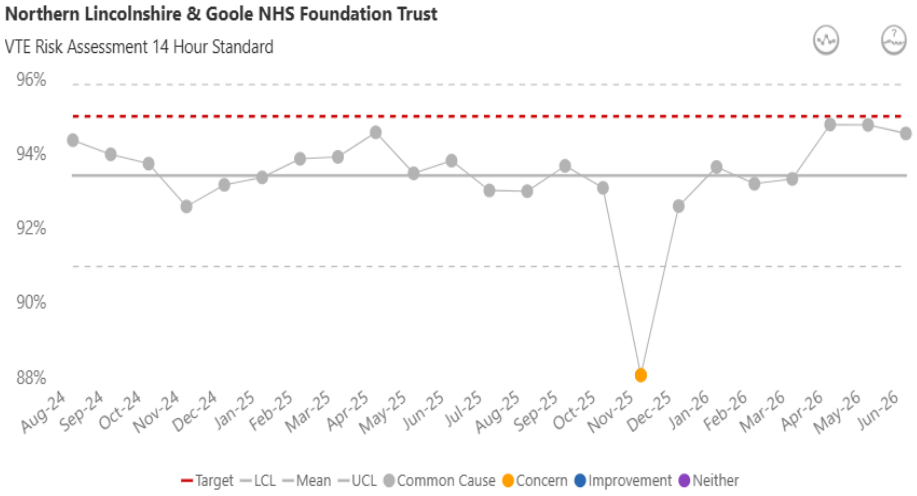
Compliance should continue to be monitored closely, with focus on consistent completion within the required 14-hour standard and follow-up of any areas falling below expected practice.

Continued operational oversight is required to ensure timely VTE assessment completion, with escalation where ward or specialty-level compliance is inconsistent.

National changes to VTE Risk Assessments for Emergency Admissions needing to include time from DTA will have a material impact upon our performance in Quarter 3.





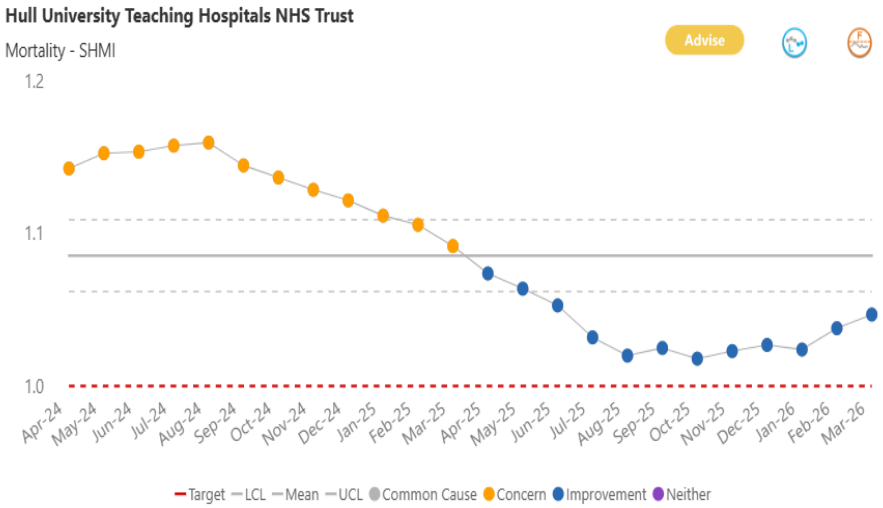


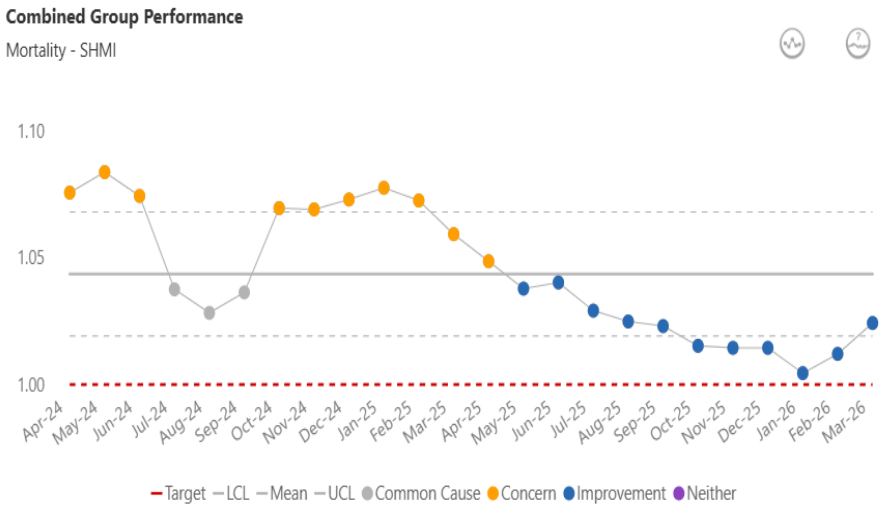
ii. Summary Hospital Mortality Indicator

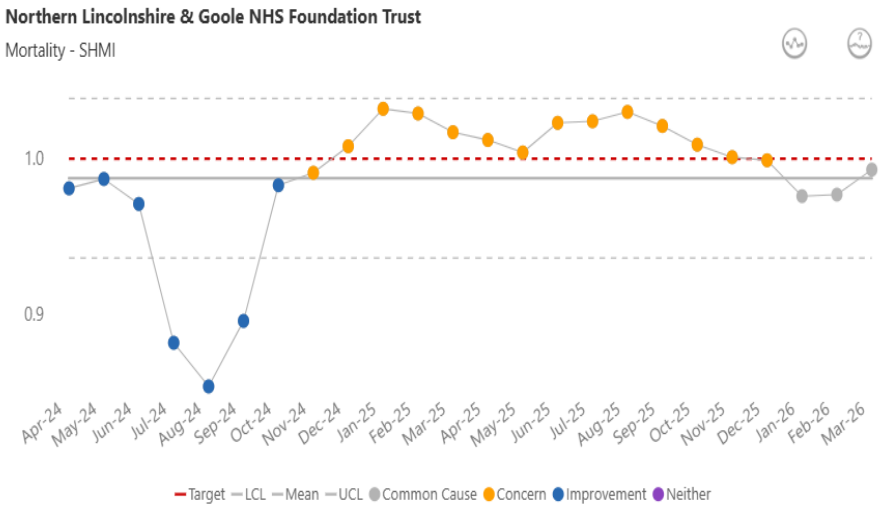
The recent data points should be interpreted as a statistical trend position only, with review focused on whether the indicator remains within expected limits or shows any sustained variation.

Separate and detailed SHMI reporting is providing to Clinical Leads upon each release of national data.

Several factors can impact and influence the SHMI score, with the ability to host well resourced Clinical Coding services crucial for accuracy.







iii. Emergency Readmissions within 30 Days

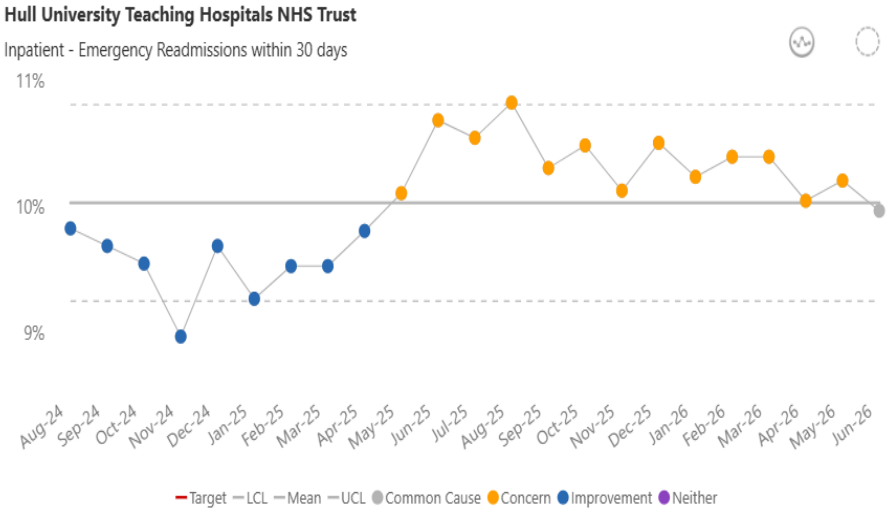
Inpatient - Emergency Readmissions within 30 days

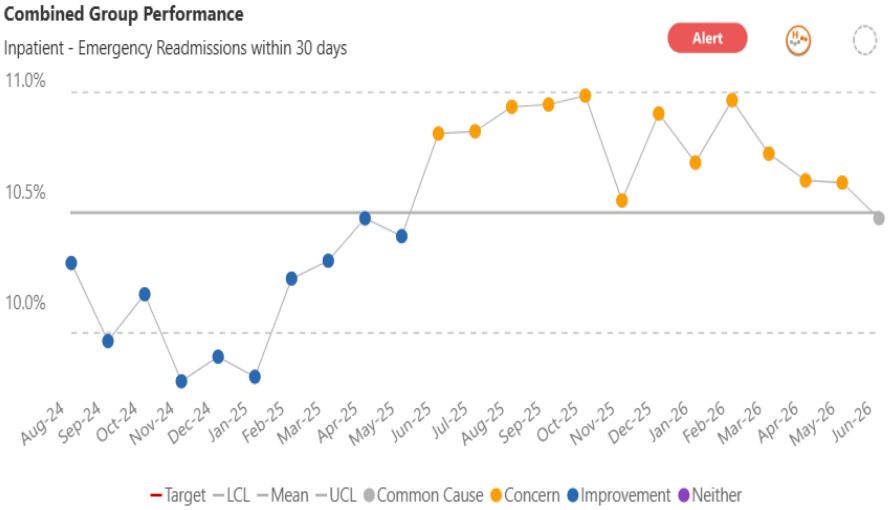
HUTH:

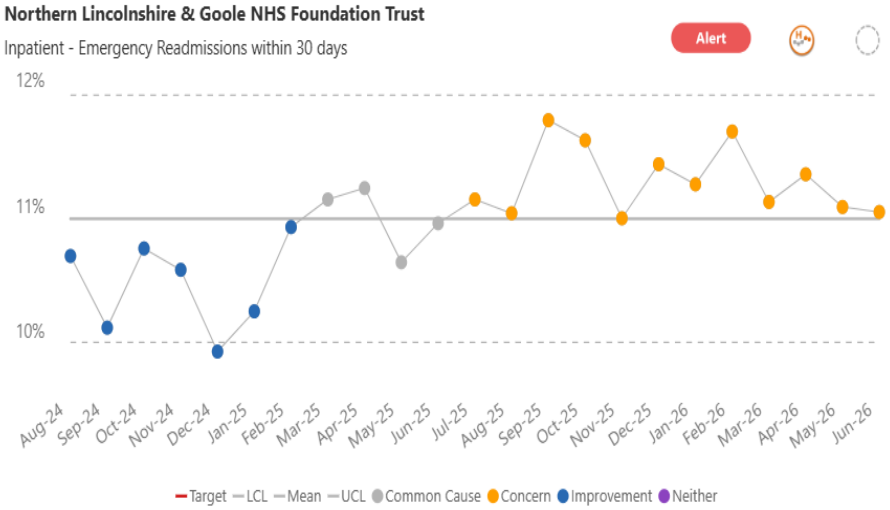
Emergency readmissions within 30 days show a relatively stable trend, with recent performance appearing to remain within expected variation rather than demonstrating a sustained improvement or deterioration. The position should continue to be monitored through specialty-level review, with focus on discharge quality, follow-up arrangements and readmission themes where variation emerges.

NLAG:

NLAG also appears broadly stable, with no clear sustained shift evident in the recent data. While the trend does not suggest an immediate deterioration, readmissions remain an important effectiveness indicator and should continue to be reviewed alongside discharge planning, frailty, community support and avoidable readmission analysis.







Sample pages only – awaiting further Lead review

6. HHP Group Executive Summary – Workforce

Executive Lead: Helen Marks, Group Chief People Officer

Accountable to:

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
Healthcare Worker Flu Vaccination Rate	Apr-26	≥ 60.0%	51.0%		
Staff Appraisal Rate (AfC)	Jun-26	≥ 85.0%	82.2%		
Staff e-Job Planning	Jul-26	≥ 95.0%	94.3%		
Staff Mandatory Training - Core	Jun-26	≥ 85.0%	88.5%		
Staff Mandatory Training - Role Specific	Jun-26	≥ 85.0%	83.5%		
Staff Sickness Absence Rate	Jun-26	≤ 4.0%	4.4%		
Staff Survey - Raising Concerns sub-score	Jul-26		6.1		
Staff Time to Employment Checks	Jul-26	≤ 20.0	21.0		
Staff Time to Offer	Jul-26	≤ 2.0	2.4		
Staff Time to Shortlist	Jul-26	≤ 5.0	7.6		
Staff Turnover Annual FTE Rate	Jun-26	≤ 8.0%	12.2%		

Northern Lincolnshire and Goole NHS Foundation Trust

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

Metric	Month	Target	Result	Var	Asr
Healthcare Worker Flu Vaccination Rate	Apr-26	≥ 60.0%	51.1%		
Staff Appraisal Rate (AfC)	Jun-26	≥ 85.0%	81.4%		
Staff e-Job Planning	Jul-26	≥ 95.0%	94.3%		
Staff Mandatory Training - Core	Jun-26	≥ 85.0%	85.5%		
Staff Mandatory Training - Role Specific	Jun-26	≥ 85.0%	82.0%		
Staff Sickness Absence Rate	Jun-26	≤ 4.0%	5.4%		
Staff Survey - Raising Concerns sub-score	Jul-26		6.1		
Staff Time to Employment Checks	Jul-26	≤ 20.0	21.6		
Staff Time to Offer	Jul-26	≤ 2.0	7.4		
Staff Time to Shortlist	Jul-26	≤ 5.0	7.5		
Staff Turnover Annual FTE Rate	Jun-26	≤ 8.0%	11.9%		

Chief People Officer Update – Workforce Overview (July 2026)

Summary

The workforce position remains mixed across the Group, with the clearest risk in workforce availability and recruitment responsiveness. HUTH sickness absence is showing a deteriorating signal, with the latest four data points above the mean, indicating a sustained adverse shift rather than normal variation. NLAG sickness absence is more stable, remaining around the mean. Across both Trusts, appraisal and role-specific mandatory training remain variable without evidence of sustained improvement. Recruitment timeliness is also variable, with NLAG **Staff Time to Offer** in **Alert**, highlighting a specific risk in converting recruitment activity into timely offers.

Progress

HUTH's workforce culture and experience position is most affected by the sickness absence trend, while appraisal and role-specific mandatory training require continued grip to improve consistency. NLAG does not show the same deterioration in sickness absence, but appraisal and role-specific training completion remain inconsistent. In recruitment and retention, HUTH appears broadly stable but variable across shortlist, offer and employment check stages, with no clear sustained improvement. NLAG shows greater risk across the recruitment pathway, particularly at the offer stage, where the alert status indicates delay against trajectory. Employment checks at both Trusts appear broadly stable but remain a potential later-stage recruitment bottleneck if not actively managed.

Action

Executive focus should remain on targeted sickness absence intervention at HUTH, including divisional hotspot review, attendance management and wellbeing support. Across both Trusts, strengthen workforce governance for appraisal and role-specific mandatory training completion, with routine escalation of areas below trajectory. Recruitment actions should focus on end-to-end pathway grip from vacancy review to start date, including manager shortlisting, interview outcome turnaround, offer approvals and employment check completion. Priority escalation is required for NLAG Time to Offer, with named ownership of delays and routine monitoring of bottlenecks to protect workforce supply.

Sample pages only – awaiting further Lead review

a. Hull University Teaching Hospital Workforce AAA Summary

Count: 6

Alert

Healthcare Worker Flu Vaccination Rate
Staff Appraisal Rate (AfC)
Staff Mandatory Training - Role Specific
Staff Sickness Absence Rate
Staff Time to Shortlist
Staff Turnover Annual FTE Rate

Count: 1

Advise

Staff Time to Offer

Count: 2

Assure

Staff Mandatory Training - Core
Staff Survey - Raising Concerns sub-score

b. Northern Lincolnshire & Goole Hospitals Workforce AAA Summary

Count: 6

Alert

Healthcare Worker Flu Vaccination Rate
Staff Appraisal Rate (AfC)
Staff Mandatory Training - Role Specific
Staff Sickness Absence Rate
Staff Time to Offer
Staff Turnover Annual FTE Rate

Count: 1

Advise

Staff Time to Shortlist

Count: 1

Assure

Staff Survey - Raising Concerns sub-score

c. Staff Culture & Experience

Summary

Staff Culture and Experience remains mixed, with no consistent improvement across the three supporting indicators. The key adverse signal is HUTH sickness absence, where the latest four data points sit above the mean, indicating a recent deterioration. NLAG sickness absence remains around the mean, while appraisal and role-specific mandatory training performance at both Trusts remain variable without sustained improvement.

Progress

HUTH has a clear sickness absence deterioration requiring focus, alongside appraisal and role-specific training trends that remain variable rather than improving. NLAG does not show the same sickness deterioration, with absence broadly around the mean, but appraisal and role-specific training completion remain inconsistent and require continued management grip.

Action

Prioritise targeted action on HUTH sickness absence through divisional hotspot review, attendance management and wellbeing support. Across both Trusts, strengthen accountability for appraisal and role-specific mandatory training completion, with routine monitoring of areas below trajectory, escalation of non-compliance and evidence of recovery through workforce governance.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Safe	Patient Safety	Staff Survey - Raising Concerns sub-score		6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.1
	People & Workforce	Healthcare Worker Flu Vaccination Rate	≥ 60.0%				28.2%	41.5%	50.8%	51.7%	51.6%	51.3%	51.0%			
Well Led	People & Workforce	Staff Appraisal Rate (AfC)	≥ 85.0%	81.0%	79.2%	79.7%	80.7%	81.4%	82.3%	80.9%	80.8%	80.1%	81.5%	81.6%	82.2%	
		Staff Mandatory Training - Core	≥ 85.0%	86.4%	86.5%	86.6%	87.7%	88.2%	88.4%	89.4%	89.0%	89.8%	89.8%	87.8%	88.5%	
		Staff Mandatory Training - Role Specific	≥ 85.0%	82.4%	79.4%	80.4%	82.6%	82.0%	82.7%	83.0%	82.0%	82.8%	83.1%	83.3%	83.5%	
		Staff Sickness Absence Rate	≤ 4.0%	4.1%	4.1%	4.2%	4.2%	4.2%	4.3%	4.1%	4.4%	4.4%	4.4%	4.4%	4.4%	

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Safe	Patient Safety	Staff Survey - Raising Concerns sub-score		6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1
	People & Workforce	Healthcare Worker Flu Vaccination Rate	≥ 60.0%				26.9%	43.0%	50.7%	51.7%	51.7%	51.4%	51.1%			
Well Led	People & Workforce	Staff Appraisal Rate (AfC)	≥ 85.0%	82.0%	82.1%	79.4%	77.9%	78.6%	79.3%	79.3%	78.9%	77.7%	79.1%	79.8%	81.4%	
		Staff Mandatory Training - Core	≥ 85.0%	85.3%	84.9%	86.4%	86.9%	87.5%	84.6%	87.1%	86.9%	89.1%	89.2%	85.1%	85.5%	
		Staff Mandatory Training - Role Specific	≥ 85.0%	85.6%	85.0%	84.7%	83.4%	84.2%	82.7%	80.9%	80.8%	81.5%	80.9%	79.5%	82.0%	
		Staff Sickness Absence Rate	≤ 4.0%	5.6%	5.6%	5.6%	5.5%	5.5%	5.5%	5.5%	5.3%	5.4%	5.4%	5.4%	5.4%	

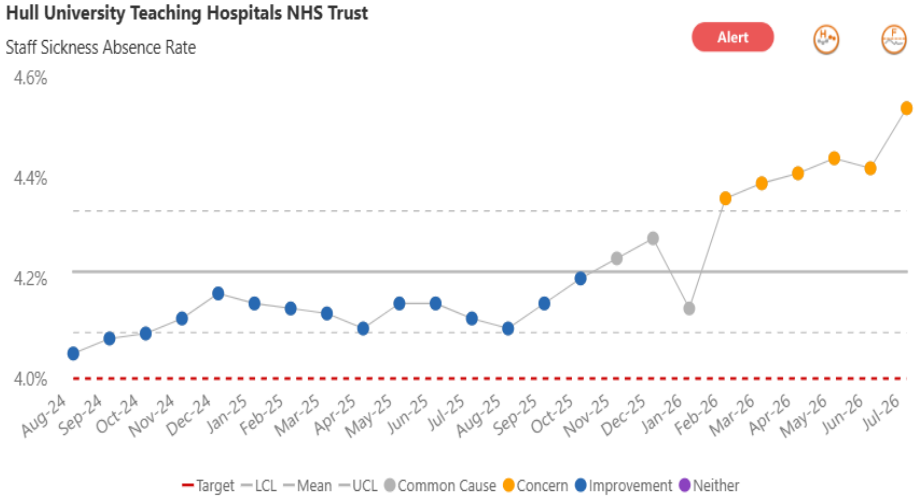
Sample pages only – awaiting further Lead review

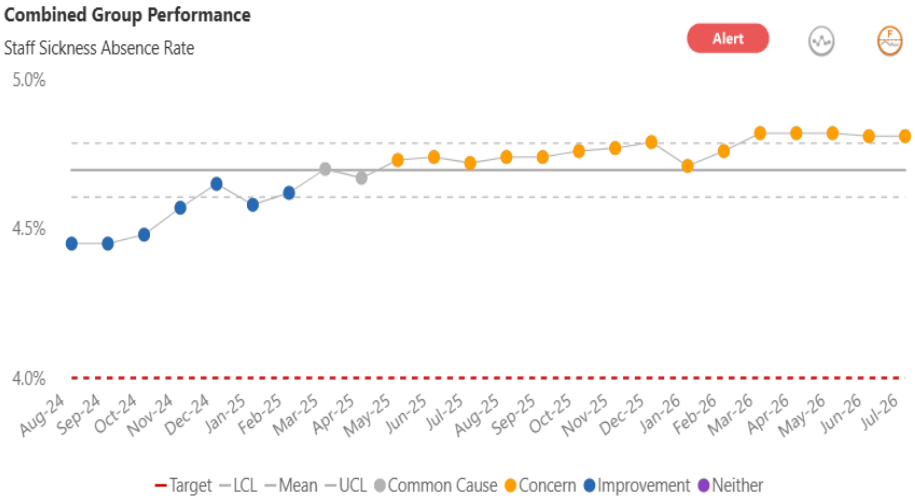
i. Staff Sickness Absence Rate

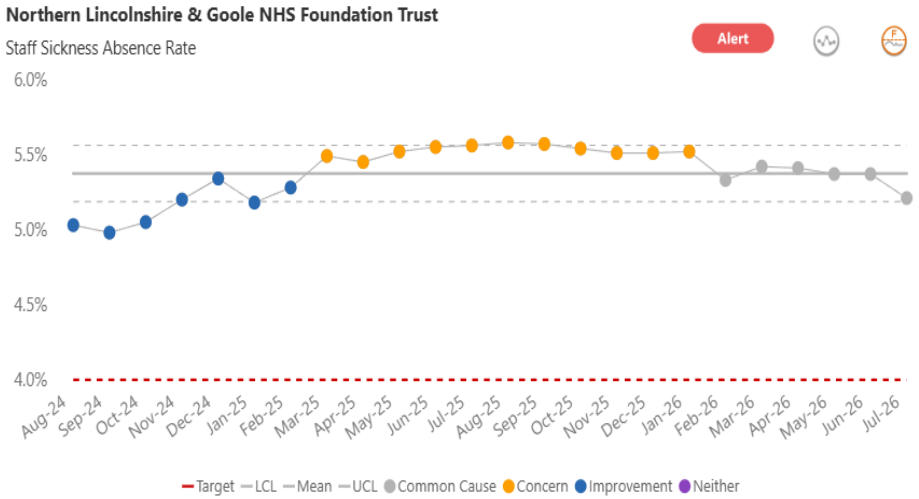
Staff Sickness Absence Rate

HUTH:
Staff sickness absence shows a recent sustained increase, with the latest four data points sitting above the mean. This indicates a deterioration rather than common-cause variation and suggests sickness absence has become a worsening workforce pressure requiring targeted divisional review, hotspot analysis and strengthened attendance management.

NLAG:
NLAG sickness absence remains broadly around the mean, with the latest data points showing normal variation rather than a sustained shift. While absence continues to require active management, the trend does not indicate the same recent deterioration seen at HUTH.







ii. Staff Appraisal Rate (AfC)

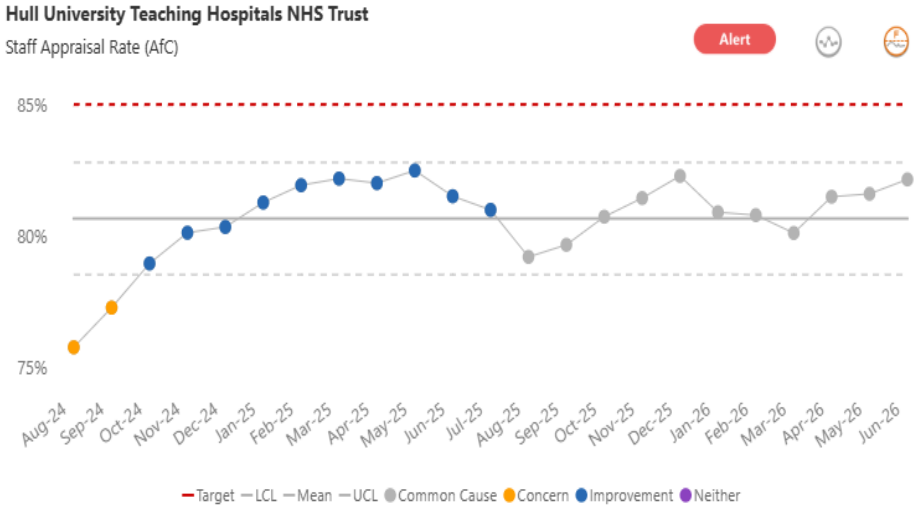
Staff Appraisal Rate (AfC)

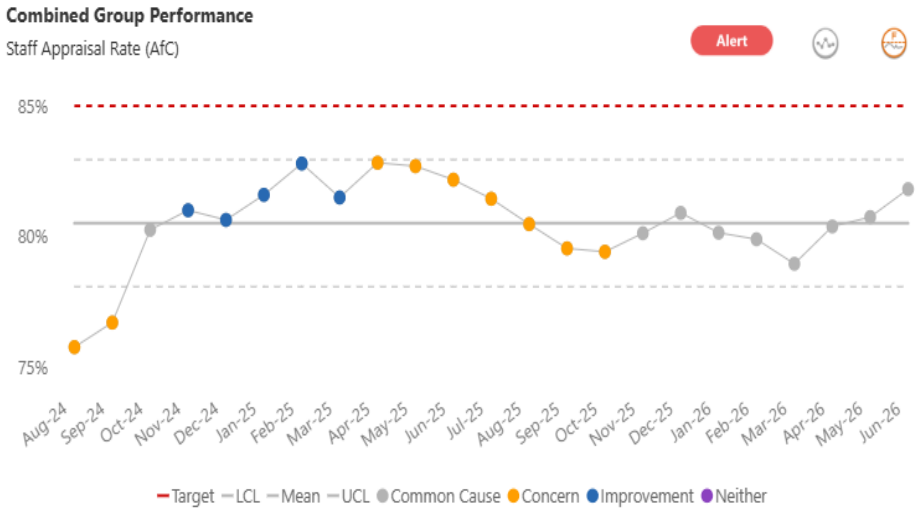
HUTH:

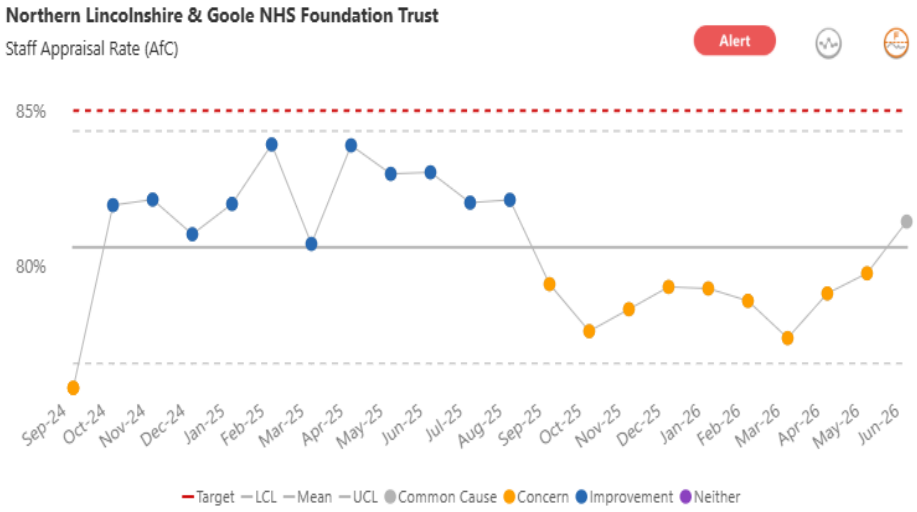
Staff appraisal performance remains variable and does not show a sustained improving trend. Recent data points appear to continue around the mean, indicating normal variation rather than clear recovery. Continued divisional focus is required to improve completion rates and ensure appraisal compliance is delivered consistently.

NLAG:

NLAG appraisal performance also remains variable, with the most recent position not demonstrating sustained improvement. The trend suggests appraisal completion remains inconsistent, requiring tighter management oversight, targeted follow-up of areas below expected compliance and clearer accountability for completion.







iii. Staff Mandatory Training – Role Specific

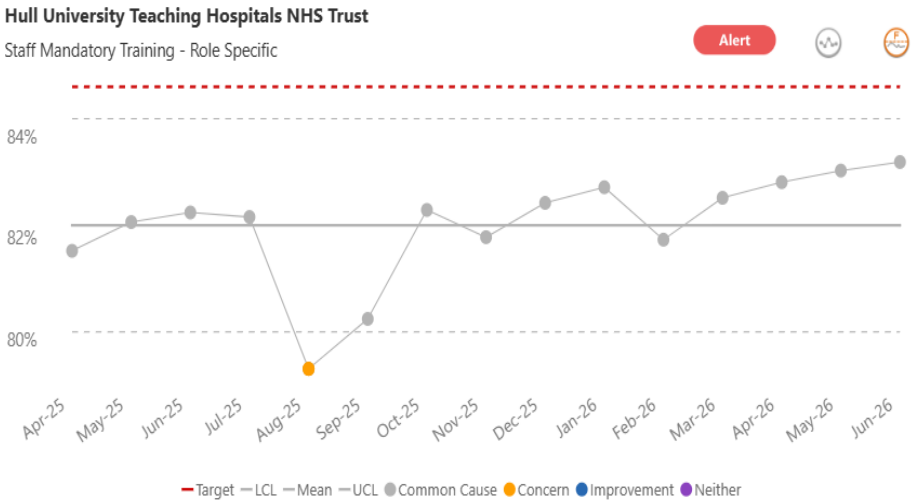
Staff Mandatory Training - Role Specific

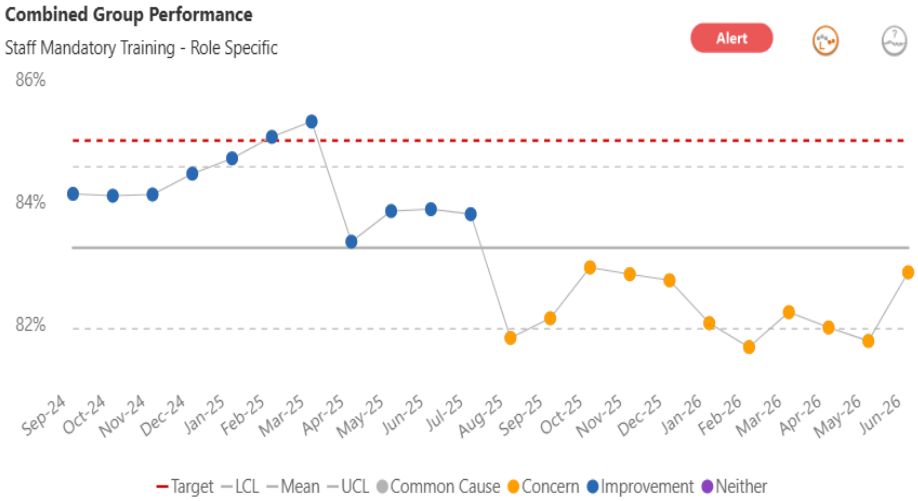
HUTH:

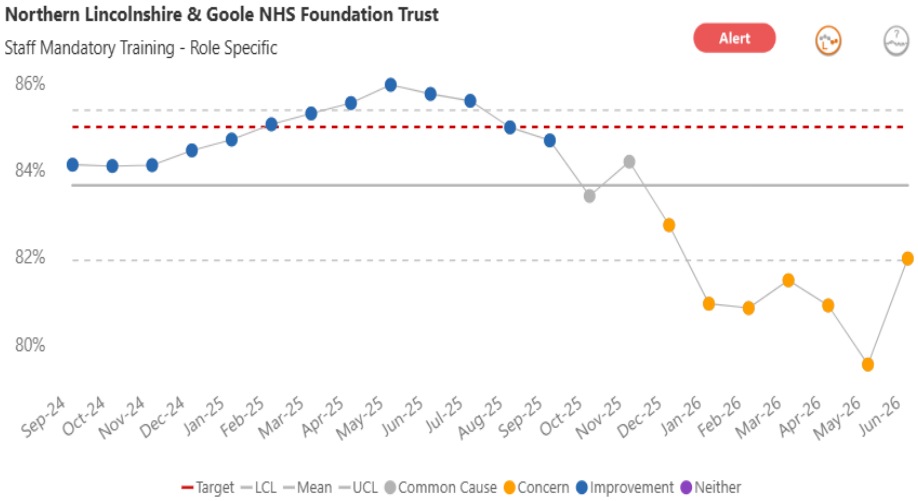
The latest position suggests compliance is not yet consistently improving at the required pace, requiring continued divisional grip, targeted follow-up with areas below trajectory and active monitoring through workforce governance.

NLAG:

NLAG shows a similarly variable trend, with performance not yet demonstrating sustained improvement. Continued focus is required on role-specific training completion, manager accountability and escalation of non-compliance to ensure training gaps do not present an ongoing workforce or assurance risk.







d. Recruitment & Retention

Summary

Recruitment process timeliness remains variable across HUTH and NLAG, with no clear sustained improvement across shortlisting, offer or employment checks. The greatest concern is NLAG Staff Time to Offer, which remains in **Alert**, indicating delays in progressing candidates to offer and a continuing risk to workforce supply.

Progress

HUTH shows broadly stable but variable performance across the recruitment pathway, with no sustained deterioration but limited evidence of improvement. NLAG also remains variable across the pathway, with particular risk at the offer stage. Employment checks at both Trusts appear broadly stable but continue to require oversight to prevent delays later in the recruitment process.

Action

Strengthen end-to-end recruitment grip through timely vacancy review, manager shortlisting, interview outcome confirmation, offer approval and employment check turnaround. Priority focus is required on NLAG Time to Offer, with escalation of overdue decisions, clearer ownership of recruitment delays and routine monitoring of pathway bottlenecks from advert close to start date.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Safe	People & Workforce	Staff Time to Employment Checks	≤ 20.0	30.2	35.0	38.8	38.5	36.4	27.7	48.2	13.8	12.6	13.6	16.0	18.9	21.0
		Staff Time to Offer	≤ 2.0	6.7	6.3	3.3	2.7	2.1	2.1	2.0	2.0	2.2	2.3	2.2	2.3	2.4
		Staff Time to Shortlist	≤ 5.0	10.0	9.2	9.4	8.6	9.0	8.2	8.5	7.1	7.2	7.0	6.6	7.6	7.6
Well Led	People & Workforce	Staff Turnover Annual FTE Rate	≤ 8.0%	6.9%	7.2%	6.4%	6.7%	6.4%	6.2%	5.8%	6.2%	6.4%	6.3%	6.5%	12.2%	

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Safe	People & Workforce	Staff Time to Employment Checks	≤ 20.0	25.7	28.7	41.2	34.6	41.2	41.3	37.4	27.5	27.0	22.0	17.3	17.8	21.6
		Staff Time to Offer	≤ 2.0	2.5	2.4	3.1	2.8	2.6	2.5	2.4	2.2	2.5	2.9	3.4	3.5	7.4
		Staff Time to Shortlist	≤ 5.0	39.0	40.0	50.6	68.2	95.7	110.8	52.3	48.8	47.8	6.1	6.8	6.9	7.5
Well Led	People & Workforce	Staff Turnover Annual FTE Rate	≤ 8.0%	8.9%	8.7%	8.4%	8.4%	8.3%	8.0%	8.0%	7.8%	7.6%	6.5%	7.2%	11.9%	

Sample pages only – awaiting further Lead review

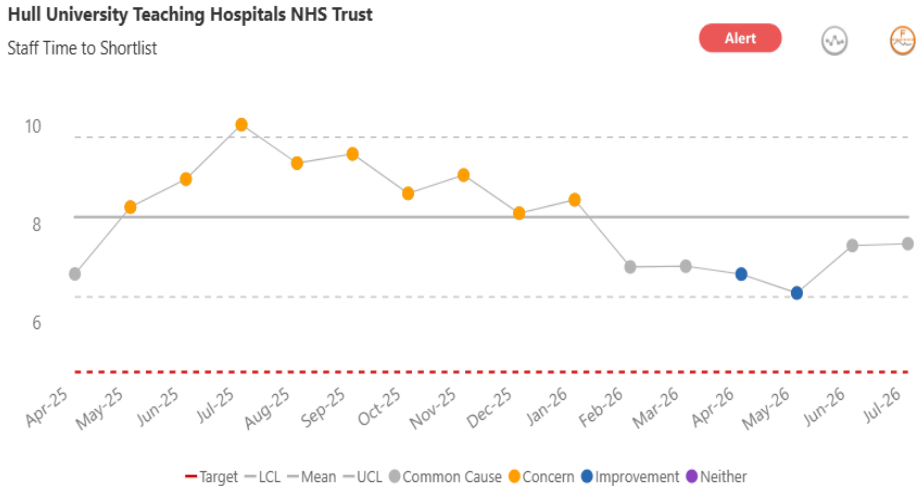
i. Staff Time to Shortlist

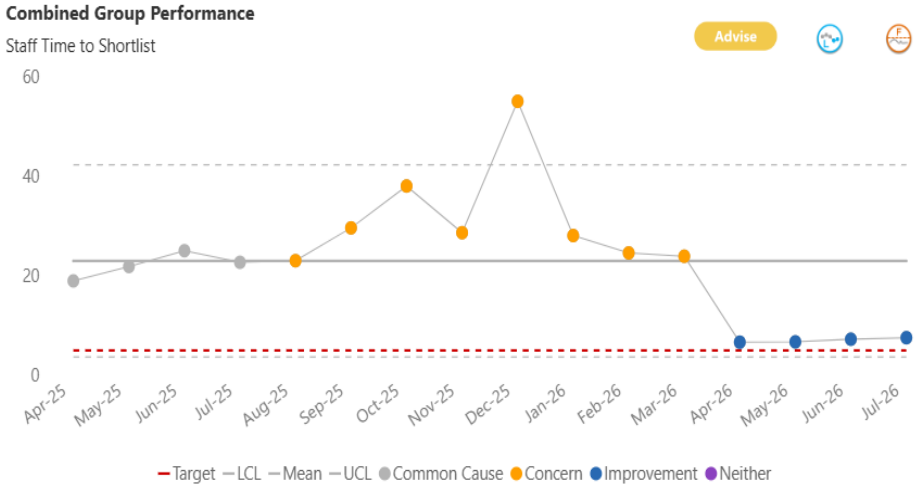
HUTH:

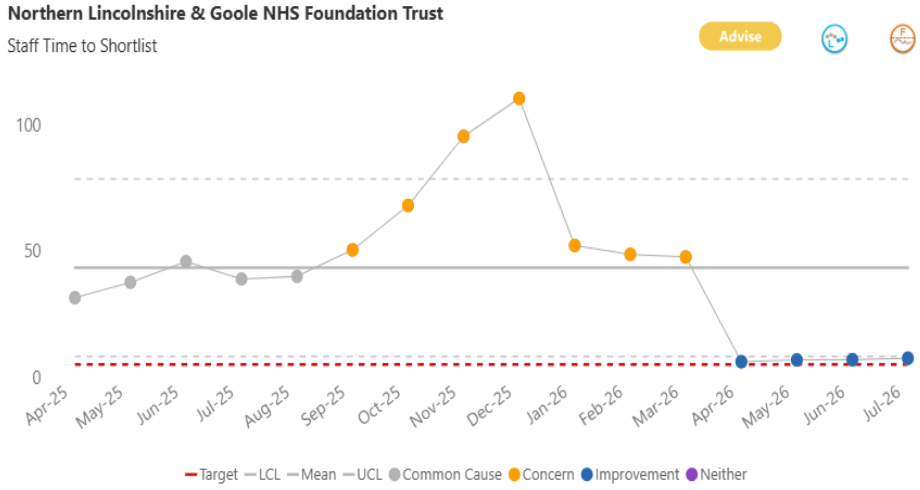
Staff Time to Shortlist shows continued variation across the period, with no clear sustained improvement. The latest position suggests the process remains vulnerable to delays at the early recruitment stage, requiring continued focus on timely vacancy review, manager shortlisting and recruitment team escalation where turnaround is off trajectory.

NLAG:

Staff Time to Shortlist also remains variable, with performance not yet demonstrating a consistent reduction. The trend indicates ongoing risk in progressing vacancies quickly from advert close to shortlist, requiring tighter operational grip on recruiting manager responsiveness, vacancy prioritisation and escalation of overdue shortlisting.







Sample pages only – awaiting further Lead review

ii. Staff Time to Offer

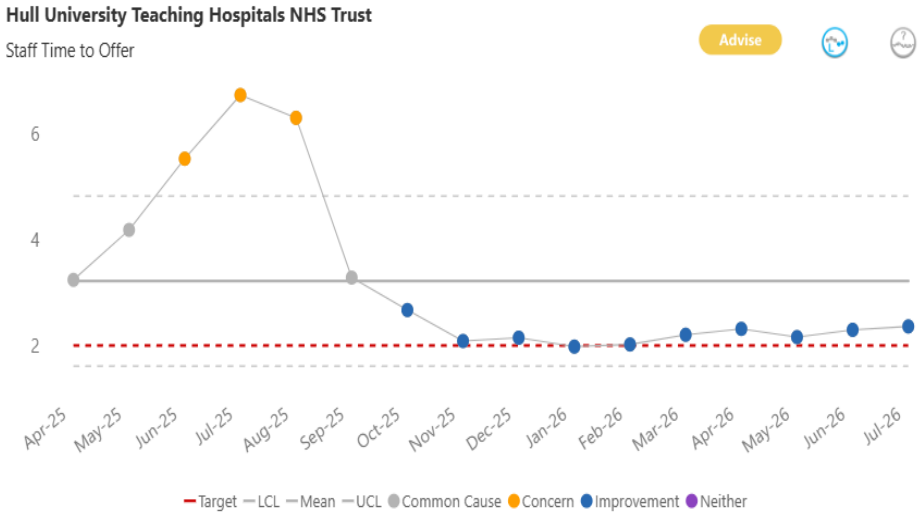
Staff Time to Offer

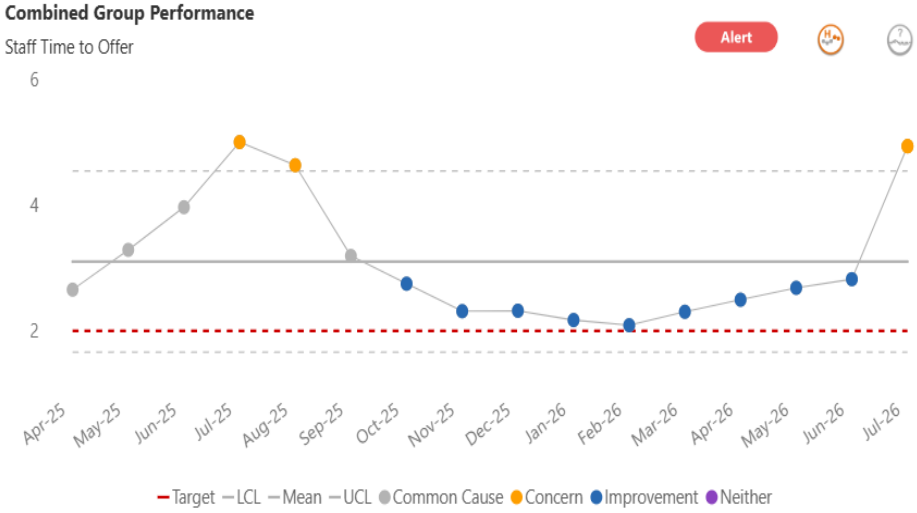
HUTH:

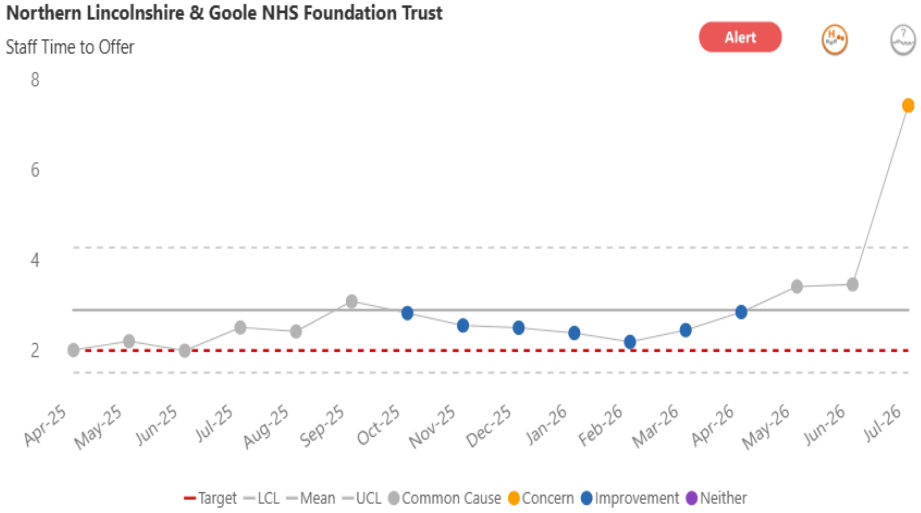
Staff Time to Offer shows variation across the period, with no clear sustained improvement. The recent position appears broadly stable but remains above the level required for consistent recruitment responsiveness, so continued focus is needed on timely interview outcomes, approval steps and offer processing.

NLAG:

Staff Time to Offer remains in Alert, reflecting a concerning position against trajectory. The trend shows continued variation without sustained recovery, indicating that delays in progressing candidates to offer remain a recruitment risk and require targeted operational grip on vacancy management, panel decision turnaround and offer approval processes.







iii. Staff Time to Employment Checks

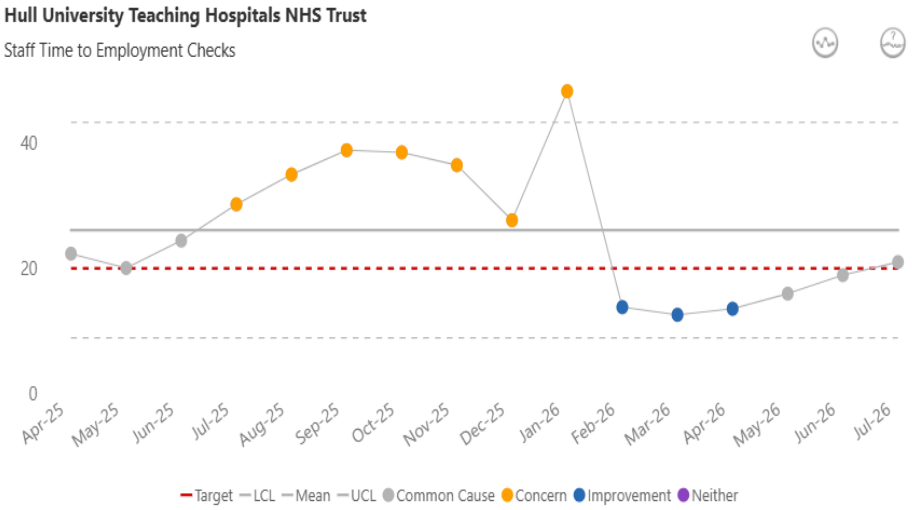
Staff Time to Employment Checks

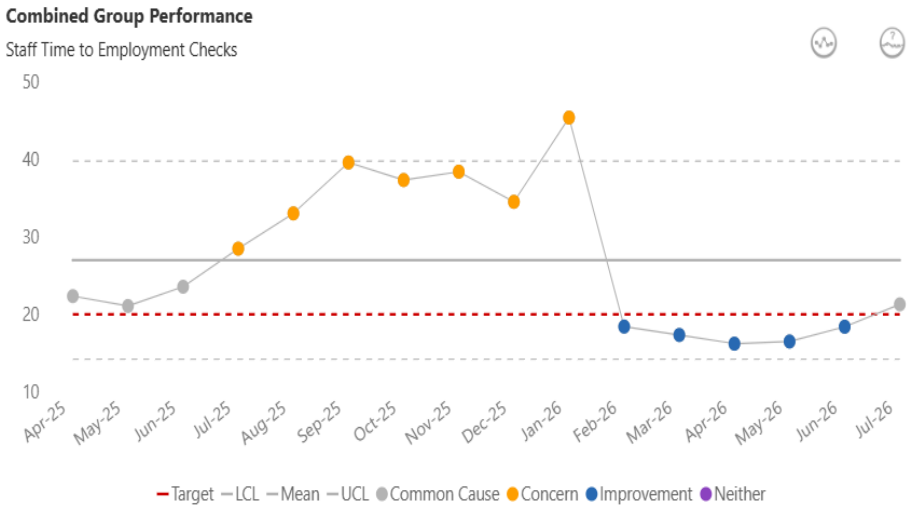
HUTH:

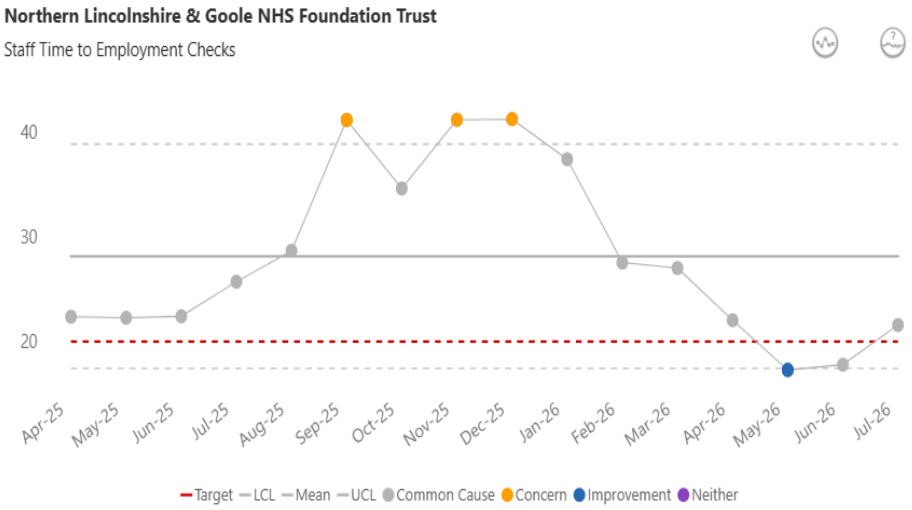
Time to employment checks shows a broadly stable trend with no clear sustained improvement; performance remains variable and should continue to be monitored to ensure checks do not become a recruitment delay point.

NLAG:

NLAG also shows variation across the period, with the position not yet demonstrating a sustained reduction. Continued focus is required on pre-employment check turnaround, escalation of delays and consistent recruitment process grip.







Appendices

1. Key to Statistical Process Control (SPC) Charts

SPC GUIDE

A guide to understanding Statistical Process Control (SPC) charts, variation and assurance icons

Statistical Process Control (SPC) charts help us understand how processes perform over time, distinguishing between normal and special cause variation. These charts follow best practice principles aligned with the **Making Data Count** (MDC) approach. Further details of Making Data Count principles can be found as follows:

https://www.england.nhs.uk/publication/making-data-count/

WHAT YOU'LL SEE

SPC Chart

Each point represents a data value over time. The chart helps you understand how the process is performing, highlighting whether variation is expected (*common cause*) or unusual (*special cause*).
Blue dots indicate improvement (special cause variation); **Amber dots** indicate concern (special cause variation); **Grey dots** indicate expected variation (common cause).

Variation Icons

These summarise the type of variation at a glance.
Blue indicates improvement; **Amber** indicates concerning variation that may require action; **Grey** indicates no significant change (common cause variation).

Assurance Icons

These indicate how reliably the target is being met.
Blue indicates target is consistently achieved; **Amber** indicates target is not consistently achieved; **Grey** indicates target is inconsistently achieved due to random variation.

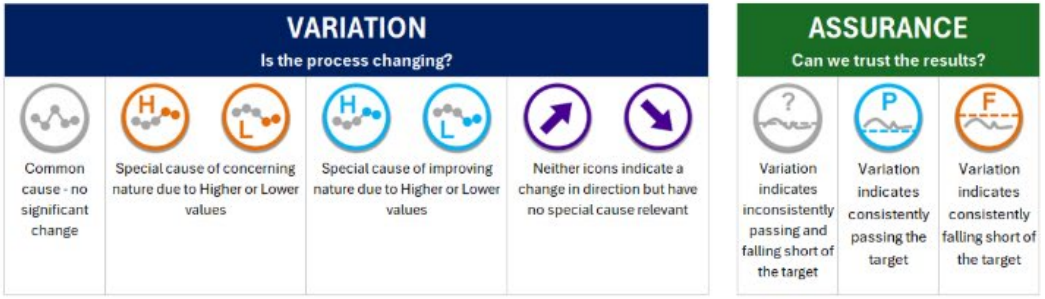
Triple-A Status

Combines variation and assurance to give an overall rating:
Assure, **Advise**, or **Alert**.

Variation	Plan / Assurance	AAA Status
Improving	Meeting	Assure
Normal	Meeting	Assure
Improving	Missing	Advise
Concerning	Meeting	Advise
Concerning	Missing	Alert
Normal	Missing	Alert

SPC Chart

Variation and Assurance Icons



2. National Oversight Framework Definitions

Establishing Average Scores

Step one: score individual metrics

Metric	Value	Score
% of patients waiting over 52 weeks	0.7%	1.00
% of patients waiting less than 18 weeks	59%	2.62
% of urgent cancer referrals diagnosed in 4 weeks	81.5%	1.00
% of cancer treatments within 62 days	82.6%	1.00
% of patients managed in A&E within four hours	80.4%	1.00
% of patients spending over 12 hours in A&E	3.1%	1.4
Planned surplus or deficit	£0.00	1.00
Latest surplus or deficit	-0.73%	3.00
NHS staff survey engagement score	7.17	1.36
NHS staff survey safety score	6.70	1.45
CQC safety rating	Good	2.00

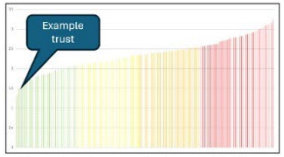
Step two: determine overall score

Sum total of metric scores
16.83

Total number of scores
11

Overall score (Sum total of metric scores / total number of scores)
1.53

Step three: Calculate initial delivery score



All raw domain scores for the organisation type are plotted and evenly quartiles. The example trust's raw score of 1.53 is in the lowest quartile giving a delivery score of 1

After this an adjustment is made for Financial Deficit:

Any provider with a segment of 1 or 2 based on its operational delivery score that is reporting a deficit or is in receipt of deficit support will automatically have its segment downrated to 3. This will be based on organisational not system-wide financial performance.

Then National segmentation is applied as follows:

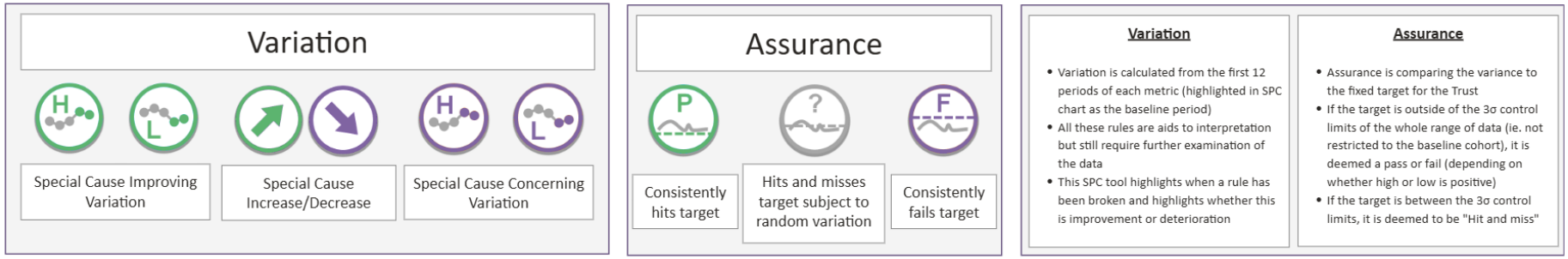
An organisation's organisational delivery score, adjusted if applicable for financial deficit, translates directly to the segment it is allocated. For some providers that are allocated to segment 4, the relevant NHS England region will consider their capability rating and determine whether they should be entered into the Provider Improvement Programme (PIP).

All providers in the PIP will be placed in segment 5.

3. Using Data Insights to identify Alert, Advise and Assure status

Making Data Count is a means to express the variation in trend and, somewhat separately, the achievement of a singular target (assurance).

In most cases, this will yield a continual 'Fail' throughout the year in terms of the MDC Assurance trigger (described below) as this wants a static target.



Equally, in the context of traditional 'National' compliance targets (e.g. ED 4hr =95%) being beyond reach, we require a focus upon what we have agreed to achieve over a performance cycle, with the Medium-Term Plan helping to set this in several key areas.

If the Trust has established a target, these are our Performance Measures for the year and if we have established a target, best practice would be to generate a trajectory to monitor its delivery.

'Assurance' would be better demonstrated by the combination of variation – still using SPC insight – and whether the latest reporting period is matching trajectory.

Using this approach, we will identify the AAA status of each Performance Measure every month based upon the matrix below.

Variation status	Status v Trajectory	AAA Group
Improving	Meeting	Assure
Improving	Missing	Advise
Concerning	Meeting	Advise
Concerning	Missing	Alert
Normal	Missing	Alert
Normal	Meeting	Assure

4. National Oversight Framework

HUTH Overview

Select a trust

Hull University Teaching Hospitals NHS Trust (RWA)

View the glossary page

Average score

3.19

Lower by 0.04 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).
Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

Yes

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

4 - Low performing

Previous quarter's segment: 4

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

134 out of 134

Previous quarter's rank: 134 out of 134

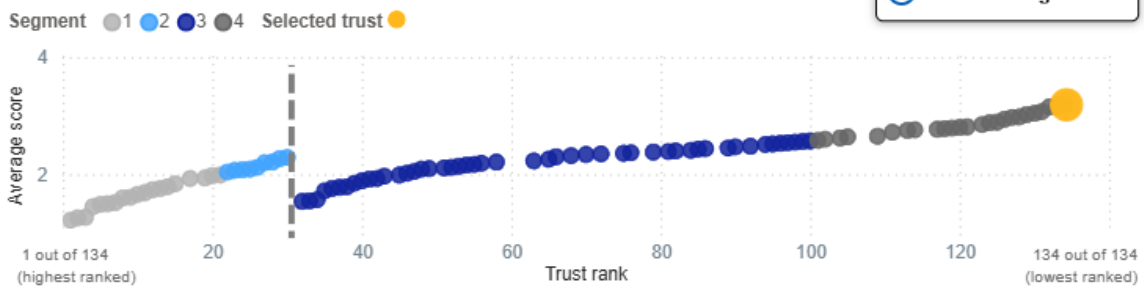
Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Access to services	4 - Low performing
Finance and productivity	4 - Low performing
Effectiveness and experience	2 - Above average
Patient safety	4 - Low performing
People and workforce	3 - Below average

Average score by trust rank placement

View full league table



Comparative League table in Appendices

NLAG Overview

Select a trust

Northern Lincolnshire and Goole NHS Foundation Trust (RJL)

View the glossary page

Average score

2.79

Lower by 0.07 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).
Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

Yes

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

4 - Low performing

Previous quarter's segment: 4

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

119 out of 134

Previous quarter's rank: 114 out of 134

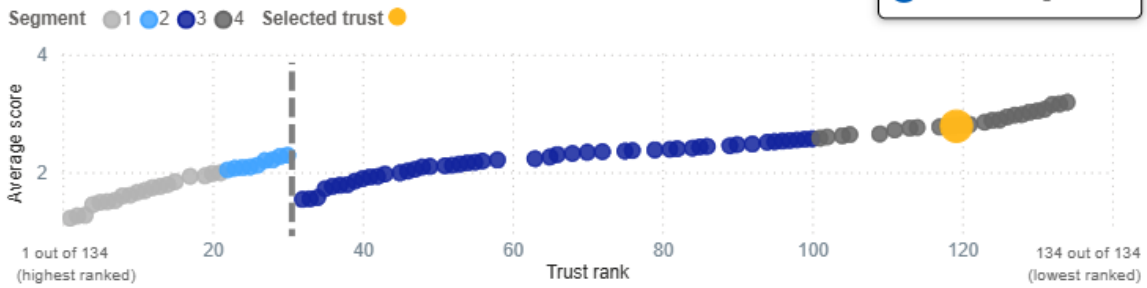
Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Access to services	4 - Low performing
Finance and productivity	4 - Low performing
Effectiveness and experience	1 - High performing
Patient safety	4 - Low performing
People and workforce	3 - Below average

Average score by trust rank placement

View full league table



Comparative League table in Appendices

Regional Context

Access to Services

Key Performance Indicator	Hull University Teaching Hospitals NHS Trust INDICATIVE DELIVERY SCORE 3.94	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.92	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 2.16	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.77
ACCESS TO SERVICES	MEAN SCORE 3.45	MEAN SCORE 3.30	MEAN SCORE 1.56	MEAN SCORE 3.18
Cancer - Patients treated within 62 of referral QTD Q1 26/27 75.00%	52.26% 3.88	64.41% 3.37	81.88% 1.00	71.15% 2.39
Cancer - Urgent referrals diagnosis within 4 weeks QTD Q1 26/27 80.0%	69.7% 3.60	62.0% 3.91	84.7% 1.00	73.6% 3.26
Community Services - Patients waiting over 52 weeks Jun 26	No Data	0.31% 2.27	2.53% 2.88	22.47% 3.69
ED - Attendances managed within 4 hours - Acute trust footprint QTD Q1 26/27 78.00%	70.67% 3.28	72.04% 3.13	73.36% 2.92	72.00% 3.16
ED - Attendances over 12 hours in department QTD Q1 26/27	7.5% 2.06	15.4% 3.63	2.4% 1.39	9.4% 2.43
RTT - Patients waiting 18 weeks or less Jun 26	56.76% 3.93	61.62% 3.40	75.88% 1.27	59.01% 3.82
RTT - Patients waiting over 52 weeks Jun 26 1.00%	3.79% 3.94	2.90% 3.79	0.01% 1.00	1.93% 3.19
RTT - Planned v actual 18 week performance Q4 25/26 0.0%	-5.5% 3.60	-3.7% 3.24	5.2% 1.00	-3.9% 3.33

Effectiveness & Experience

Key Performance Indicator	Hull University Teaching Hospitals NHS Trust INDICATIVE DELIVERY SCORE 3.94	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.92	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 2.16	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.77
EFFECTIVENESS & EXPERIENCE	MEAN SCORE 2.39	MEAN SCORE 1.96	MEAN SCORE 2.19	MEAN SCORE 2.00
Avg Days Ready Date to Discharge (inc 0 day delays) May 26	0.7 2.08	0.8 2.34	0.5 1.67	0.8 2.38
CQC inpatient survey satisfaction rate 2024	4.0 2.00	4.0 2.00	4.0 2.00	4.0 2.00
Community - Urgent response 2 hours performance QTD Q1 26/27 70.00%	No Data	97.88% 1.08	82.32% 2.48	79.01% 2.68
Summary Hospital Mortality Indicator Mar 26	1.05 2.95	0.99 2.41	0.98 2.26	0.88 1.38

Patient Safety

Key Performance Indicator	Hull University Teaching Hospitals NHS Trust INDICATIVE DELIVERY SCORE 3.94	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.92	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 2.16	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.77
PATIENT SAFETY	MEAN SCORE 2.95	MEAN SCORE 3.52	MEAN SCORE 1.72	MEAN SCORE 2.58
Number of MRSA bacteraemia cases Jun 26 0	2 2.24	5 3.13	1 2.00	5 3.13
Proportion of C-Difficile infections against threshold Jun 26 1.00	1.97 3.92	1.89 3.90	1.11 2.56	0.92 1.00
Proportion of E-Coli bacteraemia against threshold Jun 26 1.00	0.99 1.00	1.72 3.91	0.89 1.00	1.12 2.47
Staff Survey - Raising Concerns sub-score 2025	6.04 3.55	6.09 3.45	6.87 1.16	6.00 3.70

Finance & Productivity

Key Performance Indicator	Hull University Teaching Hospitals NHS Trust INDICATIVE DELIVERY SCORE 3.94	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.92	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 2.16	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.77
FINANCE & PRODUCTIVITY	MEAN SCORE 3.15	MEAN SCORE 3.17	MEAN SCORE 3.38	MEAN SCORE 3.40
Finance - Combined finance score Q4 25/26	4 4.00	4 4.00	4 4.00	4 4.00
Finance - Planned surplus/deficit Q4 25/26 0.00%	-1.36% 2.35	-2.42% 2.89	-1.39% 2.40	-1.91% 2.64
Finance - Variance year-to-date to financial plan Q4 25/26 0.00%	-2.13% 2.77	-2.25% 2.86	-5.70% 3.73	-3.50% 3.36
Productivity - Implied productivity level Mar 26	-1.0% 3.53	1.3% 2.98	-0.2% 3.35	-1.7% 3.64

People & Workforce

Key Performance Indicator	Hull University Teaching Hospitals NHS Trust INDICATIVE DELIVERY SCORE 3.94	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.92	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 2.16	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.77
PEOPLE & WORKFORCE	MEAN SCORE 2.73	MEAN SCORE 3.12	MEAN SCORE 1.96	MEAN SCORE 3.16
Sickness Absence Rate QTD Q1 26/27	4.21% 1.70	4.93% 2.65	4.82% 2.42	5.20% 2.96
Staff Survey - Engagement Theme Score 2025	6.40 3.75	6.46 3.59	7.07 1.50	6.51 3.36

5. Trust League Tables

a. HUTH – Filtered to Teaching Hospitals

Quarter	Select trust type(s)	Select trust(s)
Q4 2025/26	Acute - Teaching	All

Statistics methodology | Return to overview

Trust type	Trust	Average score	Segment	Trust in financial deficit?	Rank	Likely range of rank	Previous quarter's rank
Acute - Teaching	Hull University Teaching Hospitals NHS Trust (RWA)	3.19	4	Yes	134	114 to 134	134
Acute - Teaching	James Paget University Hospitals NHS Foundation Trust (RGP)	3.07	4	Yes	131	113 to 134	127
Acute - Teaching	Nottingham University Hospitals NHS Trust (RX1)	3.04	4	Yes	130	103 to 134	132
Acute - Teaching	York and Scarborough Teaching Hospitals NHS Foundation Trust (RCB)	3.02	4	Yes	129	108 to 134	131
Acute - Teaching	East Kent Hospitals University NHS Foundation Trust (RVV)	2.97	4	Yes	127	90 to 134	124
Acute - Teaching	University Hospitals of Derby and Burton NHS Foundation Trust (RTG)	2.89	4	Yes	125	92 to 132	97
Acute - Teaching	Barking, Havering and Redbridge University Hospitals NHS Trust (RF4)	2.88	4	Yes	124	73 to 134	99
Acute - Teaching	Wirral University Teaching Hospital NHS Foundation Trust (RBL)	2.85	4	Yes	123	80 to 133	124
Acute - Teaching	Lancashire Teaching Hospitals NHS Foundation Trust (RXN)	2.81	4	Yes	121	80 to 131	129
Acute - Teaching	University Hospitals Sussex NHS Foundation Trust (RYR)	2.81	4	Yes	121	79 to 132	121
Acute - Teaching	University Hospitals of Morecambe Bay NHS Foundation Trust (RTX)	2.77	4	Yes	117	76 to 130	95
Acute - Teaching	Blackpool Teaching Hospitals NHS Foundation Trust (RXL)	2.72	4	Yes	111	66 to 131	106
Acute - Teaching	Northern Care Alliance NHS Foundation Trust (RM3)	2.72	4	Yes	111	76 to 128	115
Acute - Teaching	Liverpool University Hospitals NHS Foundation Trust (REM)	2.65	4	Yes	109	60 to 128	113
Acute - Teaching	Mid Yorkshire Teaching NHS Trust (RXF)	2.64	4	Yes	105	57 to 129	112
Acute - Teaching	University Hospitals of Leicester NHS Trust (RWE)	2.64	4	Yes	105	64 to 128	99
Acute - Teaching	University Hospitals Plymouth NHS Trust (RK9)	2.64	4	Yes	105	63 to 126	119

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b. NLAG – Filtered to Medium

Quarter	Select trust type(s)	Select trust(s)
Q4 2025/26	Acute - Medium	All

Statistics methodology | Return to overview

Trust type	Trust	Average score	Segment	Trust in financial deficit?	Rank	Likely range of rank	Previous quarter's rank
Acute - Medium	Northampton General Hospital NHS Trust (RNS)	2.98	4	Yes	128	94 to 134	126
Acute - Medium	North Cumbria Integrated Care NHS Foundation Trust (RNN)	2.80	4	Yes	120	81 to 131	130
Acute - Medium	Northern Lincolnshire and Goole NHS Foundation Trust (RJL)	2.79	4	Yes	119	76 to 131	114
Acute - Medium	Medway NHS Foundation Trust (RPA)	2.76	4	Yes	114	64 to 132	116
Acute - Medium	Great Western Hospitals NHS Foundation Trust (RN3)	2.75	4	Yes	113	77 to 129	85
Acute - Medium	Wrightington, Wigan and Leigh NHS Foundation Trust (RRF)	2.56	3	Yes	99	57 to 124	117
Acute - Medium	Gateshead Health NHS Foundation Trust (RR7)	2.53	3	Yes	96	54 to 122	65
Acute - Medium	Croydon Health Services NHS Trust (RJ6)	2.45	3	Yes	89	51 to 118	97
Acute - Medium	Royal United Hospitals Bath NHS Foundation Trust (RD1)	2.40	3	Yes	82	47 to 114	102
Acute - Medium	Sherwood Forest Hospitals NHS Foundation Trust (RK5)	2.40	3	Yes	82	49 to 112	60
Acute - Medium	Surrey and Sussex Healthcare NHS Trust (RTP)	2.35	3	Yes	72	41 to 118	63
Acute - Medium	The Shrewsbury and Telford Hospital NHS Trust (RXW)	2.35	3	Yes	72	41 to 117	78
Acute - Medium	Bedfordshire Hospitals NHS Foundation Trust (RC9)	2.26	3	Yes	65	41 to 104	52
Acute - Medium	Bolton NHS Foundation Trust (RMC)	2.23	3	Yes	63	39 to 103	76
Acute - Medium	The Dudley Group NHS Foundation Trust (RNA)	2.21	3	Yes	58	39 to 96	68
Acute - Medium	Ashford and St Peter's Hospitals NHS Foundation Trust (RTK)	2.16	3	Yes	54	38 to 97	54
Acute - Medium	Stockport NHS Foundation Trust (RWJ)	2.09	3	Yes	48	35 to 89	45

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6. HHP Foundation Scorecards

Embedded in the HHP NOF Scorecard are 4 Foundation Scorecards:

- Quality (CQC: Caring, Safe, Effective),
- Performance (CQC: Responsive)
- Finance (CQC: Effective, Well-led)
- Workforce (CQC: Effective, Well-led)

Each Foundation Scorecard will contain every relevant metric signed off by lead Exec.

Subject to available thresholds each metric will be RAG rated. All RAG rated metrics will be used to derive sub-domain and domain assessment scores

Each metric will also be identified as a defined or enabling NHSE NOF Indicator along with the defined Subject Area (Elective Care, Cancer, UEC, Financial Balance, Productivity).

Each metric will be allocated a unique identifier allowing any combination of summary scorecards to be generated

Every Metric has clear definitions and SPC graphs to support further understanding and act as presentational templates for Care Group performance updates

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)199

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**10th September 2026**
Director Lead	**Murray Macdonald, Chair of Performance, Estates and Finance Committees-in-Common**
Contact Officer / Author	**Rebecca Crashley, Deputy Director of Assurance**
Title of Report	**Performance, Estates and Finance Committees-in-Common Highlight / Escalation Report to the Trust Boards**
Executive Summary	This report sets out the items of business considered by the Performance, Estates and Finance Committees-in-Common at their meeting held on 1 September 2026 including those matters which the committees specifically wish to escalate to either or both Trust Boards. **Recommendation/s** The Boards-in-Common are asked to note the contents of the report.
Background Information and/or Supporting Document(s) (if applicable)	**N/A**
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	**All financial implications are included in the report**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**N/A**
Recommended action(s) required	✓ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

BAF to which the paper relates:	Tick all those appropriate
Our Patients - Access	✓
Our Patients - Safety	☐
Our People	☐
Our Partnerships	☐
Our Pioneers	☐
Our Public Purse	✓

V3

ADVISE, ALERT and ASSURE REPORT	
Meeting	Performance, Estates and Finance Committees-in-Common
Meeting date	01 September 2026
Chair	Murray Macdonald, Non-Executive Director
Quoracy requirements met	Yes

1. **Key items discussed**

TO ALERT (Areas of non-compliance or matters that need addressing urgently)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Digital				
EPR requires organizational focus	EPR oversight, committee governance and capacity to support the pace of improvement was required.		EPR chosen supplier in place, designs being developed and to be approved before build phase. April 27 go live. Being managed through contractual processes.	
Cost Pressures outstripping budgets	Rising digital costs, including both core systems and transformational spend was raised as a concern.		Foundations business case being written in the next 3 months which will outline the baseline on system costs currently. This will be managed at budget planning	

			sessions for 2026/27.	
Digital Oversight clarification	Need for clarity regarding oversight of cyber security, information governance and digital development activity.		Governance team to advise on best split between ARG and PEF.	**Update at Board meeting**
Finance				
Year to date £13.3m adverse to plan	The month 4 financial position was on plan in month for NLAG and saw a very small improvement in run-rate for HUTHT.		The financial recovery programme board was now in place and the minutes would be presented to PEF for review.	Updates to the next CiC September 2026
Year-end position estimated between £26m and 76M adverse to plan	The year-end financial forecast was still being reported as deficit to plan through the Provider Assurance Model including scenarios for Best Mid and Worst cases.		The finance teams were carrying out forecast scenario planning.	
Cash position requires NHS support	There was a material cash risk requiring ongoing NHS E support. The CiC was asked to recommend Board approval of £29.6m cash support for Q3.		The CiC recommended Board approval of the cash support from NHS E.	Update at Board

Performance				
UEC non-compliance with constitutional standards	Whilst the North Bank performance had improved, there were still further actions in progress with the South Bank. The CiC required evidence that improvements could be sustained under winter pressure. Paediatric 4 hour performance remains a risk, due to ED workforce. South Bank performance remains fragile with 12 hour waits being above trajectory (longer than planned wait times) and ambulance handover deterioration. Paediatric flow remains a risk.		UEC Board has executive oversight via the CDO. North Bank Ambulance handover has improved significantly and there have been a reduction in 12 hour waits. Temporary Escalation Spaces in place on the North and South bank with digital support across the wards. Although TES remain outside of the normal ward footprint, it is not classified as corridor care as the spaces have designated facilities for safe patient care. UTC at HRI to open 24/7 in October 2026. This will help ensure right clinical care for type 3 patient cohort away from ED at HRI. Increased grip and control measures are being implemented on the South and North Bank to improve earlier discharges through the SHOP model.	Updates to the next CiC September 2026

			Internal Professional Standards and red lines on safety being implemented to support clinical leadership teams in managing safe patient flows across both the organisations, with impetus in the South in the next 4 weeks	
RTT 52+ non compliance with constitutional standards	Performance remains off trajectory and requires continued attention. Validation remains critical.		GiRFT review of the waiting list management and data quality validation has been signed off by the CDO. Planning for implementing the recommendations is in progress ensuring a clear and streamlined governance structure on assurance and delivery from specialty to Board. There will also be alignment with the Care Group Performance and Accountability meetings ensuring an integrated approach preventing duplication. The process will be based on an earned autonomy basis with final sign off by the CDO through the Planned Care Board. The work on outpatient transformation programme is	

			progressing to include clear deliverables for 2026/27 around pathway and process redesign. Progress update to PEF will be provided in October 26 by the CDO.	
Cancer 28/62 day non compliance with constitutional standards	The 28 day faster diagnostic standard is a critical sustainability measure because any variability and capacity constraints continue to impact the 62 day backlog.		An expert cancer resource supported by NHSE as the recovery director is expected to start soon supporting in-year cancer performance recovery and pathway redesign. This will include implementing best-practice timed pathways at tumour site towards delivering longer-term sustainability in performance. Demand and capacity modelling completed for outpatients. The admitted element is being finalised. The aim is for the tool to be used at specialty level for the management of demand and capacity. This will be a critical shift from a reactive to proactive operational planning with impact assessment on performance as well as	

			workforce outputs linked to productivity.	
ADVISE (Areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Estates and Facilities				
Cleaning Harmonisation	Confirmation that the cleaning tender remained on schedule and the Group was waiting for an update from Capsticks regarding TUPE of staff.		Contract start date was June 2027 The proposed increase in cost was clarified at £497,700 per year. An extension of the programme management (as dedicated resource was required) secondment had been submitted through the vacancy control process and was awaiting a decision.	June 2027
Fire Safety Annual Report	The Fire Safety Annual Report was received.	N/A	There was no material concerns raised as core standards were being monitored and managed.	
Winter Plan	A comprehensive winter plan is in place. There has been significant preparatory work		The CiC gave approval for Board sign off with the caveats that demonstrating	

	on discharge, length of stay, flu vaccination, SDEC pathways and alternatives to ED.		sustainability, testing winter performance and reliance on system partner support were all key to successful implementation. Board sign off 10/09/26 for National sign off 30/09/26	
ASSURE (Areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Committee Business				
Car parking – security Tender	Tendered through the market with one successful bid.	N/A	The CiC required further clarification on the three exclusions and confirmation on affordability. ES suggested that the revised information could be considered virtually ahead of the 29 September PEF due to the award proceeding to the Board.	
Group Performance Report	The CiC identified gaps in the new report, particularly the absence of clear variable pay measures and a stronger finance-workforce-quality triangulation.	N/A	The CiC agreed that the GPR and the BAF should be positioned prominently at the start of the Board agendas to drive discussion.	

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)200

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**10 September 2026**
Director Lead	**Julie Beilby, Chair of Committees-in-Common**
Contact Officer / Author	**Julie Beilby, Chair of Committees-in-Common**
Title of Report	**Workforce, Education and Culture Committees-in-Common Highlight / Escalation Report to the Trust Boards**
Executive Summary	This report sets out the items of business considered by the Workforce, Education and Culture Committees-in-Common at their meeting(s) held on 22 July 2026 including those matters which the committees specifically wish to escalate to either or both Trust Boards. **Recommendation/s** The Boards-in-Common are asked to note the contents of the escalation report.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Any financial implications will be highlighted in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Any EDI implications will be highlighted in the report.
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

BAF to which the paper relates:	Tick all those appropriate
Our Patients - Access	☐
Our Patients - Safety	☐
Our People	✓
Our Partnerships	☐
Our Pioneers	☐
Our Public Purse	☐

V3

ADVISE, ALERT and ASSURE	
Meeting:	Workforce, Education and Culture Committees in Common
Meeting Date:	22 July 2026
Chair:	Julie Beilby, Non-Executive Director
Quorate:	Yes

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Board to areas of non-compliance or matters that need addressing urgently)				
Issue	**Update**	**Assurance received:**	**Action**	**Timescale**
Workforce				
Care Group restructuring	Review of Care Group structure. Further engagement with the clinical leads and Triumvirates was ongoing regarding what the Care Groups will look like	Workforce update	Options will be published at the end of July 2026. Consultation will follow.	August 2026 Consultation and implementation to be in place before Winter
Resident doctor industrial action and financial impact	Industrial action has been stood down due to a pay award and an updated version of the 10 point plan	Workforce update	NED champion appointed (Chair of WEC) and the revised 10 point plan to be reviewed at the next meeting.	September 2026

Workforce consolidated report	Keith Haynes leading on the IPR updates. The CIC asked for clear metrics to link workforce with the financial statistics. NED lead noted – Murray McDonald		An overarching report to be produced with trends identified. Financial scenario to be monitored. CiC expressed concern re effectiveness of grip and control on variable pay Oversight of all workforce KPIs to be included.	As part of the Governance review
People Strategy Update	The NEDs noted the challenges relating to headcount reductions and wanted assurance that the Group had the right people in the right posts.	Limited assurance	Job planning to focus on demand and capacity The NEDs asked for clarity on how the Care Group targets are driven. Are they clinically or financially led. Who determined and owns targets?	Progress updates will be received at each meeting
Guardian of Safe Working	HUTH – Family Services Care Group and other services with significant exception reporting had been highlighted for further scrutiny. NLAG – Higher reporting levels, although lower staffing levels caused concern. Additional unscheduled hours were the main reason for the reports.	The CIC provided reasonable assurance on the process and governance arrangements	Escalation was required regarding the need for improved responsiveness to identified hot spots, particularly on the South Bank	Update next meeting

ADVISE (Provide here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Workforce				
Consultant Industrial Action	The consultants did meet the requirement for industrial action. There had been no further communication to date, but industrial action was possible in the future	N/A	Advise the Board	
Board Assurance Framework	WECC recognised the full refresh that was taking place with Keith Haynes, Interim Board Secretary as the lead.	N/A	New BAF risks to be reviewed and progressed with input from Executive and NED leads. NHSE are supporting the work stream and actions from the Integrated Improvement Plan will be aligned.	September 2026
ASSURE (Provide any areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Workforce				
Modern Slavery Statement	Presented to the CIC explaining compliance measures around local procurement and	N/A	The CIC endorsed the statement and recommended it for Board approval	Next Board meeting

	multidisciplinary involvement			
Workforce IPR	Recruitment process challenges were discussed, delays in shortlisting and the impact of AI generated applications. AI potential to assist in some stages was noted	N/A	Workforce recruitment metrics were being reviewed with ongoing efforts to streamline processes	Regular updates to be received
Nursing and Midwifery Education Report	The CIC noted the positive educational outcomes and student experience. Areas of concern; • Declining student numbers • Reduced tariff income • Forthcoming national change to nursing education requirements Midwifery student feedback was less positive than the nursing feedback. However work was ongoing with the teams to address this.	For information	The CIC suggested future reports would include the learning from less positive experiences as well as successes. Concern was raised around limited awareness of Freedom to Speak Up arrangements and whether messaging should be strengthened	
Revalidation Report	The CIC and the Deputy GCMO gave positive feedback, stating the there had been significant improvement in the last 12 months	Reasonable assurance was given to the South Bank. Limited assurance was given to the North Bank due to the number of unauthorized missed appraisals (150) and lack of	Clarification required regarding the outstanding 150 appraisals (HUTH). CiC noted the considerable improvement made compared to last year	Update to be given at the next meeting

		clarity regarding their resolution.		

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)202

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	10 September 2026
Director Lead	Jane Hawkard, Non-Executive Director / Chair of HUTH Audit, Risk and Governance Committee-in-Common
Contact Officer / Author	Jane Hawkard
Title of Report	**Audit, Risk and Governance Committees-in-Common Highlight / Escalation Report – July 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 30 July 2026. The Trust Boards-in-Common are asked to: • Note the public highlight report from the July 2026 ARC CiC meeting and consider as necessary.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – 30 July 2026
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Assurance ✓ Other – please detail below: For noting and consideration as necessary

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

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

Report for meeting of the Trust Boards to be held on:	10 September 2026 – Public
Report from:	Audit, Risk and Governance Committees-in-Common
Report from meeting(s) held on:	30 July 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 30 July 2026 including those matters which the Committees specifically wish to escalate / highlight to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The ARG CiC considered the following items of business:

- NLAG & HUTH Final Auditors Annual Reports 2025/26
- NLAG and HUTH External Auditor Recommendations – Status Updates
- HUTH Additional Audit Fees 2025/26
- Group Internal Audit Progress Report 2026/27
- Group LCFS Progress Report
- Group EPRR Highlight Report
- The Value Circle Implementation Plan Update
- HHP NPIP Assessment Report
- Group Board Assurance Framework
- Group Risk Register
- Annual Review of Risk Management Strategy
- Review of External Consultancy Fees
- Review of Legal Fees
- Annual Claims Report 2025/26
- Group Overseas Visitor Processes Review Findings
- Briefing Papers – Annual Indexation for Valuations
- Policy for Managing Conflicts of Interest in an Outsourced Internal Audit Service
- Group Annual Cyber Security Assurance Report (Private item)
- Group Data Protection & IG Report (Private item)
- HUTH & NLAG DSPT Internal Audit Reports (Private item)
- Digital Governance Update (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:

ITEMS TO BE ALERTED TO THE BOARDS:

a) **Group Internal Audit Progress Report 2026/27 – Cost Improvement Programme (CIP) Review Deferral** – KPMG presented a request from management to undertake an audit of Emergency Preparedness, Resilience and Response (EPRR) as it is due its cyclical three-year review (national requirement) and would need to be completed by September 2026 ready to be included in its national EPRR submission. In order to accommodate this request in the existing annual Internal Audit plan, it was proposed to remove the CIP audit from the plan and defer this into 2027/28, on the basis that CIP was now subject to external scrutiny by a consultancy firm as part of the National Provider Improvement Programme (NPIP) process. Following discussion, the ARG CiC approved the change to the audit plan with the caveat that the deferred CIP audit was undertaken in Q1 of 2027/28.

b) **Group Internal Audit Progress Report 2026/27 – Mortuary Services Review** - the ARG CiC discussed the findings of the Mortuary Services review and considered there was low assurance in relation to certain aspects of the service**.** The Committees discussed the need for the agreed management actions to be in a consolidated action plan relating to Fuller 2 report being overseen by the Quality and Safety CiC.

ITEMS TO ADVISE THE BOARDS ON:

a) **Legal Services Annual Report 2025/26** – The ARG CiC was not assured that learning from claims is embedded, however it was noted that the Quality and Safety CiC would be highlighting this matter to the Trust Boards-in-Common. It was also noted that there could be an average four and a half year time lag between an incident (treatment) and a claim being settled. Additionally, the ARG CiC considered that this was an area for adding to the long list of potential Internal Audit reviews for 2027/28.

b) **NLAG & HUTH Auditors Annual Reports 2025/26 & Audit Completion Certificates** – Final reports received from the External Auditors. Audit Completion Certificates remain unissued until the National Audit Office (NAO) complete their work on the national Group accounts.

c) **NLAG & HUTH External Audit Recommendations Action Plan Update** – Action plan received showing the status of the financial recommendations resulting from the 2025/26 year end audit work for both Trusts. A further update will be brought to the next ARG CiC meeting, as well as updates on the non-financial recommendations made.

d) **Group OSV Processes Review Findings** – the ARG CiC concluded only low assurance that processes were in place which would optimise financial recovery of chargeable overseas visitors treatment fees, although it was not clear what the potential additional income would be. A Group approach was stated to require an increase in establishment for the team involved, and as

such would go through the Business Case process (including providing data on additional income opportunities).

e) **Annual Indexations for Valuations Briefing Paper** – the Committees noted the briefing paper, which set out that from 2026/27, NHS organisations are required to move from annual professional land and buildings valuations to a five-year valuation cycle supported by annual indexation. The revised approach is intended to reduce cost and administrative burden whilst still maintaining materially accurate asset values. There are potential financial implications to this change (higher future depreciation charges, increased public dividend capital (PDC) dividend costs, potential impairment reversals) however until further national guidance is received it is not possible to calculate the financial impact.

f) **Group EPRR Highlight Report** – As a result of bringing forward the date of the next ARG CiC meeting from November to October 2026, the EPRR and Business Continuity Regulatory Report 2026 will not be ready for the October meeting. Instead, the report will be circulated virtually to ARG CiC members for review and comment as soon as it is available in late October 2026, following which it will be presented to the Trust Boards-in-Common for approval. The highlight report provided good assurance on EPRR processes but with more work to do on ensuring that all areas review their business continuity plans. The ARG CiC were informed that a cyber resilience exercise was scheduled to take place the following week.

g) **Group Risk Register Report / Group Risk Management Strategy Update** – The ARG CiC considered the reports provided low assurance on the basis that although there is a process in place and an increase in scrutiny of risks, the number of risks on the register remained a concern, as well as the age of some of the risks and the number of overdue reviews. The Committees requested that the next scheduled Group Risk Register report provided a risk age profile, as well as benchmarking data, if possible, to understand if the Group was an outlier or not. The ARG CiC noted that the Risk Management Strategy report was a detailed report, but linked to the low assurance level on the Risk Register report. The Committees discussed showing RAG ratings on the KPI's and it was agreed that the KPI format received by the Care Groups will be incorporated into the report in future.

h) **Policy for Managing Conflicts of Interest in an Outsourced Internal Audit Service** – The Group has an existing policy in relation to External Audit performing non-audit work, as this is a national requirement, however there is no such policy/requirement in relation Internal Audit. The ARG CiC considered previously that it would be good practice to have one and KPMG kindly supplied a template used at some of their other NHS clients, which the ARG CiC has adjusted slightly to incorporate some additional requirements and placed into the Group policy format. The ARG CiC approved the policy for implementation.

ITEMS FOR ASSURANCE:

a) **Review of External Consultancy Fees** – The ARG CiC received details relating to 2025/26 and were assured as to the process for capturing items for formal approval protocols required in relation to consultancy fees.

b) **Group LCFS Progress Report** – The Committees were assured by the latest progress report on counter fraud activity within the Group.

c) **The Value Circle (TVC) Implementation Plan Update / NPIP Assessment Report** – All actions from the TVC report have been mapped across to the Integrated Improvement Plan (IIP) and the various workstreams contained within the IIP. The IIP Oversight Delivery Group reports directly into the Trust Boards-in-Common. The ARG CiC was assured that there was a process in place for ensuring implementation of the actions, and commented that it was now about delivery and pace of delivery to start effecting changes that were needed.

4.0 Matters on which the committees have requested additional assurance:

4.1 As set out in section 3.

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

5.1.1 The Board Assurance Framework (BAF) was received, but noted that there was a refresh of the BAF being undertaken to make improvements to it by the Interim Board Secretary. Following discussion, it was agreed that the cyber risk which was assigned to the ARG CiC in the BAF should now sit with the Performance, Estates and Finance CiC. The ARG CiC will continue to receive the full BAF for oversight.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the highlight report from the ARG CiC.

Jane Hawkard
HUTH ARG CiC Chair / NED
30 July 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)203

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	10th September 2026
Director Lead	Helen Marks, Group Chief People Officer
Contact Officer / Author	Lucy Vere, Group Director of Learning and Organisational Development Karl Portz, Equality Diversity and Inclusion Lead
Title of Report	**Modern Slavery Statement – NHS Humber Health Partnership**
Executive Summary	The purpose of this paper is to share the Trust's 2025/26 Modern Slavery Statement with the Trust Boards in Common for approval. Once approved, the statement will be published on the Trust's website as soon as possible, and by the very latest, the 30 September 2026 to meet statutory requirements. To **Alert** the Trust Boards in Common under the Modern Slavery Act 2015 we must publish a Modern Slavery Statement each year before 30 September using the format detailed below. To **Assure** the Trust Boards in Common that by publishing this statement and reporting using this format we are compliant with the Modern Slavery Act 2015 requirements. To **Advise** the Trust Boards in Common on the requirements of the Modern Slavery Act 2015. **Recommendation** To approve the Modern Slavery Statement so that it can be published on our website before the 30 September deadline.
Background Information and/or Supporting Document(s) (if applicable)	Following the introduction of the Modern Slavery Act in 2015, businesses are required to produce a statement setting out the steps they have taken to ensure there is no modern slavery in their own business and supply chains.
Prior Approval Process	None
Financial Implication(s) (if applicable)	None
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	To support meeting the Trust Public Sector Equality Duty and to meet the requirements of the Modern Slavery Act 2015. Once approved the statement must be published on the Trust internet in line with statutory requirements (by 30 September 2026).
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

NHS Humber Health Partnership

Modern Slavery Statement
1 April 2025 to 31 March 2026

1. Introduction

The Modern Slavery Act 2015 requires organisations to publish an annual Modern Slavery Statement on their website within six months of the end of the financial year (i.e., for the Trust this would require the statement to be published by 30 September).

With reports[1] of modern slavery victims increasing year on year and an estimate of more than 130,000 people being trapped in modern slavery, costing the UK £33 billion per year, it is imperative that the Trust/Group continues to be committed to the principles of the Modern Slavery Act 2015 and the abolition of modern slavery and human trafficking.

This statement sets out the steps that the Trust has taken over the financial year 1 April 2025 to 31 March 2026 to ensure that slavery and human trafficking is not taking place in any part of its business or supply chains and covers the following:

- Organisational structure and business
- Policies in relation to slavery and human trafficking
- Due diligence and managing risks in the Trust's business and supply chains
- Training and performance indicators

2. Organisational Structure and Business

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) operate out of three main hospital sites in Grimsby, Scunthorpe and Goole and one main community site in Scunthorpe. The Trust is one of the biggest employers in this region with nearly 8,000 members of staff. The Trust has an annual income of circa £559m.

Hull University Teaching Hospital NHS Trust (HUTH) is a large acute NHS Trust situated in Kingston upon Hull and the East Riding of Yorkshire. The Trust employs over 10,000 staff, has an annual income of circa £909m and has two main sites: Hull Royal Infirmary and Castle Hill Hospital. Outpatient services are also delivered from locations across the local health economy area.

Further details regarding the Trust's business and structure can be found in the Annual Report and Accounts 2024/25, available on the Trust website.

NLaG Annual Report & Accounts 2024/25
https://www.nlg.nhs.uk/wp-content/uploads/2021/11/annualReport2425.pdf

[1] https://www.antislavery.org/slavery-today/slavery-uk/

- Note the NLaG and HUTH Annual Reports for 2025/2026 are not currently available.

3. Policies in Relation to Slavery and Human Trafficking

The Group has several policies to support staff in relation to modern slavery, including:

- Freedom to Speak Up Policy for the NHS.
- Group Conflict Resolution Policy.
- Domestic Abuse Guidance/Policy.
- Raising Concerns at Work Policy (HUTH).
- Equality, Diversity and Inclusion in Employment Policy (HUTH)
- Raising Concerns via:
    - Zero Tolerance to Racism Framework
    - Zero Tolerance to Ableism Framework
    - Zero Tolerance to LGBTQIA Discrimination Framework

The Trust publishes a broad range of safeguarding policies and factsheets, for both service users and staff, which include:

- Safeguarding Adults Policies.
- Safeguarding Children Policies.

Any new campaigns/policies in relation to modern slavery are published on the Group intranet.

All Trust policies go through a robust consultation and ratification process and are available on the Group's internal website.

4. Due Diligence Processes in the Trust's Business and Supply Chains

Due Diligence in Business

The Group is committed to preventing slavery and human trafficking in corporate activities and ensuring that workers are not exploited, that they are safe and that relevant employment (working hours etc.), health and safety, human rights laws and international standards are adhered to.

To support staff, the following steps are taken:

- All staff are employed on employment contracts which comply with UK law.
- Pre-employment checks are undertaken on all workers directly and non-directly employed by the Trust (e.g., employees, agency staff, contractors, volunteers, students, and trainees on work experience etc.).
- All staff undertake mandatory safeguarding training, which covers modern slavery.
- As an equal opportunities' employer the Trust is committed to creating an inclusive working environment for all staff, which enables staff to feel confident that they can raise concerns without any risk to themselves via several avenues, including a Freedom to Speak up Guardian.

- A comprehensive range of modern slavery and safeguarding information for service users and staff is available for staff on the Trust intranet.
- All active agencies who supply staff to the Trust are asked to provide assurance that they are compliant with the Modern Slavery Act 2015 on an annual basis.
- Modern slavery is a term used that includes any form of human trafficking, slavery, servitude or forced labour, as set out in the Modern Slavery Act 2015.
- Modern slavery is widespread and can go unnoticed in our daily lives. Victims may face physical violence or coercion and may be forced into overwhelming debt. Additionally, they may have their passports taken away and be threatened with deportation. To safeguard against this, the Trust is constantly seeking ways to support and protect staff and service users from modern slavery and human trafficking. Some of the steps taken to achieve this include:

  - Participation in the Humber Modern Slavery Partnership (HMSP) Strategic Board, a network of over 60 organisations in the Humber region dedicated to preventing and combating modern slavery.
  - Participation in the North East Lincolnshire Modern Slavery Partnership, a local network aimed at raising awareness of modern slavery.
  - Incorporating modern slavery into mandatory safeguarding adults training.
  - Sharing knowledge and information, including providing access to training across the Trust through the intranet.
  - Monitoring the number of concerns raised to the Trust safeguarding adults' team regarding exploitation and/or modern slavery. While these numbers are low, they show that staff understand of this aspect of safeguarding.
  - Collaborating with individuals to ensure that the principles of Making Safeguarding Personal are followed. Support and referrals should be consent-based and involve the person's input.
  - Professionals should also consider child trafficking and the possibility of the child or young person being used in different forms of exploitation such as child sexual exploitation, fraud, forced marriage, criminal activity such as pick pocketing, cannabis cultivation or domestic servitude. The consequences of such involvement can have both short- and long-term consequences for the child, including guilt and confusion.
  - The safeguarding children team raise awareness of the issue of modern slavery, child criminal exploitation (CCE) and child sexual exploitation (CSE) in their safeguarding children training.
  - The safeguarding children team are active members at Multi Agency Child Exploitation (MACE) meetings and at National Referral Mechanism (NRM) meetings following completion of safeguarding referrals to Police and Children Social Care.

Due Diligence in Supply Chains

The Group contracts with suppliers through relevant procurement frameworks and is part of the Humber and North Yorkshire Procurement Collaborative (HNYPC) which is a shared collaborative procurement and logistics service. The HNYPC Modern Slavery Statement can be seen in appendix 2.

The only local procurement activities which may fall outside of the HNYPC are the use of local providers by our estates department, but they are working with the HNYPC to standardise approaches to all their procurement activities.

5. Training and Performance Indicators

Compliance with the Trust's modern slavery agenda is measured by reviewing the number of staff who have completed the following mandatory courses/eLearning packages (which include modern slavery):

- Safeguarding Adults
- Safeguarding Children

As of June 2026, 89% of NLaG staff and 91% of HUTH staff are compliant with the required safeguarding training.

The Safeguarding training and advice:

- Modern Slavery is included with the safeguarding adults and children training.
- The safeguarding adults and children's teams are available Monday / Friday 9.00 – 5.00pm to offer advice, support, and information to staff if they have concerns about identification of modern slavery and how to make appropriate referrals to safeguard adults and children.
- Gaining Respect and Finding Trust team) in children social care deliver bespoke training to wards and departments within the Trust which covers modern slavery, child criminal exploitation and child sexual exploitation.

6. Summary

The Trust continues to be committed to preventing modern slavery and human trafficking in any part of its business or supply chains. The Trust is committed to:

- Continuing to educate staff on the importance of preventing modern slavery and to meet the obligations under the national modern slavery agenda.
- Monitoring and reviewing ongoing modern slavery legislation and best practice.
- Obtaining assurances from main suppliers/agencies etc. that they comply with the Modern Slavery Act 2015 and record and monitor these as required.
- Reviewing Trust policies and including references to modern slavery where appropriate.

Trust Board has considered and approved this statement and will continue to support the requirements of the legislation.

Signed **Chairman**	Signed **Chief Executive**

NHS
Humber and North Yorkshire
Procurement Collaborative

HUMBER & NORTH YORKSHIRE PROCUREMENT COLLABORATIVE

Modern Slavery Statement

Version 2.0
May 2026

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Document History

Version No.	Implemented by	Organisation	Revision date	Approved by	Approval date	Description of change
0.1	Edward James	HNY Procurement Collaborative	16/03/2022	Operational Delivery Group	04/04/2022	First draft
1.0	Edward James	HNY Procurement Collaborative	28/05/2025			
2.0	Hazara Rahman	HNY Procurement Collaborative	21/05/2026			Updated to reflect the NHS Modern Slavery Procurement Regulations 2025, NHS England guidance, PPN 009 and the updated HNYPC Procurement Policy. Added clearer wording on HNYPC's role, risk assessment, due diligence, Atamis record keeping, contract management, escalation, framework assurance and 2026/27 priorities.

Foreword

Modern slavery remains one of the greatest challenges of our time. It can affect children and adults across the world and can exist within complex, multi-tier supply chains, including those used by public sector and healthcare organisations.

The supply chains within the health system are varied, complex and far reaching. It is not enough to state a zero-tolerance approach. HNYPC is committed to supporting the partner Trusts to identify, prevent and manage modern slavery and human trafficking risks through procurement, contracting and contract management activity.

This 2026 statement reflects the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025, NHS England guidance, PPN 009, and the updated HNYPC Procurement Policy. It introduces clearer risk rating criteria (low/medium/high), mandatory risk assessment before tender publication, formal record keeping on Atamis, enhanced contract management obligations (KPIs, audit rights, improvement plans), and defined escalation routes for modern slavery concerns. These changes ensure compliance with the new NHS Procurement Regulations and align HNYPC with national good practice.

HNYPC will continue to work with suppliers, framework providers and partner Trusts to apply a proportionate, risk-based approach to modern slavery risk. This includes clearer controls around risk assessment, due diligence, Atamis record keeping, contract management and escalation where concerns are identified.

This statement is our commitment to support the partner Trusts in taking reasonable and proportionate steps to reduce the risk of modern slavery and human trafficking in NHS procurement and supply chains.

Signed by the three CEOs:

Hull University Teaching Hospitals NHS Trust	**Northern Lincolnshire and Goole NHS Foundation Trust**	**York and Scarborough Teaching Hospitals NHS Foundation Trust**
Name:	**Name:**	**Name:**
Signature:	**Signature:**	**Signature:**
Date:	**Date:**	**Date:**

1. Introduction

1.1 The Modern Slavery Act 2015 requires certain organisations to publish an annual Modern Slavery Statement setting out the steps taken during the financial year to prevent slavery and human trafficking in their own business and supply chains.

1.2 The National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025 come into force on 17 May 2026. The Regulations apply to public bodies procuring goods or services for the purposes of the NHS in England and require modern slavery risk to be assessed and addressed through reasonable and proportionate steps.

1.3 The Humber & North Yorkshire Procurement Collaborative (HNYPC) is a shared collaborative procurement and logistics service supporting Hull University Teaching Hospitals NHS Trust, Northern Lincolnshire and Goole NHS Foundation Trust and York and Scarborough Teaching Hospitals NHS Foundation Trust.

1.4 HNYPC supports the partner Trusts with procurement, contracting and supply chain activity. HNYPC is not a separate statutory body in its own right; this statement therefore supports the partner Trusts' wider assurance position and should be read alongside relevant partner Trust policies and procedures.

1.5 This is a Modern Slavery and Human Trafficking Statement. It is not a standalone policy. It is supported by the HNYPC Procurement Policy, including Section 18: Modern Slavery Act 2015 and NHS Modern Slavery Regulations 2025, and by relevant safeguarding, recruitment, whistleblowing, procurement, contract management and supplier management arrangements across the partner Trusts.

1.6 The three NHS Trust Chief Executives have overall accountability for this statement. This statement covers the period from 1 April 2026 to 31 March 2027 and sets out the forward controls HNYPC will apply from 2026/27 in light of the new NHS procurement requirements.

1.7 The statement covers the following:

- Organisational structure, business and spend;
- Policies and procedures in relation to slavery and human trafficking;
- Risk assessment and due diligence in procurement and supply chains;
- Procurement actions, contract management and Atamis record keeping;
- Training and awareness raising;
- Working with partners and framework providers;
- Priorities for 2026/27.

2. Structure, Business and Spend

2.1 HNYPC is a shared collaborative procurement and logistics service supporting Hull University Teaching Hospitals NHS Trust, Northern Lincolnshire and Goole NHS Foundation Trust and York and Scarborough Teaching Hospitals NHS Foundation Trust.

2.2 Collectively, the partner Trusts deliver a wide range of acute, community and specialist healthcare services across Humber and North Yorkshire. The Trusts employ thousands of staff and hold a significant portfolio of commercial contracts across clinical and non-clinical categories.

2.3 The main categories of expenditure include medical and surgical consumables, medical and surgical equipment, estates and facilities, digital solutions, professional services and other goods and services required to support healthcare delivery. Some of these categories may carry increased modern slavery risk due to labour intensity, complex supply chains, manufacturing locations, subcontracting arrangements or known sector risks.

2.4 Suppliers that meet the criteria under section 54 of the Modern Slavery Act 2015 are expected to publish their own modern slavery statements. Their own activities are not covered by this HNYPC statement, but their approach to modern slavery may be considered as part of proportionate supplier due diligence.

2.5 HNYPC does not knowingly enter into business with any organisation, in the UK or abroad, which supports or is found to be involved in slavery, servitude, forced or compulsory labour, or human trafficking.

3. What is Modern Slavery & Human Trafficking?

3.1 Modern slavery can take many forms, including human trafficking, slavery, servitude, forced or compulsory labour, bonded labour, forced or servile marriage, descent-based slavery and domestic servitude.

3.2 Modern slavery involves the recruitment, movement, harbouring or receiving of children, young people or adults through force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Any apparent consent is not relevant where a person has been coerced, deceived or exploited.

3.3 In a procurement context, modern slavery risk may arise in direct suppliers, subcontractors, labour providers, manufacturing sites, logistics arrangements or lower tiers of the supply chain. The risk may be higher in categories that are labour intensive, low margin, geographically dispersed or dependent on complex international supply chains.

4. Modern Slavery Policies

4.1 The HNYPC Procurement Policy requires procurement activity to be undertaken in a way that supports transparency, equal treatment, non-discrimination, proportionality, value for money, public benefit, integrity and appropriate record keeping.

4.2 Section 18 of the HNYPC Procurement Policy has been updated to reflect the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025, NHS England guidance on tackling modern slavery in NHS procurement and PPN 009: Tackling Modern Slavery in Government Supply Chains.

4.3 The Procurement Policy requires modern slavery risk to be considered during procurement planning, supplier selection, evaluation, contract award and contract management. Identified risks, mitigations and contract management requirements must be recorded in the relevant procurement documentation and retained on Atamis as part of the procurement record.

4.4 This statement should be read alongside relevant partner Trust policies and procedures, including safeguarding, recruitment, whistleblowing, standards of business conduct, procurement, contract management and supplier management arrangements.

4.5 HNYPC uses standard NHS terms and conditions and relevant framework terms where appropriate. These include contractual obligations requiring suppliers to comply with applicable legislation, including requirements relating to modern slavery and human trafficking.

5. Commitment

5.1 HNYPC is committed to supporting the partner Trusts to identify, prevent and manage the risk of modern slavery and human trafficking in procurement activity, contracts and supply chains.

5.2 By publishing this statement, HNYPC confirms its commitment to:

- support compliance with the Modern Slavery Act 2015 and relevant NHS procurement requirements;
- reflect the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025 in procurement and contract management activity;
- have regard to NHS England guidance and PPN 009 where applicable;
- make suppliers aware of HNYPC's expectations in relation to modern slavery and ethical supply chains;
- apply a proportionate, risk-based approach to supplier due diligence and contract management;
- record modern slavery risk assessment, decisions and mitigation on Atamis where relevant;
- escalate concerns through senior procurement, governance, legal, safeguarding and/or contract management routes where appropriate.

6. Risk Assessment and Due Diligence

6.1 Modern slavery can affect virtually any industry or country. HNYPC will therefore target action where the risk of exploitation is most severe, salient and strategic, taking account of the nature of the goods or services, the sector, country of origin, supply chain complexity, labour intensity, subcontracting arrangements and any known risk intelligence.

6.2 Modern slavery risk should be assessed on a proportionate basis and recorded as low, medium or high risk. Higher-risk procurements may require enhanced due diligence and additional contract management controls.

6.3 The Procurement Lead or Category Manager responsible for the procurement is responsible for ensuring that modern slavery risk is considered and recorded at the appropriate stage of the procurement process.

6.4 Where a risk is identified, the proposed mitigation must be proportionate and reflected in the relevant procurement documentation, including the Procurement Strategy, sourcing plan, Contract Award Recommendation Report, award report and/or contract management plan as appropriate.

6.5 Due diligence may include supplier declarations, supplier self-assessment questionnaires, review of supplier modern slavery statements, supply chain mapping, review of policies and procedures, additional questions for higher-risk categories and contract management reporting or KPIs.

6.6 Modern slavery risk should not be treated as a one-off procurement question. Where the risk profile requires it, the risk should continue to be monitored during contract

management through review meetings, supplier reporting, evidence checks, audit rights, improvement plans or escalation where concerns are not addressed.

6.7 Modern slavery risk should be reassessed where there is a material change in the contract or supply chain. This may include a change in supplier, subcontractor, country of origin, manufacturing location, sourcing model, product specification, service delivery model, contract scope or where new risk intelligence becomes available.

7. Procurement Actions

7.1 HNYPC will embed modern slavery considerations into procurement and contract management activity in line with the updated HNYPC Procurement Policy.

7.2 A modern slavery risk assessment should normally be completed before publishing a tender notice or inviting suppliers to participate in a competitive procurement; before awarding a below-threshold contract where no tender notice is published; before establishing a framework agreement or dynamic market; and before using a framework, dynamic market or other route where HNYPC is responsible for the procurement decision and modern slavery risk remains relevant.

7.3 Where modern slavery risk is identified, reasonable and proportionate steps may include:

- supplier declarations and due diligence questions;
- review of supplier modern slavery statements, policies and procedures;
- supply chain mapping or additional information for higher-risk categories;
- use of exclusion grounds where there is sufficient evidence of modern slavery or human trafficking offences;
- inclusion of modern slavery obligations in tender documents and contract terms;
- evaluation questions where relevant and proportionate to the subject matter of the contract;
- contract management checks, KPIs or reporting obligations;
- escalation to senior procurement, legal, safeguarding or governance colleagues where concerns are identified.

7.4 A record of the modern slavery risk assessment, decision-making, mitigation and any contract management requirements must be retained on Atamis as part of the procurement record. This supports compliance with section 98 of the Procurement Act 2023, audit requirements and the partner Trusts' wider governance responsibilities.

7.5 Where modern slavery concerns are identified before or after contract award, the matter must be escalated to the appropriate senior procurement, governance, legal, safeguarding and/or contract management colleagues. Depending on the nature and severity of the concern, action may include further supplier clarification, enhanced due diligence, a supplier improvement or remediation plan, additional monitoring, use of contractual remedies, suspension or termination where appropriate.

7.6 Where relevant and proportionate, HNYPC will support the use of good practice tools, including risk mapping, supplier self-assessment questionnaires, supply chain mapping or tier visibility summaries, contract clauses, KPIs and annual reporting of key actions, risks, improvements and remediation outcomes through this statement.

8. Training and Awareness Raising

8.1 HNYPC will support relevant training and awareness for procurement, commercial and contract management staff so that modern slavery risks are identified, recorded and managed consistently across procurement activity.

8.2 Relevant procurement staff are encouraged or required, depending on role, to complete appropriate ethical procurement training, including CIPS Ethical Procurement and Supply training and relevant Government Commercial Function or NHS training where applicable.

8.3 The partner Trusts provide safeguarding training for staff, and modern slavery concerns should be escalated through established safeguarding, Freedom to Speak Up, whistleblowing and line management routes where relevant.

8.4 HNYPC will continue to raise awareness of modern slavery risks through procurement guidance, policy updates, contract management conversations and proportionate support to procurement leads and contract managers.

9. Working with our Partners

9.1 HNYPC uses national and public sector framework agreements, including NHS Supply Chain arrangements, where appropriate. NHS Supply Chain operates a Supplier Code of Conduct and undertakes supplier assurance activity across its arrangements.

9.2 Where a framework agreement, dynamic market or NHS Supply Chain route is used, procurement leads may take account of modern slavery due diligence undertaken by the framework owner or central purchasing body.

9.3 However, use of a framework does not automatically remove the need to consider local risk, the nature of the goods or services, and any additional proportionate steps required. HNYPC must still consider whether the local requirement, supplier, product, service, supply chain or contract management arrangements create any additional modern slavery risk that requires local mitigation or recording.

9.4 HNYPC will continue to work with NHS Supply Chain, Crown Commercial Service, regional procurement partners, framework providers and the partner Trusts to share intelligence, good practice and assurance in relation to modern slavery risk.

10. Priorities for 2026/27

10.1 HNYPC is committed to delivering the following priorities:

- Align this statement with the updated HNYPC Procurement Policy and Section 18 modern slavery requirements;
- Apply the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025 in procurement and contract management activity where relevant;
- Reflect NHS England guidance and PPN 009 in procurement documentation, due diligence and contract management practice;
- Record modern slavery risk assessments, decisions, mitigations and contract management requirements on Atamis where relevant;
- Use low, medium and high risk rating to support proportionate due diligence;
- Strengthen escalation routes for modern slavery concerns, including procurement, governance, legal, safeguarding and contract management input where appropriate;

- Develop practical good practice tools, including risk mapping, supplier self-Assessment questions, contract clauses, KPIs and reporting prompts;
- Review higher-risk categories and consider additional supplier due diligence where proportionate;
- Support training and awareness for procurement and contract management staff;
- Review and refresh this statement annually through the appropriate governance route.

11. Publishing the Statement, Governance & Review

11.1 The HNYPC Modern Slavery and Human Trafficking Statement will be published through the appropriate HNYPC or partner Trust route.

11.2 The statement will be reviewed annually and updated to reflect changes in legislation, NHS England guidance, procurement policy and HNYPC governance arrangements.

11.3 The three Trust Boards or appropriate governance routes will consider and approve the statement and continue to support the requirements of the legislation and relevant NHS procurement requirements.

11.4 This statement should be read alongside the relevant partner Trust safeguarding, recruitment, procurement, whistleblowing, contract management and supplier management policies and procedures.

12. Associated Documents

12. 1 This Statement should be read in conjunction with the following policies, procedures and guidance:

- Standing Orders, SFIs and Scheme of Delegation
- Procurement Policy
- Code of Practice for Company Representatives
- Procurement Strategy
- Savings Policy
- Conflicts of Interest / Standards of Business Conduct
- Gifts, Hospitality and Sponsorship Policy
- NHSE Modern Slavery and Human Trafficking Statement https://www.england.nhs.uk/safeguarding/slavery-human-trafficking-statement/
- NHS England: Tackling Modern Slavery in NHS Procurement Guidancehttps://www.england.nhs.uk/long-read/tackling-modern-slavery-in-nhs-procurement/
- The National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025
- Procurement Policy Note 009: Tackling Modern Slavery in Government Supply Chains: https://www.gov.uk/government/publications/ppn-009-tackling-modern-slavery-in-government- supply-chains/ppn-009-guidance-on-tackling-modern-slavery-in-government-supply-chains-

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)204

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**10 September 2026**
Director Lead	Alan Downey, Group Chair
Contact Officer / Author	Alan Downey, Group Chair
Title of Report	**NLaG and HUTH Charities**
Executive Summary	The paper explains the arrangements for governance and management of the two main trust charities – The Health Tree Foundation and WISHH. It makes recommendations concerning: • membership of the NLaG board's charitable funds committee; • the nomination of two members of the HUTH board to become trustees of WISHH; • arrangements for reporting to the NLaG and HUTH boards-in-common; • relations between the trusts and the charities; • closure of the HUTH charity which pre-dated WISHH.
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

NLaG and HUTH Charities

The two main charities associated with our hospitals are the Health Tree Foundation (HTF) and WISHH. This paper explains the arrangements for governance and management of these charities and makes recommendations concerning:

- membership of the NLaG board's charitable funds committee which oversees the activities of the Health Tree Foundation;
- the nomination of two members of the HUTH board to become trustees of WISHH;
- arrangements for reporting to the NLaG and HUTH boards-in-common;
- relations between the trusts and the charities;
- closure of the HUTH charity which pre-dated WISHH.

There are several other charities linked to our hospitals, including, but not limited to, the Scunthorpe Hospital League of Friends, the Grimsby Hospital League of Friends, the Baby Unit Fund and the Daisy Appeal. They are not considered in this paper.

Health Tree Foundation

The official name of the charity is Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds and Other Related Charities. Health Tree Foundation is a working name.
In terms of governance, HTF is a typical NHS charity, in that the NLaG board is the corporate trustee, accountable for the governance and management of the charity in accordance with charity law.

However, there are two atypical features:

- The charitable funds committee has an independent chair, Neil Gammon, a former NLaG NED. The trust board owes a debt of gratitude to Mr Gammon, as he devotes considerable time and energy to matters that would otherwise fall to a member of the trust board.
- Day-to-day management of the charity is contracted out to another local charity, HEY Smile Foundation. This arrangement was started in 2015 and has been renewed several times since then. The current contract between the trust and HEY Smile Foundation was renewed on 1 July 2026.

The charitable funds committee is generally referred to as the HTF trustees' committee. Strictly speaking, however, there is only one trustee (the trust board in its capacity as corporate trustee).

For quoracy, the HTF constitution requires three "trustees" to be in attendance at meetings of the committee. Recent meetings have been attended by the Chief Financial Officer, Interim Medical Director and Vice Chair. The CFO takes the lead on contractual and financial matters, and the Interim Medical Director acts as executive clinical champion, providing clinical input as required.

Twice a year, the independent chair makes a written report to the trust board, but does not usually attend board meetings.

For discussion and decision

Members of the boards-in-common are invited:

- **to take note of the governance arrangements for HTF;**
- **to confirm membership of the charitable funds committee / HTF trustees' meeting;**
- **to agree that there should be more active engagement between the trust board and the charity. In particular, it is recommended that:**
    - **the independent chair presents his reports to the board in person, for discussion, rather than submitting a report for information only.**
    - **the board extends an invitation to Jamie Lewis, CEO of HEY Smile Foundation, to discuss his charity's support for HTF.**

WISHH

HUTH had a charity that was the North Bank equivalent of HTF – i.e. a charity of which the HUTH board was the corporate trustee. That charity was called the Hull and East Yorkshire Hospitals NHS Trust General Purposes Charity (usually referred to as the general purposes charity).

Around ten years ago the HUTH board resolved to set up an independent charity, with its own board of trustees, because the trust board felt it was unable to devote sufficient time and attention to the activities of the charity and considered that an independent charity would take a proactive approach to fundraising, which would increase the level of charitable funds raised. It believed that a dedicated charity board would do a better job of overseeing and developing charitable activities in support of Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH). This approach – establishing an independent charity – is not common within the NHS, but there are several precedents, and it was the result of the HUTH board considering the various charitable models then operating within the NHS.

The official name of the independent charity is the Hull and East Yorkshire Hospitals Health Charity. At the outset, trustees established a branding for the new charity, and WISHH (which stands for Working Independently to Support Hull and East Yorkshire Hospitals) is a working name that was adopted in 2015/16. The relationship between the trust and the independent charity has been defined, over the years, and is governed by jointly agreed memoranda of understanding.

When the independent charity was set up, some ten years ago, the HUTH board initially decided to retain within the general purposes charity the funds that had been raised up to that point. However, in 2018, the HUTH board, having confidence in the operation and governance of the WISHH charity, decided that all charitable funds received from October 2018 should be managed by WISHH. More recently – just over a year ago, as part of the agreement set out in the current memorandum of understanding – the HUTH board decided to transfer all the remaining funds to WISHH and to close the general purposes charity. The sum transferred was approximately £1.6m, most of which is held as restricted funds, as it was before transfer. The general purposes charity now has the status of a "removed charity". Its final year accounts remain to be finalised and audited.
We should now stand down the HUTH charitable funds committee which has overseen the

activities of the general purposes charity, and resolve that residual matters relating to that charity, including the final charity accounts, should be presented to the trust board.

The WISHH board of trustees is accountable for the governance and management of the charity, in accordance with charity law, in the same way that the NLAG board is accountable for the governance and management of HTF. The WISHH board consists of an independent chair, Sue Lockwood, a solicitor by profession and former High Sheriff of the East Riding of Yorkshire, and currently five other long-serving and experienced independent trustees, plus two trustees nominated by the HUTH board. The HUTH board owes a debt of gratitude to Miss Lockwood and the other independent trustees, as they devote considerable time and energy to matters that would, under more common governance arrangements for an NHS charity, be the responsibility of the trust board.

Currently the nominated trustees are Dr Kate Wood and David Sharif, both of whom have recently left the organisation. It is not possible, under the WISHH constitution, for another person to deputise for a nominated trustee.

Although the trust board does not have the corporate trustee responsibility for WISHH, it should nevertheless take an interest in WISHH, because WISHH provides valuable support to both HRI and CHH, for the benefit of patients, members of staff and the wider community. For that support to be as effective as possible, and for expenditure of charitable funds to represent good value for money, there needs to be a close working relationship between the trust and the charity. For example, the charity needs to understand the trust's strategy, so that it can raise and spend charitable funds in a way that is consistent with the strategy, while still retaining its independence. The WISHH board has sought to develop this relationship in the past, but churn in the membership of the HUTH board has made it difficult to achieve. The WISHH trustees hope to see the relationship develop further, and this is reflected in the charity's strategy. The two trustees nominated by the HUTH board have an important role to play in promoting a close working relationship, and they should provide regular reports to the trust board.

For discussion and decision

Members of the boards-in-common are invited:

- **to take note of the governance arrangements for WISHH;**
- **to agree on the nomination of one NED (Jane Hawkard) and one executive director (to be determined) to the WISHH board of trustees;**
- **to agree that there should be more active engagement between the trust board and the charity. In particular it is recommended that:**
    - **the nominated trustees report back regularly to the boards-in-common;**
    - **the chair of WISHH, Sue Lockwood, and the chief executive, Carl Wheatley, are invited to attend occasional meetings of the trust board.**
- **to agree to stand down the HUTH charitable funds committee that has overseen the activities of the general purposes charity;**
- **to agree that residual matters relating to the general purposes charity, including the final charity accounts, should be presented to the trust board.**

Alan Downey
Group Chair

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)205

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	Thursday 10 September 2026
Director Lead	David Sulch, Committee Chair of Quality & Safety CiC
Contact Officer / Author	David Sulch, Committee Chair of Quality & Safety CiC
Title of Report	**Quality & Safety Committees in Common Minutes – June 2026**
Executive Summary	The Quality & Safety Committees in Common minutes from the meeting held on 25 June 2026
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees-in-Common held on 23 July 2026
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 25 June 2026 at 9.00am to 1.00pm via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

David Sulch	Non-Executive Director (HUTH) - Chair
Julie Beilby	Non-Executive Director (NLaG)
Jo Ledger	Interim Group Chief Nurse

In Attendance:

Sam Peate	Group Chief Delivery Officer
Rebecca Crashley	Deputy Group Director of Assurance
Richard Dickinson	Associate Director of Quality Governance (NLaG)
Tracy Campbell	Director of Nursing (North)
Simon Thackray	Chief of Staff – Cardiovascular Care Group
Yvonne McGrath	Group Director of Midwifery
Debbie Bray	Nurse Director for Paediatrics
Vicky Thersby	Group Head of Safeguarding
Sarah Garton	Quality Assurance & Patient Safety Lead
Wendy Wigglesworth	Deputy Director of IPC
Nicola Buckle	Senior Matron IPC
Deborah Wearmouth	Consultant in Microbiology
Lorraine Cullen	Consultant Pharmacist (HUTH)
Ana Megias Bas	Consultant Pharmacist (NLaG)
Chloe Walsh	Consultant in Infectious Diseases (HUTH)
Vicky Sharman	Site Nurse Director (HUTH)
Beverley Hayward	Deputy Head of PMO
Kristy Costa	Fall Prevention Sister
Simon Treacher	Patient Experience Lead
Kevin Allen	Governor Observer
Jo Palmer	PA to the Committees-in-Common (Minutes)

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

0.1 Patient Story

Tracy Campbell presented a patient story relating to a non-verbal teenage patient with autism and a learning disability who attended ED on the North bank. There had been a reported increase in incidents of self-harm and the parents were very concerned that the patient may be in pain. During the attendance, the parents made repeated

requests for pain relief, but these were continuously denied as the staff felt the problem was more behavioural. The story highlighted the importance of listening to families who know the patient best and substantial learning was taken from the situation not being dealt with effectively and by not involving the correct support services. Jo Ledger added that a patient or family member who had experienced this type of treatment was very valuable in being involved in various forums within the organisation with a view to improving the patient experience.

Julie Beilby was disappointed to hear of this poor experience and stressed it was important the organisation learns from it. It was recognised that vulnerable patients should be flagged as such on the appropriate systems and this was missed in this case. She suggested whether such patient stories could be videoed with agreed parental participation where appropriate as this would perhaps have an increased impact on staff.

Sam Peate asked on the progress of the roll-out of the Oliver McGowan training and Tracy Campbell replied that it had commenced but had not yet reached organisational compliance but was moving in the right direction. It was agreed that this should be raised at the Care Group Performance & Accountability meetings.

David Sulch questioned the provision of services in community that could may well have negated the need to visit ED.

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee Chair, David Sulch, welcomed those present to the meeting. Apologies for absence were received from Dr Kate Wood, Group Chief Medical Officer, Dr Peter Sedman, Deputy Group Chief Medical Officer, David Sharif, Group Director of Assurance and Michela Littlewood, Associate Director of Quality Governance (HUTH).

1.2 Staff Charter & Values

The Chair reminded colleagues to be mindful of these throughout the course of the meeting.

1.3 Declarations of Interest

No declarations of interest were received in respect of any of the agenda items.

1.4 To approve the minutes of the meeting held on 28 May 2026

The minutes of the meeting held on 28 May 2026 was accepted as a true and accurate record, with the following correction to the wording of Item 4.12 – “Julie Beilby referred to the complaints which involved a legal perspective and questioned whether these were *genuine or AI generated,* to which Michela Littlewood responded it was a combination of both”.

1.5 Matters Arising

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

1.6 **Review of Action Tracker**

The following updates to the Action Tracker were noted:

Item 1.3a - 1.12 – January 2026 – it was agreed to close these actions as they were in the process of being incorporated into the new Integrated Improvement Plan.
Item 3.6b - February 2026 – Jo Ledger and Dr Peter Sedman to address. Action closed
Item 4.1a - March 2026 – the current position to be clarified later in the meeting
Item 4.2a – April 2026 – Hilda Gwilliams not present at the meeting therefore deferred until July
Item 4.4a – April 2026 – Yvonne McGrath confirmed that no support was required. Action closed
Item 4.4b – April 2026 – David Sulch and Yvonne McGrath to discuss
Item 4.5 – April 2026 – action closed
Item 4.4 – May 2026 – David Sulch asked that Hilda Gwilliams provide an update in readiness for the next meeting
Item 4.10 & item 4.11 – May 2026 - David Sulch asked that Hilda Gwilliams provide an update in readiness for the next meeting

1.7 **Operational Pressures Update**

Sam Peate advised colleagues that work was underway in reducing corridor care and shared that at HRI all the temporary escalation spaces (TES) had been removed in the tower block. Work was ongoing with the Yorkshire Ambulance Service (YAS) and system partners regarding the bringing onto site of inappropriate patients. The Estate was being moved around to accommodate the forthcoming ED majors floor renovation and the MSDEC work. On the South bank, the ambulance handover delays were proving challenging. Corridor care and TES spaces had been removed and planned care reviews were due to be undertaken with the individual Care Groups.

Jo Ledger added that the CQC well-led interviews had been held during the week and she also provided an update on the Listeria position, sharing that a brief had been circulated to Trust Board and a patient line having been opened.

Julie Beilby referred to the operational pressures report of the previous day and noted eight patients in ED TES spaces and queried how that could be if, as previously advised, the spaces had been removed. Sam Peate responded that the spaces had been removed from the HRI tower block, currently not ED, but efforts were being made to reduce the spaces in this area.

Julie Beilby referred to the previous week's meetings with the Care Groups on their cost reduction plans and questioned what happens when patients were to be moved out of ED as they do not need to be there. Historically, the assessment bedspace and MSDEC have been at capacity but by the end of the year, through the various major improvements, this should be greatly improved. Sam Peate also advised that the UTC was due to open 24/7 from late Autumn 2026 which would greatly assist with flow. Finally, some focused work was underway with the ICB

and system partners around alternatives to flow within ED. Julie Beilby suggested an update be provided later in the year.

ACTION: An update on alternatives to flow within ED to be provided at the November meeting

Simon Thackray joined the meeting at 9.26am

2. MATTERS REFERRED

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

There were no matters referred.

3. RISK & ASSURANCE

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

There were no external or internal audit report & recommendations to note.

3.2 Review of Relevant External Reports, Recommendations & Assurances

- **External TAVI Review**

Simon Thackray reminded colleagues that in June 2022, there had been concern raised over the potential under reporting on the cause of death in patients that had undergone TAVI. The ICB and NHSE commissioned a review following this which found that no under reporting of TAVI-related deaths had occurred within the organisation. He reminded colleagues of the statutory obligations for medical examiners from Autumn 2024 onwards to become involved in the death certification process. It had been found that there had been a change in the death certification of Fractured Neck of Femur (FNOF), therefore it was now included routinely but previously, there was no statutory requirement to include the operation.

David Sulch remarked on the update regarding FNOF and questioned whether not including it on the death certificate was because of a desire to avoid a referral to the coroner. He considered it would also be interesting to know whether the coroner was looking into the level of reporting of FNOF. Simon Thackray advised that Dr Peter Sedman, Deputy Group Chief Medical Officer, was having active conversations with Fiona Thompson, the Lead Medical Examiner, who had also reviewed all the cases and who acknowledged the change in reporting. He understood that she was due to meet with the coroner to ensure that the process was fully embedded.

ACTION: Dr Peter Sedman to update on the outcome of discussions with the Coroner at the September meeting

Simon Thackray also provided an update on the improvements in the cardiology service and was pleased to advise it was in a much-improved position, with an improved dynamic within the service. Trainees were reporting positive feedback, enabling the service to rank favourably on a national basis. Simon Thackray was also pleased to report that there had been a cultural shift in that staff were willing to

come forward with their concerns and issues were being dealt with efficiently at an early stage.

David Sulch, on behalf of the Committee, thanked Simon Thackray for his update and was pleased to hear of the positive improvements within the cardiology service.

Jo Ledger informed the meeting that IQIG had requested a presentation on patient and staff experience and suggested this may be presented at a future meeting.

The Committee gave significant assurance on the process of death certification of patients who had undergone a TAVI procedure.

ACTION: The IQIG presentation to be shared at a future meeting

4. COMMITTEE SPECIFIC BUSINESS ITEMS

PATIENTS – SAFETY

4.1 Quality & Safety

Integrated Performance Report (IPR): Quality & Safety Metrics

Richard Dickinson outlined this paper and updated that there had been a higher-than-expected rate for gastrointestinal haemorrhage reported in the SHMI which was currently being investigated. There was a reported improved position on the Duty of Candour and a positive position on HSMR.

David Sulch noted an increase in the frequency of pressure ulcers which appeared to be related to data input into Ulysses compared to what had been input previously into Datix. Jo Ledger responded that work was underway to ensure the correct data was inputted and that the data presented to this Committee had been validated. David Sulch also referred to VTE compliance which was not ideal and was consistently low at HRI needing close attention. Richard Dickinson replied that there was a thrombosis committee to oversee this and the subject was raised at the Patient Safety & Learning Group as well as at the Care Group P&A meetings.

Julie Beilby asked that in the front cover, a comment could be included in future reports as to whether there were any national outliers due to the requested focus on this. She also referred to a potential Never Event at HRI under investigation and Richard Dickinson gave the history behind this relating to incorrect site of procedure. He understood that checklists were in place, however the patient was prepared incorrectly. Sam Peate was of the view that some strong learning had been taken from the review so far to assist with ensuring there was no repeat of such an incident. Richard Dickinson confirmed that Duty of Candour had been followed and the patient would be involved in the investigation.

Richard Dickinson also confirmed that the Estates team were working to implement a contract arrangement into ensuring there was a maintenance contract in place for the future bed rails national outliers.
Jo Ledger advised that the Group had been placed into escalation from an ICB perspective, particularly around Clostridioides difficile infections (CDi).

4.2 **Annual Quality Accounts**

Richard Dickinson outlined the paper and advised that work was underway to consider how to engage better with Lincolnshire County Council service providers.

Julie Beilby questioned the level of interaction with Lincolnshire County Council considering a large amount of the organisation's footprint was in Lincolnshire but outside the ICB area. Richard Dickinson considered there were potentially options around a partnership arrangement. Sam Peate confirmed that the Group was engaging frequently with the Council on No Criteria to Reside (NCTR) patients and anticipated some NHSE support for service to patients in this area.

Yvonne McGrath and Vicky Thersby joined the meeting at 9.57am

Julie Beilby reflected that the report, along with several others, missed reporting on some recent challenges around the National Oversight Framework (NOF) and the work underway to address issues.

The Committee approved the report.

4.3 **Maternity & Neonatal Assurance Report (including Ockenden, CNST, MIS, incidents/MNSI)**

Yvonne McGrath updated that the Nottingham Ockenden report had recently been received and a benchmarking exercise was underway. This would be worked through once the findings of the forthcoming Amos report were available.

Alerts of note were related to Entonox exposure, a risk around element 3 of Saving Babies Lives (SBL) related to scan capacity.

Assurances of note were that the Patient Experience and Communications Lead Midwife role recruitment was soon to be underway. Work around the cultural issues that had been raised within the service continued to be addressed with a fresh look at Internal Professional Standards (IPS) and expectations. A further listening event had been arranged to address student midwife concerns.

Yvonne McGrath further added that there continued to be delays with the Induction of Labour and issues were being addressed.

Debbie Bray joined the meeting at 10.06am.

David Sulch considered that the approach to the Ockenden findings was correct, but he was concerned that the issues around Induction of Labour and the obstetric ultrasound were not progressing and questioned whether there were other ways to address this. Yvonne McGrath replied that in terms of ultrasound, there would need to be a focused review on workforce development working alongside Jo Ledger. In terms of IOL, the organisation was not classed as an outlier and despite various initiatives, nothing appeared to be effectively addressing this so far.

David Sulch asked whether Entonox was a significant issue or whether it could become a broader challenge. Yvonne McGrath considered that the organisation should be able to manage the risk and details would be included within a future paper once costs were available.

At this point, David Sulch informed the meeting that the CQC had recently confirmed that both Non-Executive Directors and Executive Directors were able to provide assurance at assurance committees. Assurance was considered as reasonable.

Children & Young People Assurance

4.4

Debbie Bray notified colleagues that the mandatory training position for medical colleagues had deteriorated and this was being actively discussed within the service to formulate a plan to address this. It was currently unclear why compliance had dropped. She updated that the team were working on a gap analysis on the standards that were published at the end of 2025 along with a refresh gap analysis from a workforce perspective. Debbie Bray advised she would include an update on the outcome of this in the next report.

ACTION: An update on gap analysis to be provided within the next quarterly report

Provisional findings report that gaps exist, but no incidents reported to date. Low numbers of issues had been reported but unsure whether this was because of a lack of reporting therefore a focused piece of work on the importance of near misses was underway. Estates were supporting with necessary improvements on the SGH site. A second review was underway on the Hospital at Home service provision on the South bank with a project team being set up to look at such a service on the North bank due to low utilisation.

Sarah Garton joined the meeting at 10.25am

Points of assurance included an improving trajectory on the deteriorating child overall, despite a couple of areas requiring attention. The team were on track to deliver Martha's Rule, the Paediatric Emergency nursing service was ready to move into a 24/7 service from August 2026 in readiness for the winter period and Debbie Bray thanked the Committee in supporting this initiative. Mandatory training within the nursing team was consistently improving and positive patient experiences continued to be reported.

Julie Beilby was disappointed to note the declining mandatory training within the medical team and considered when a HR process would be initiated. Debbie Bray confirmed that HR had been involved for some time and as it had been a CQC outstanding action from 2019, it had been added to the Risk Register. Jo Ledger added that the document that featured at the SLT meeting would now be presented at the Clinical Policy Group (CPG) which would support the Care Groups in adhering to the process and identifying staff that were not complying.

Julie Beilby was pleased to note there were no CQC actions outstanding but again disappointed to note that the tea trolley rounds in HUTH neonatal where a member of staff was unaware of the Freedom to Speak Up (FTSU) process despite it being frequently communicated to staff. Debbie Bray agreed this was frustrating and considered that this may be an exceptional case, as the initiative was well signposted around the unit.

Debbie Bray was of the view that there needed to be further discussion around the CYP Board. She had looked at the Terms of Reference with the Group Director of Assurance, but the forum now needed development.

ACTION: Jo Ledger to follow up with Debbie Bray on the CYP Board development

David Sulch noted that the Facing the Future standards were not embedded at HUTH despite being so at NLaG. Debbie Bray responded that the workstreams needed to commence to address this. He also noted that Estates concerns were being reported in several forums and at Trust Board and the Estates strategy would be looked at. Debbie Bray expressed her thanks to Tom Myers for his support and reported improvements on the Disney ward but there was more to be done.

David Sulch also made a positive comment on the clarity of the paper, noting relevant issues were clearly identified.

Assurance was noted as limited, due to the uncertainty around the outcome of the workforce review, mandatory training and Estates issues.

Jo Ledger acknowledged the hard work of Debbie Bray and her team.

4.5 **Safeguarding including MCA & DOLS**

Vicky Thersby advised colleagues that the ED Navigator service which operated solely on the North bank was in the process of being redesigned and due to be implemented by the end of the year and she was pleased to advise that the team had received a further award for this service. The transition nurse role on the South bank had had some strong positive patient feedback and whilst there were no formal transition pathways on the North bank, the team were looking at potential opportunities to work with Children & Young People services to replicate the service there.

Vicky Thersby highlighted an error on page 6 of the paper relating to gaps regarding workforce and the ongoing review and confirmed that no such gap existed. On page 7, in relation to Restraint & Restriction, she confirmed that Exec level support was now available.

Work was ongoing to align some adult safeguarding processes, but it was apparent that different local authorities had different safeguarding thresholds, and this was expected to cause an issue for the foreseeable future in regard to the implementation of training.

Following the loss of the Domestic Abuse co-ordinator role on the South bank, a review was underway as to how to provide such a service from a Group perspective.

Tracy Campbell spoke of the culture change in relation to patient watch that was now apparent in a short period of time following the new Restraint & Restriction process and this was echoed by David Sulch and Julie Beilby.
Julie Beilby was of the view that the issues around workforce needed close attention. Safeguarding was the responsibility of everyone, but the team did require

the appropriate level of support. She welcomed the presentation of the annual report at the earliest opportunity which in turn, would support any workforce requirements. She was pleased to see the recognition of the ED Navigator service and the member of staff working on the transition programme.

Jo Ledge clarified that a review of the service was underway, including benchmarking against national standards, following a request from Trust Board and this would be presented at its September meeting. Julie Beilby asked that this be aligned with the appropriate budget settings timescales.

David Sulch reflected that staffing was currently being arranged by changing circumstances and considered it was the right time to undertake a workforce review.

Assurance was noted as reasonable with a lot of good work ongoing, although staffing required careful monitoring. The CiC looked forward to the presentation of the workforce review.

Vicky Thersby left the meeting at 10.50am

Putting Patients First

4.6 Sarah Garton introduced herself and shared her presentation detailing the initial pilot feedback and the planned rollout of the initiative.

Jo Ledger acknowledged and thanked the team for the work achieved so far in such a large project and a short space of time, as well as noting Care Group engagement.

Julie Beilby reminded Jo Ledger that, as a Non-Executive Director, it was an initiative she had expressed a wish to be involved in, alongside the Governors, but had not yet received any correspondence. Jo Ledger replied that dates and briefings would be forwarded in due course and Tracy Campbell acknowledge the importance of NED involvement.

ACTION: NEDs and Governors to be sent details of the Putting Patient First ward area visits and working group

Tracy Campbell commented that it was important to ensure sufficient engagement with the clinical team in respect of meeting specific standards in board/ward rounds and patient flow.

Deborah Wearmouth joined the meeting at 10.57am
Wendy Wigglesworth joined the meeting at 11am

The meeting paused for a ten-minute break at 11am

Lorraine Cullen & Ana Megias Bas joined the meeting at 11.10am
IPC –

- **BAF Q4 & overview**

4.7

Nicola Buckle was pleased to advise an improved position against the BAF since the last paper. The outstanding element at NLaG related to facial fit testing and education but a plan was in place to mitigate this.

She continued to share that the main concern and risk were currently in relation to CDi rates across the Group. An improvement plan would be devised once the stakeholder group had completed a peer review. The new IPC digital system was in the process of being rolled out. All policies had now been incorporated into Group-wide policies and training compliance had improved since the last report, resulting in all Care Groups being compliant with IPC and training.

David Sulch asked if there were any emerging themes in relation to prescribing and whether the deteriorating Estate was causing any impact. Wendy Wigglesworth replied that Debbie Wearmouth was undertaking a detailed review of the CDi cases across the Group, which was expected to be complete within a couple of weeks. Debbie Wearmouth added the quality of the RCA data was insufficient in many of the cases and a focus was needed to look at improving the post-infection review process, considering the Group's position had significantly deteriorated.

David Sulch asked whether community prescribing was causing an impact and Debbie Wearmouth confirmed that it would be, although the Group was performing well against the community benchmark.

Assurance was noted as limited, largely due to the CDi challenges.

- **Action against AMR presentation**

On behalf of the North bank, Lorraine Cullen introduced herself and shared her presentation, which centred around the NHSE request for each organisation to focus and prioritise antimicrobial stewardship (AMS) and IPC with the aim to reduce antimicrobial resistance, which the WHO considers as one of the major global public health threats. Increased prescribing was resulting in increased resistance making infections more difficult to manage. She clarified that the Group was experiencing a range of challenges across the two Trusts which explained the need for different priorities to be agreed. There was no mandatory AMS education in place within the Group, which was a challenge considering the need to increase awareness by 10% by 2029. NHSE predicts that if IV antibiotics can be reduced by 10%, over 11,000 nursing hours could be reduced per year, patient safety would improve with reduced rates of bloodstream infection and IV site reactions, it would support the patient in being discharged earlier and be cost reducing. For HUTH, that would equate to around £126K. Lorraine Cullen stated that around a quarter of patients remain on IV antibiotics despite meeting the criteria to switch to oral use. She advised that HUTH was not meeting the overall usage National Action Plan target.

The team were looking for Executive level support as per the NHSE request, and resources to address the priorities. Gaps were identified in clinical workforce knowledge of issues and how they link to patient safety, a non-infection specialist clinician and the AMS IPC leadership role.

Ana Megias Bas shared her presentation for NLaG and advised that the Trust remained a regional outlier in the use of broad-spectrum antimicrobial prescribing.

Key challenges were reported as achieving the targets from the National Action Plan and some operational issues impacting AMS. The main challenge was around a gap in workforce, particularly for the role of data analyst.

Ana emphasised that AMS should be classed as a Trust-wide safety and quality priority, needing clinical leadership support.

Jo Ledger confirmed that AMS, as part of IPC, was a Trust Quality Priority for this year. Nursing staff should be empowered to challenge the medics, but it was necessary for medical staff to receive the necessary education and ultimately be confident in the switch. Wendy Wigglesworth confirmed that there was lots of activity in terms of her team working with ward staff to encourage the move to oral prescribing.

Sam Peate advised that Dr Sedman had agreed for the AMR team to present at the next CPG meeting in July 2026, which would support clinical engagement.

Vicky Sharman and Bev Hayward joined the meeting at 11.35am
Simon Treacher joined the meeting at 11.51am

Julie Beilby considered it important to understand what could be achieved within current staffing resources but was unsure who the responsible Executive was. In terms of data analyst resources, unlike the HUTH presentation, the NLaG presentation did not include an example of potential cost savings. In advance of presentation at Trust Board, Julie Beilby recommended a business case being considered, along with potential partnership opportunities and a clear indication of what options have been considered within the current resources.

Jo Ledger confirmed she was the Executive lead on this but welcomed the support of the Deputy Group Chief Medical Officer to look at this work going forward, particularly on the South bank. She understood that there was a Board Development session planned on IPC for September 2026 which would be an opportunity for a thorough discussion prior to presentation of the NHSE request at Public Trust Board to alert them to the challenges and requirements from a national perspective.

ACTION: Jo Ledger to liaise with Deputy Group Chief Medical Officer and the IPC team to discuss approach to Board Development session planned for September 2026

The CiC were reassured with the evidence of good teamwork across the Group in terms of IPC and particularly AMS and noted the excellent quality of the reports.

Kristy Costa joined the meeting at noon

EQIA – including ED Flooring HRI – EQIA score of 20

4.8 Julie Beilby reminded colleagues that at the last meeting, a list of schemes was reviewed, including low risk schemes that had been approved and were awaiting further information. They applied to one of three categories; low risk, requiring

discussion at the EQIA panel and high risk (20+) requiring discussion at the ARG CiC. The meeting particularly considered what impact the low risk EQIA of staff transport had had on staff and the CiC was of the view that such subjects should be raised at Exec meetings or with the Interim Group Chief People Officer, and a consultation take place with staff. Julie Beilby reflected that an indication of savings would have been helpful in justifying the move and this should be considered in the future.

David Sulch reflected on the role of the CiC in relation to EQIAs and determined that it was to check a robust process was in place which could identify appropriate concerns and the CiC was not to assess the EQIAs individually.

Beverley Hayward advised that the EQIA policy was due for review in August 2026 and the team would take the opportunity to look at the policy against national guidance. The team recognised the importance of having Comms involved in the process. Richard Dickinson offered his support due to the fact he had worked on developing the process previously.

Beverley Hayward reassured the CiC that as the organisation moved to align with the Integrated Improvement Plan, there would be more non-CIP EQIAs moving through the system.

Julie Beilby asked that careful attention was given to the wording of Comms in relation to EQIAs to avoid any potential confusion and upset. She also asked whether any of the scores had been reviewed and Beverley Hayward responded that they had not, but the process currently stated that EQIAs were reviewed every six months and the Comms team would now also be a part of this process.

- **ED Flooring HRI – EQIA score of 20**

Vicky Sharman introduced the scheme of work which was due to commence on 13 July 2026 at HRI. As the EQIA produced a risk score of above 16, Trust policy was followed in that discussion was required at the relevant Committees-in-Common. She highlighted that due to subsidence in the flooring, the replacement work was required urgently, as there were risks to patient and staff safety and infection control. It was anticipated that additional necessary Estates work could be carried out at the same time.

Whilst the EQIA highlighted significant short-term risks associated with operating within a reduced footprint, the risks were being mitigated through the strengthening of the operational plans and Executive oversight.

Sam Peate pointed out that if the work was not undertaken at this point, then it would still require completion at a time later in the year which would pose a larger patient safety risk during winter pressures. Vicky Sharman expected that the work would be completed by the end of August 2026.

Julie Beilby advised colleagues that the Audit, Risk & Governance (ARG) CiC had requested that the paper be presented at the QSC CiC to assess whether any further mitigations could be put into place. From discussions at this meeting, there were clearly some additions to be made to the EQIA document. She also recalled that the detail of the risk around capacity was not available at the time of the ARG CiC where the paper had originally been presented, but she did consider it was

essential to note, along with the reason the work should go ahead now. It was clear that the risk score of current arrangements would be higher than the risk of doing the work. Vicky Sharman agreed to include a reference to the capacity risk.

The CiC gave approval for the planned work to go ahead.

Learning from Experience and Reviewing Never Events

4.9 Richard Dickinson introduced the report, referencing the IPC and Never Event work and ongoing activity in relation to safer surgery, along with a good amount of engagement with TAAC.

David Sulch noted that the report was currently received monthly and suggested it be for information purposes, with assurance being provided in the first month of each quarter, except for Never Events, in which case the process followed required assuring as soon as possible.

Deep Dive – Falls Annual Report 2025/26

4.10 Kristy Costa introduced herself and shared her presentation. She advised that the organisation compared favourably against other organisations, particularly HUTH, and there was considerable work ongoing at NLaG which was expected to ensure a positive rating next year.The Falls lead at HUTH was found to be very proactive and Kristy Costa highlighted reductions in falls rates, the audit findings, education initiatives and challenges with a lack of clinical leadership at NLaG, financial issues around equipment and new technology, staffing issues, governance challenges and ultimately, an ageing population. She highlighted plans centred around policy development and a Group Risk Register.

Tracy Campbell and Jo Ledger thanked Kristy Costa and her team for their continuing hard work.

Jo Ledger added that there was to be a service review to consider whether additional staffing resources were required at NLaG.

David Sulch asked whether the process of reducing falls risk was to be audited and Kristy Costa replied that there was some work ongoing with the frailty registrars around pre and post falls assessment, with a proforma devised. He was also aware that patients who suffer FNOF as an inpatient were delayed reaching theatre compared to patients who attend ED with same and asked whether there was any data to show that these patients were not being disadvantaged over those from ED. Kristy Costa replied that whilst there was no data at present, it was not a situation that was seen too often due to good relationships with the trauma co-ordinators. Jo Ledger considered this would be a worthwhile comparative exercise.

ACTION: Jo Ledger to lead on a review of patients suffering with FNOF admitted through ED compared to acquiring as an inpatient

Assurance was noted as reasonable and the CiC were reassured to note the number of falls reducing and were pleased to note an enthusiastic team in place.

However, it recognised that a clinical lead was also required at NLaG to improve oversight.

Kristy Costa left the meeting at 12.51pm

ANNUAL REPORTS

5. Patient Experience Annual Report

5.1 Simon Treacher outlined the report and updated that a significant amount of feedback had been received into the organisation. Key themes were consistent across the Group, centred around delays in waiting times, communication and treatment-related issues, however patient experience remained positive despite the increase in operational pressures and workforce demands. Learning from feedback was progressing well with various workshops having been held with the majority of Care Groups and various initiatives underway to improve processes and backlog of responses.

Julie Beilby noted the key patient experience performance measures for 2026/27 which she assumed would be reflected in the new IPR for patient experience. She had a question on the PALS response time target and an anticipated increase in the number of PALS complaints. Simon Treacher accepted this would be a challenge for the Care Groups to meet that KPI currently. It was a target that was already in place so would need to be mitigated into future reports stating that there would be a deterioration at least until the recovery plan was implemented.

Jo Ledger added that there was clearly a significant issue with PALS, particularly at HUTH and The Value Circle had enabled process mapping of the full process in relation to PALS, with clear KPIs. She had increased the staffing element to be able to support working through the backlog, but the focus was around having the correct process in place. The presentation that had been circulated to the Patient Safety & Learning Group (PSLG) meeting was to be forwarded to the CQC, following their concern around a lack of replies for a length of time at HUTH in relation to Friends & Family.

Julie Beilby was pleased to see the focused support for the minority population in terms of improving access for those patients hard of hearing and with LanguageLine and asked whether the same level of support was available for patients with learning difficulties. Simon Treacher replied that this was an area of work needing some focus and learning from other organisations.

ACTION: Patient Experience/recovery plan presentation to be circulated to Committee members

The CiC approved the annual report.

PSIRF Learning Response Annual Report

5.2 This report was deferred to the July meeting.

HIGHLIGHT REPORTS

6. Maternity & Neonatal Assurance Group

6.1 This was noted.

Risk & Compliance

6.2 This was noted.

Patient Experience Learning Group

6.3 This was noted.

ITEMS FOR INFORMATION

7. CQC Statement of Purpose – HUTH & NLaG

7.1 Sam Peate highlighted a couple of discrepancies around the wording, particularly in relation to DPoW and the support from HUTH from travelling clinicians being worded differently to that of SGH and Goole Hospital.

The CiC were happy to virtually approve the Statements once these amendments had been made.

ACTION: Amendments to be made and recirculated to the CiC for virtual approval

Unplanned Care Board Minutes

7.2 These were noted.

ANY OTHER BUSINESS

8.

8.1 **Any Other Urgent Business**

There was no other urgent business.

9. MATTERS TO BE REFERRED BY THE COMMITTEES

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

There were no matters to be referred to other Board Committees.

9.2 **Matters to be escalated to the Trust Boards including any proposed changes to the BAFs**

The following items would be escalated to Trust Board:

<u>Alert</u>

- Delays in induction of labour and obstetric ultrasound capacity

- CDi rates increase although Group were above the mean
- EQIA on HRI ED flooring replacement work, along with the noting of the EQIA process
- Significant backlog of PALS and complaints

Advise

- HUTH VTE compliance with no patient safety concerns
- Deterioration in mandatory training compliance in medical staff
- AMS presentation received and key challenges noted in relation to the National Action Plan

Assure

- External TAVI review – there was no evidence of any systematic under-reporting of cases
- North Bank Navigators and Transition Nurse for Safeguarding were advised as award winners and a positive CESAS visit had taken place
- Deep Dive on Falls was received detailing staffing, performance and improvements
- Patient Experience Annual Report was approved
- CQC Statements of Purpose to be virtually approved once amendments made

10. DATE OF THE NEXT MEETING

10.1 **The next meeting of the Quality & Safety Committees-in-Common will be held on Thursday 23 July 2026 at 9.00am-1.00pm via MS Teams**

The Chair closed the meeting at 13.06pm.

Cumulative Record of Attendance at the Quality & Safety Committees-in-Common 2026/2027

Name	Title	2026 / 2027											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y									
Julie Beilby	Non-Executive Director (NLaG)	Y	Y	Y									
Dr Kate Wood	Group Chief Medical Officer	D	D	N									
Jo Ledger	Interim Group Chief Nurse	Y	D	Y									
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	N	N									
Rebecca Crashley	Group Deputy Director of Assurance	Y	Y	Y									
Yvonne McGrath	Group Director of Midwifery	Y	Y	Y									
Sam Peate	Group Chief Delivery Officer	Y	D	Y									
Hilda Gwilliams	Group Chief Patient Safety Officer	Y	Y	N									
Michela Littlewood	Associate Director of Quality Governance (HUTH)	N	Y	N									
Richard Dickinson	Associate Director of Quality Governance (NLaG)	Y	Y	Y									
Kevin Allen	Governor Observor	Y	Y	Y									
OTHER BOARD ATTENDEES													
Murray MacDonald	Interim Group Chairman	N	N	N									

KEY: *Y = attended* *N = did not attend* *D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)206

Name of Meeting	**Trust Boards-in-Common (meeting held in Public)**
Date of the Meeting	10 September 2026
Director Lead	Dr Peter Sedman, Deputy Medical Officer
Contact Officer / Author	Joanne Goode, Chief Pharmacist
Title of Report	Annual Medicines Optimisation Report 2025/26
Executive Summary	The Annual Medicines Optimisation report provides an account of medicines management and optimisation activities undertaken over the last year. It is intended to update the Board on the Trust's medicines optimisation arrangements, outlining progress made in year, as well as the key areas of concern and plans going forward for the next year. Key achievements: • Medication safety dashboard for the group working well and shared through care groups • Single system Area Prescribing Committee and single formulary approach in place • Trainee pharmacist programme means new pharmacists will now qualify as independent prescribers • Retention and development of the pharmacy team across the group improved • Commitment to new Electronic Patient Record (EPR) and Electronic Prescribing and Medicines Administration (ePMA) for Humber Health Partnership (HHP) • Development of the ideal ward standard for medicines management • Biosimilar switches made as medicines become available • New policy for management of unaccounted loss of controlled drugs • Groupwide task and finish groups for Insulin safety, intravenous to oral switch of medicines and discharge medication ongoing Key areas of concern: • Lorenzo ePMA concerns around product alert notices, reporting functionality and integration with other systems at HUTH • Antimicrobial usage at NLaG • Insulin never event at NLaG • Controlled drug incidents – unaccounted losses • Medicines reconciliation rates across the partnership

	Key plans for next year • Support the quality priority to improve insulin safety across HHP • Orbis U ePMA roll out across HHP • Nitrous oxide pipeline decommissioning at NLaG • Review pharmacy services across the group and consolidate where appropriate. Explore the option of a single procurement, store, aseptic unit, clinical trials and medicines information service for the group based at Castle Hill site. • Share learning on successful antimicrobial strategies to ensure appropriate prescribing and use at NLaG • Review safe storage of medicines across the group and explore the use of automated cabinets and electronic keys • Continue to review and standardise medication related policies across the group **Recommendation to the Board** This report is presented for the Board's assurance and approval.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality and Safety Committees-in-Common meeting held on 23 July 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:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Medicines Optimisation

Annual Report

2025/26

Joanne Goode
Chief Pharmacist HHP

June 2026

Executive Summary

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

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

Key achievements:

- Medication safety dashboard for the group working well and shared through care groups
- Single system Area Prescribing Committee and single formulary approach in place
- New trainee pharmacist programme means new pharmacists will shortly qualify as independent prescribers
- Retention and development of pharmacy team members across the group
- Commitment to new ePR/ ePMA for Humber Health Partnership (HHP)
- Development of the ideal ward standard for medicines management
- Biosimilar switches made as medicines made available
- New policy for management of unaccounted loss of controlled drugs
- Groupwide task and finish groups for Insulin safety, intravenous to oral switch of medicines and discharge medication ongoing

Key areas of concern:

- Lorenzo ePMA concerns around product alert notices, reporting functionality and integration with other systems at HUTH
- Antimicrobial usage at NLaG
- Insulin never event at NLaG in 2025
- Controlled drug incidents

Key plans for next year

- Support the quality priority to improve insulin safety across HHP
- Orbis U ePMA roll out across HHP
- Nitrous oxide pipeline decommissioning at NLaG
- Review pharmacy services across the group and standardise where appropriate. Explore the option of a single procurement, store, aseptic unit, clinical trials and medicines information service for the group based at Castle Hill site.
- Share learning on successful antimicrobial strategies to ensure appropriate prescribing and use at NLaG
- Review safe storage of medicines across the group and explore the use of automated cabinets and electronic keys
- Continue to review and standardise medication related policies across the group

Medicines Optimisation Annual Report 2025/26

1. Introduction

The purpose of this report is to:

- Provide assurance to the Board that medicines are managed appropriately and effectively throughout the organisation.
- Summarise the activities and achievements relating to medicines optimisation undertaken over the last year
- Highlight the progress and areas for development with regards medicines optimisation

Following the creation of a Group operating structure, this paper aims to draw together several items previously reported separately across Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). There are no national standards guiding the content of an Annual Medicines Optimisation report meaning different information has historically been reported in each Trust. Similarly, a number of measures are not directly comparable due to differences in data, numerator and denominator.

2. Medicines Optimisation Strategy

A medicines optimisation strategy drives the organisation's approach to medicines optimisation. It provides the framework through which medicines optimisation is managed under the overarching framework of the Trust Clinical strategy.

Medicine optimisation is the term used to describe four important principles that focus on patients and outcomes, rather than symptoms and processes:

3. Clinical Effectiveness

3.1. Medicines and Therapeutics Group

The role of the Medicines and Therapeutics Group is to approve and monitor all policies and guidance concerning medicines management within the respective Trust and agree the Trust position on Humber Area Prescribing Committee business, which includes controlling and managing the entry of new medicines to the joint formulary.

The Medicines and Therapeutics Group met six times out of twelve planned meetings over the year 2025-2026 and report to the Patient Safety and Learning Group.

The move to a group operating model has resulted in a refresh of membership and has helped to ensure attendance over the year. Compliance with the formulary has been maintained across the group, ensuring patients are prescribed appropriate treatment.

3.2. Humber Area Prescribing Committee

Work to align formularies and shared care agreements has continued. Work is ongoing with the Integrated Care Board to address the historical inequalities arising from different funding models across the Primary Care Networks prior to the formation of Integrated Care System and the negative impact this has had on shared care.

The Humber and North Yorkshire Integrated Care System have worked together to form a single system Area Prescribing Committee (APC) bringing together the Humber APC and North Yorkshire and York APC to further reduce unwarranted variation and inequality. The group meets monthly and HHP representatives have been present at all twelve meetings in 2025-26

3.3. Audit

All pharmacy and medicines management nurse led audits have been transferred across to the new Audit Management and Tracking (AMaT) system. This has several benefits, including improved visibility of results for ward managers and email notifications from within the system which improves ownership for developing action plans and accountability for their delivery by the correct teams.

3.3.1. Safe and Secure Handling of Medicines Audit

We are aligning our audit standards across the group, and a dashboard has been developed.

		Humber Health Partnership			HUTH			NLaG		
		2025 A1	2025 A2	2025 Av.	2025 A1	2025 A2	2025 Av.	2025 A1	2025 A2	2025 Av.
	Full Safe & Secure Audit	87.1%	87.1%	**87.1%**	90.1%	89.2%	**89.7%**	81.2%	84.0%	**82.6%**
Audit Sections	Resus Equipment	93.7%	91.4%	**92.5%**	98.3%	94.5%	**96.4%**	89.2%	87.6%	**88.4%**
	Medical Gases	80.4%	83.2%	**81.8%**	94.8%	93.0%	**93.9%**	57.7%	67.0%	**62.3%**
	Treatment Rooms	85.5%	85.7%	**85.6%**	85.4%	81.5%	**83.4%**	85.7%	91.3%	**88.5%**
	SAMPOD	52.9%	57.1%	**55.0%**	33.3%	33.3%	**33.3%**	100.0%	75.0%	**87.5%**
	IV Fluids	83.3%	91.7%	**87.5%**	93.7%	97.4%	**95.5%**	70.8%	84.2%	**77.5%**
	Drug Fridges	88.7%	87.4%	**88.0%**	89.5%	84.7%	**87.1%**	87.6%	90.5%	**89.0%**
	Controlled Drugs	95.9%	95.6%	**95.8%**	94.8%	95.5%	**95.1%**	97.5%	95.7%	**96.6%**
	Green MM Folder	94.2%	65.2%	**79.7%**	94.2%	96.9%	**95.6%**	Not Audited	26.3%	**26.3%**
	Staff Knowlegde	81.7%	90.7%	**86.2%**	81.7%	90.5%	**86.1%**	Not Audited	91.0%	**91.0%**
	Observations	89.8%	78.0%	**83.9%**	89.8%	80.4%	**85.1%**	Not Audited	69.6%	**69.6%**

Standards of concern when the results of the 2 audits from 2025 are combined

HUTH

Organisation	HUTH
Resus Equipment	85.0%
Daily checks completed?	85.0%
Medical Gases	73.3%
(HUTH) Checklist completed three times a week ? Please select NA if the area doesn't store medical	73.3%
Treatment Rooms	52.8%
Previous feedback poster displayed on treatment room?	75.0%
Are all cupboards locked?	68.9%
All medicines are stored in locked cupboards/fridges/medicines trolleys/POD lockers? (no medicines unsecured in treatment room, e.g.: on worktops)	65.6%
(HUTH) If there are TTOs pack in use, is the logbook correctly completed?	33.3%
All medicines are stored in original packages?	21.3%
SAMPOD	33.3%
If there are any patient self-administering, there is evidence that an assessment has been completed ?	33.3%
Drug Fridges	73.3%
The fridge is locked?	83.3%
The drug fridge temperature is recorded at least once every 24h and the thermometer has been reset afterwards or a remote monitoring temperature tag is in place?	80.7%
Insulin vials/pens for individual patients are labelled appropriately: ID (Name/DOB/NHS numbers) and date opened?	56.0%
Controlled Drugs	88.5%
CD monitoring log clearly demonstrates CD stock has been checked every 24 hours?	88.5%
Staff Knowlegde	56.7%
Staff can tell you about the BOC time remaining app?	56.7%
Observations	73.4%
Did the staff member use scanner for ID?	83.9%
Allergy confirmed PRIOR to medication administration	77.2%
The medication trolley is not left unlocked/unattended	58.9%

NLAG

Organisation	NLAG
Resus Equipment	83.9%
(NLaG) Monthly check completed monthly? Please select NA if NO crash trolley.	86.2%
Daily checks completed?	81.7%
Medical Gases	50.3%
AVSU glass is intact and clean or reported to estates if any damage noted?	85.8%
Appropriate warning notice is displayed at each location where medical gases cylinders are stored	36.3%
All medical gases cylinders are stored securely (within a box or chained to a wall in a clean utility	28.8%
Treatment Rooms	77.4%
Is the room locked when not in use?	85.6%
Medicines delivered are stored securely whilst awaiting transfer to medicine cupboards or POD	76.7%
All medicines are stored in locked cupboards/fridges/medicines trolleys/POD lockers? (no medicines unsecured in treatment room, e.g.: on worktops)	76.4%
All medicines intended for return to pharmacy are stored securely and appropriately, and if there is a green returns bin, it is secured to the wall?	70.9%
SAMPOD	87.5%
If there are any patient self-administering, there is evidence that an assessment has been	87.5%
IV Fluids	69.5%
The area for the storage of fluids is locked	82.4%
Stock rotation is evident and there are no out of date IV fluids?	81.1%
Local anaesthetics (including epidurals) are segregated from all other IV solutions and clearly	67.5%
Large volume IV fluids (>50mL) are kept in the original packages or are stored in clearly labelled	58.6%
Small volume IV fluids (<20mL) are kept in the original packages?	57.7%
Drug Fridges	59.7%
The drug fridge temperature is recorded at least once every 24h and the thermometer has been reset afterwards or a remote monitoring temperature tag is in place?	85.7%
Insulin vials/pens for individual patients are labelled appropriately: ID (Name/DOB/NHS numbers) and date opened?	33.7%
Staff Knowlegde	79.4%
Staff can explain the key points for safe storage of insulin (e.g.: 28 days, labelling, etc)?	80.4%
Staff can tell you 2 examples of when they would consider an IV to Oral switch for patients	78.4%
Observations	71.0%
The medication trolley is not left unlocked/unattended	86.7%
Medication taken in front of nurse administering (except SAM)	80.0%
ID confirmed PRIOR to medication administration	69.6%
Allergy confirmed PRIOR to medication administration	47.6%
Green MM Folder	22.3%
PGDs are annually reviewed and signed off ?	32.1%
There is evidence that the keypad and Digi locks codes are changed at least every 6 months?	12.5%

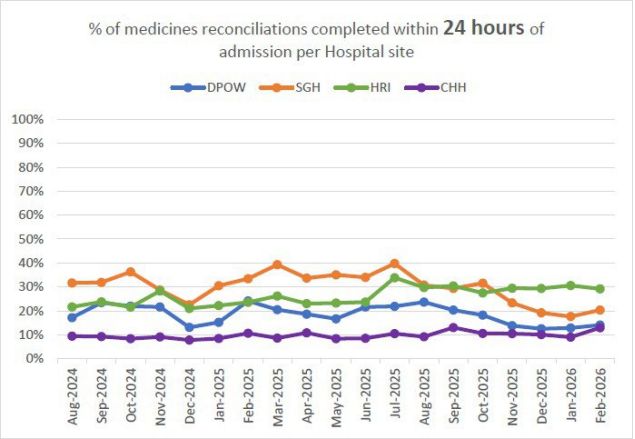
3.4 Safe and Secure Storage of Controlled Stationary

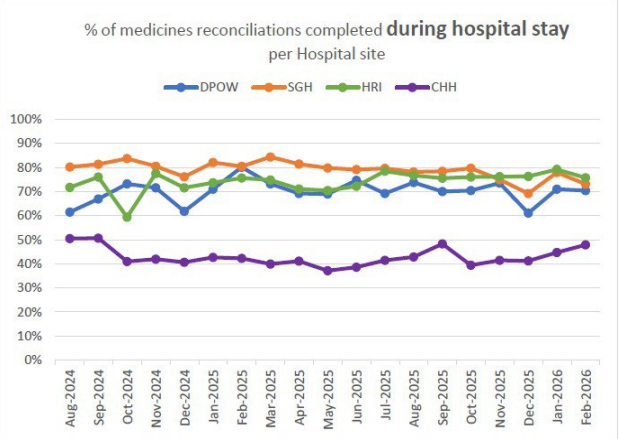
The group has developed a joint policy on the management of FP10HNC prescriptions. This policy focuses on the security of FP10HNC prescriptions specifically as they can be dispensed via community pharmacy.

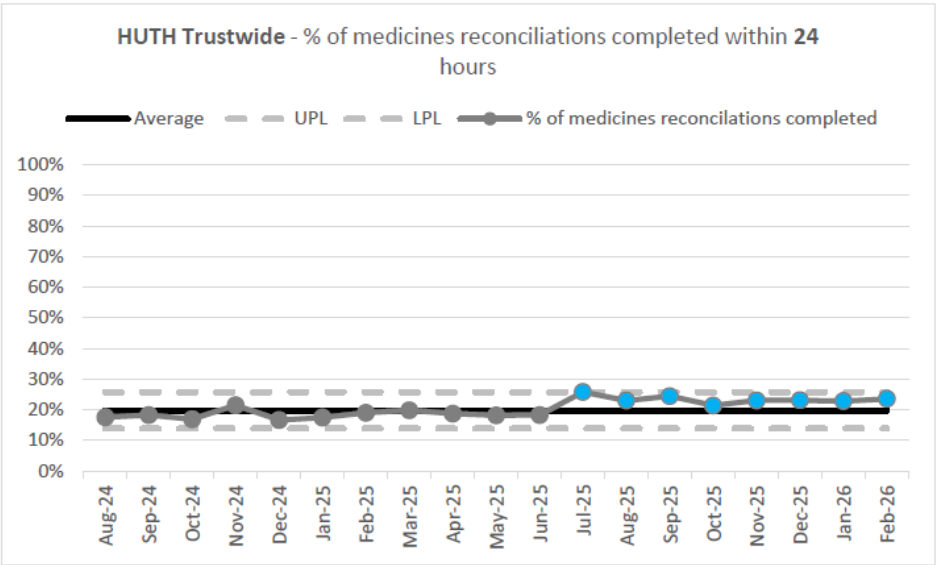
Other secure stationary in use is only valid at the hospital inpatient or outpatient pharmacies and therefore less liable to diversion and misuse. To further mitigate risks of diversion and misuse all prescription forms require secure storage in a locked cupboard with an Abloy lock or a key under the control of the nurse in charge of the ward/department at NLaG. At HUTH these are ordered on secure stationary via the dispensaries.

3.4 Medicines Reconciliation

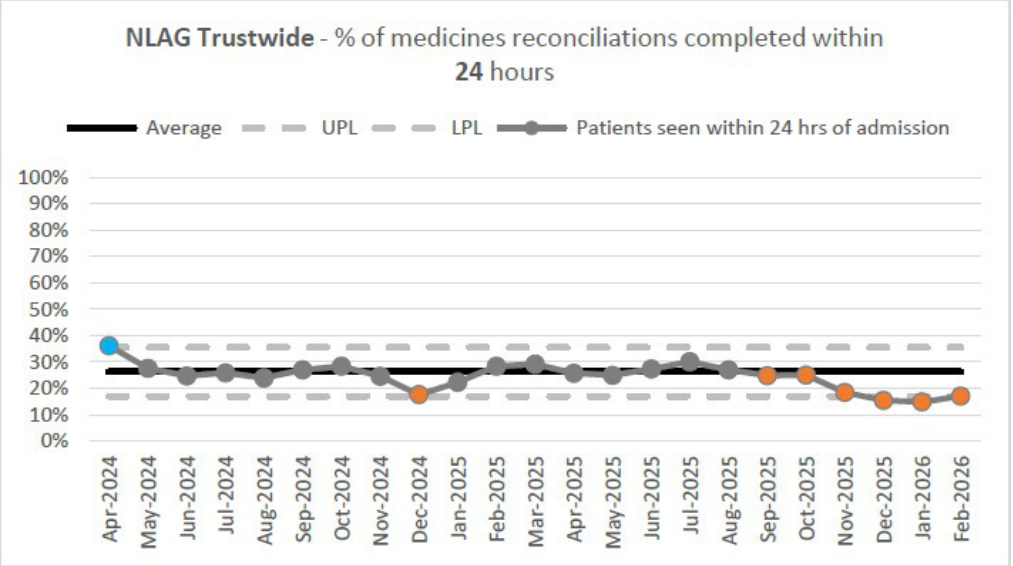
The pharmacy service must ensure that medicine reconciliation is conducted in line with the National Institute for Health and Care Excellence Quality Statement 120 and audited in line with trust policy. The target is to undertake medicines reconciliation within 24 hours of admission for 80% of inpatients.







SPC Trend Status	6 Month Average
Significant Increase	23.0%



SPC Trend Status	6 Month Average
Significant Decrease	19.3%

A new clinical lead pharmacist for the HHP pharmacy service has been appointed and is working on improving our efficiency of medicines reconciliation across the group. With current pharmacy resources it is unlikely these figures will significantly improve without either substantial investment in the pharmacy team or improvements in automating processes involved in medicines reconciliation.

4. Medicines Safety

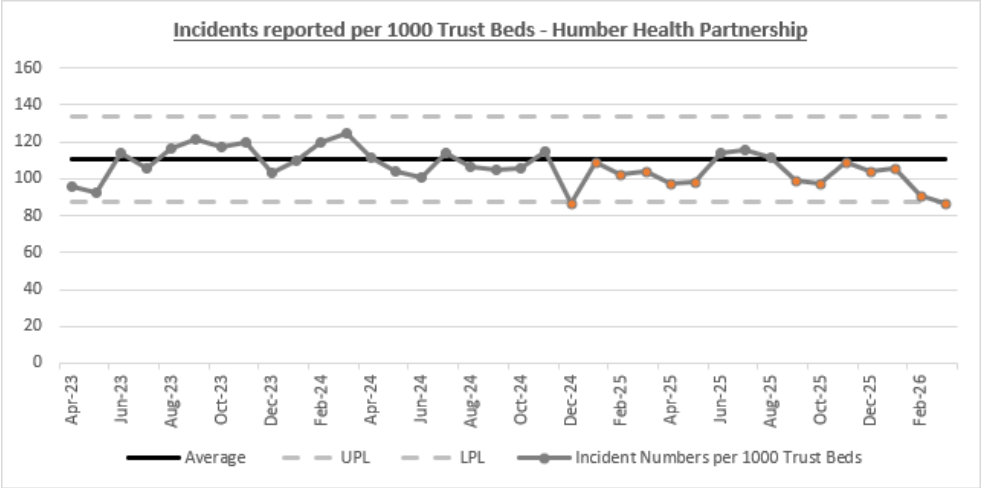
The role of the Safer Medication Group is to promote and support safer medication practice and provide assurance that the trust has in place the necessary controls to manage risk in relation to medication practice. It achieves this through its multi-disciplinary membership providing advice on the safe and effective use of medicines, sharing lessons from medication errors, seeking assurance from divisions on matters relating to medication safety and overseeing actions against recommendations outlined in National Patient Safety Alerts.

The Safer Medication Group reports into the Patient Safety and Learning Group. The Safer Medication Group met eleven times out of twelve planned meetings in 2025-26 and became a joint HHP meeting in August 2024 having been run as separate HUTH and NLaG prior to this date.

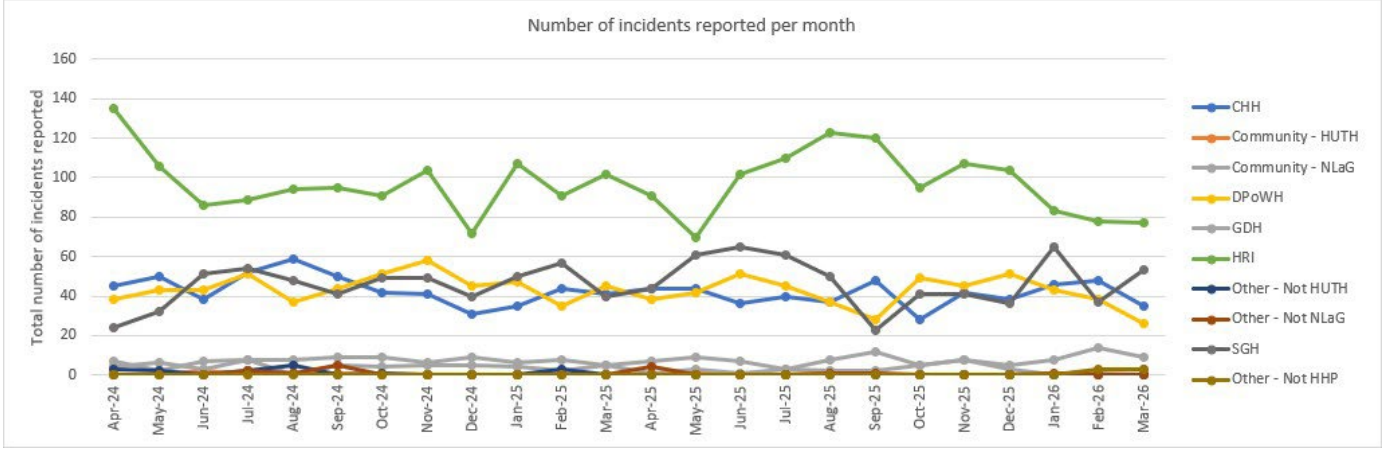
The group have a single Medication Safety Officer (MSO) from April 2025 and they engage in the regional and national MSO groups and share learning across the group. In 2025, the national patient safety alerts issued on https://www.cas.mhra.gov.uk. included nine alerts related to medicines and Pharmacy.

4.1. Medicines Incidents

The medicines safety team have worked to develop a joint medication safety dashboard for the group, bringing together data from Datix and Ulysees and sharing each month with the care groups. Medicine incident monthly reporting fluctuated in line with natural variation in 2025-26 although a downward trend of reported medication incident has been noted.

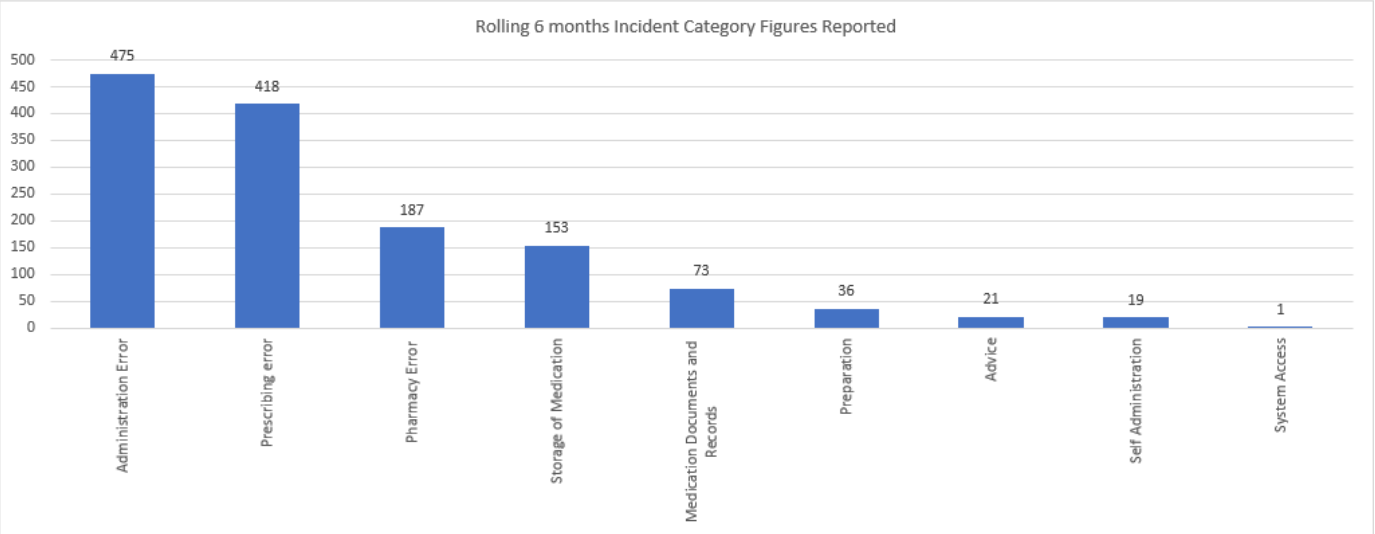


Reported Incident Figures

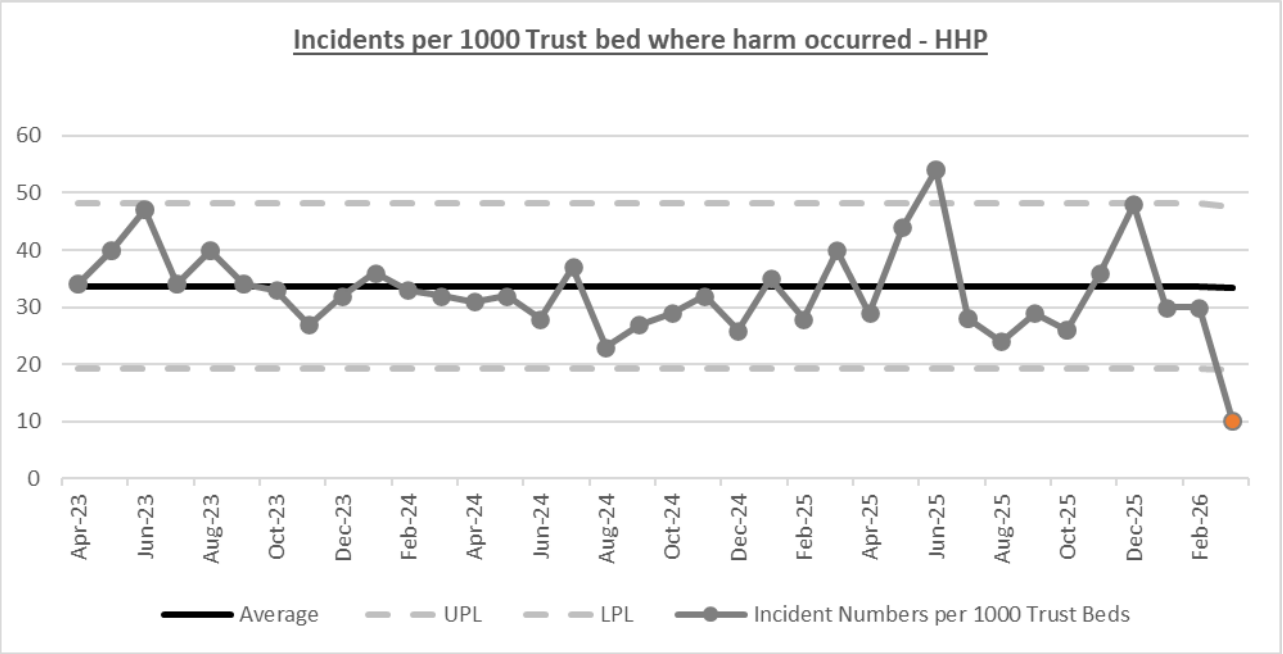


The top 3 categories of incident in HHP relate to administration, prescribing and pharmacy error.

Reported Incident Category Figures

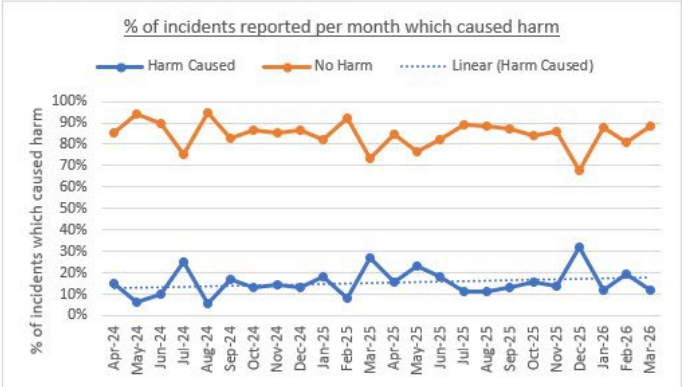


There were 2859 reported medication incidents across the HHP in 2025-26. The majority of reported incidents (99.27%) were near miss, no harm or low/minor. There were no patient deaths related to medication errors in 2025-26 and 1 medication related never events.



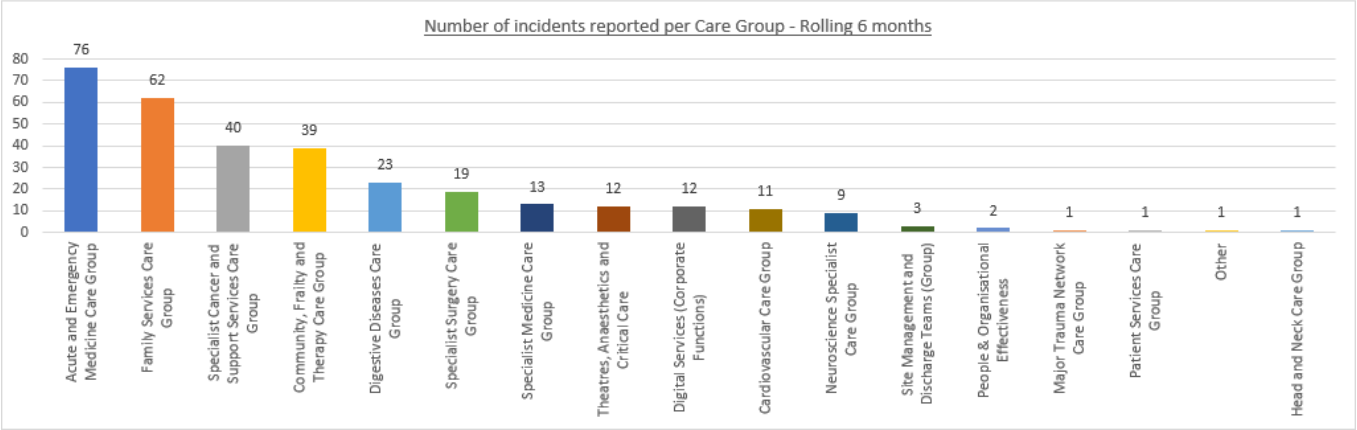
Total Reported

% Which Resulted In Harm For The Patient



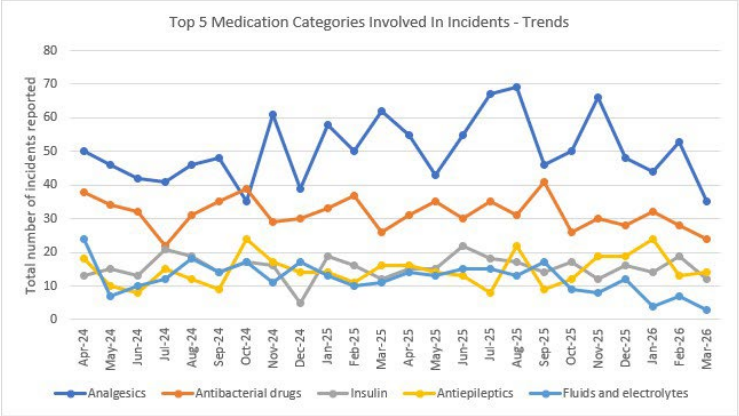
The most medication errors were reported in the Acute and Emergency Medicine care group, followed by Family Services and Specialist Cancer and Support Services care groups. Each care group receives a tailored medication error report each month to discuss at their governance meeting and the overall errors are analysed and reported at Safer Medication Group to identify themes, trends and learning within care groups and across the whole group.

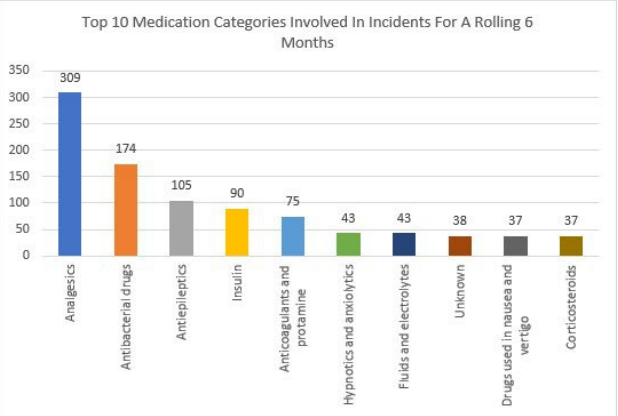
Total Reported Per Care Group



The top 3 medication categories for errors relate to analgesia, antibiotics and anti-epileptics as was the same in the previous year.

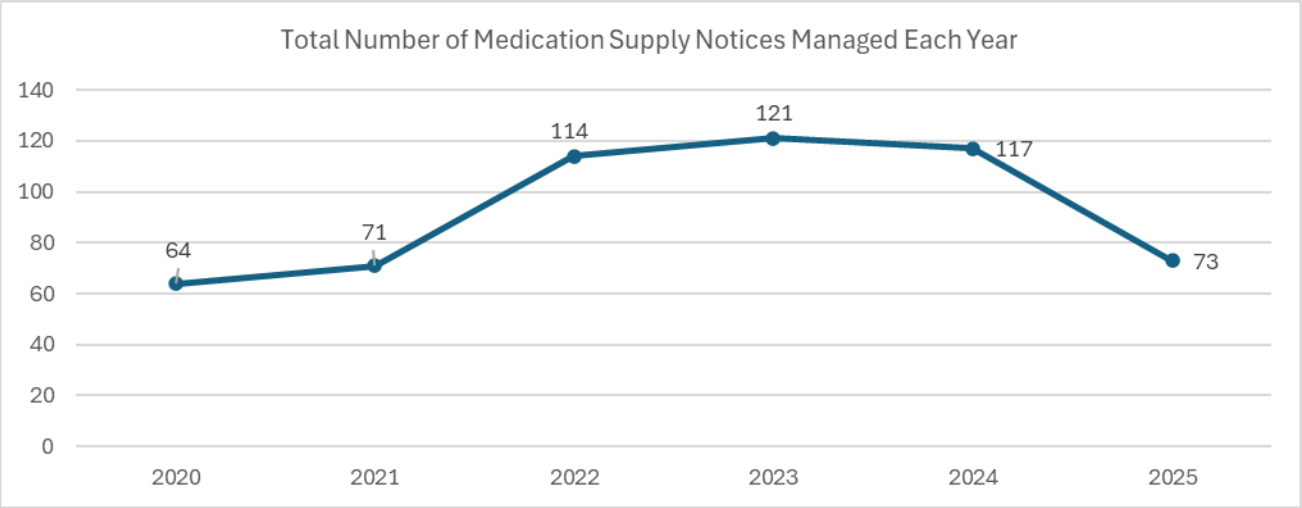
Medication Category





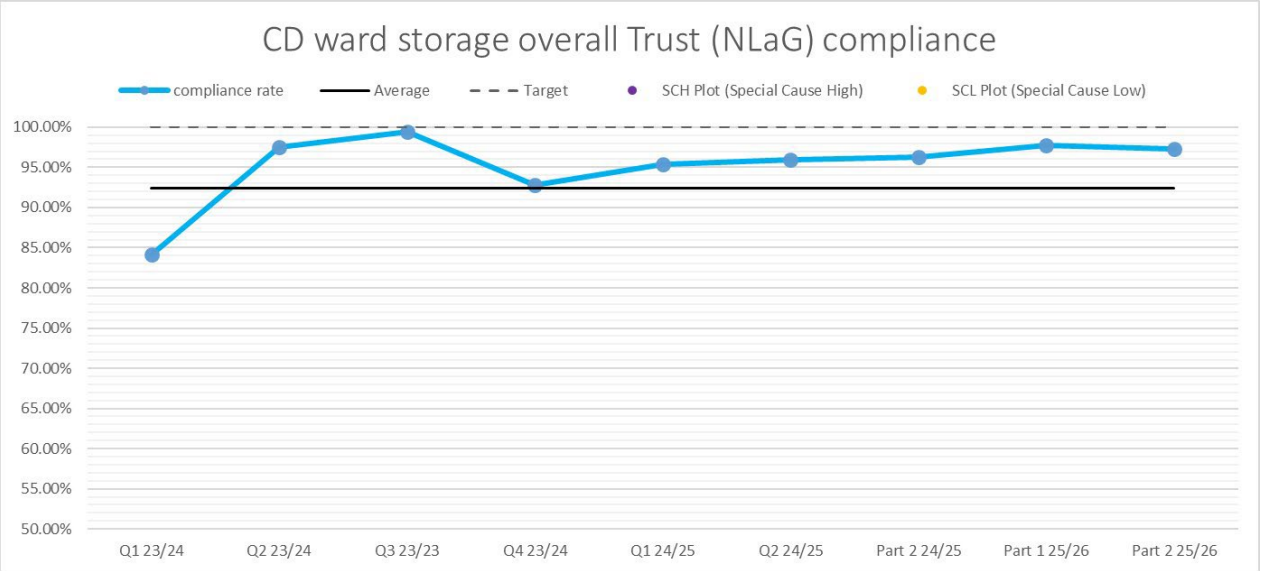
The Pharmacy teams at both HUTH and NLaG actively encourage reporting of incidents to maximise the opportunity for shared learning and improvement from near misses. The expectation is that as overall reporting increases, the proportion of incidents causing harm will decrease.

HUTH and NLaG are working collaboratively to manage national medication shortages across the group and minimise the impact on our patients. There were 73 medication shortages managed in 2025, a large decrease from the previous 3 years figures.



4.2. Controlled Drugs

All healthcare organisations are required to promote safe and secure use of controlled drugs and ensure compliance with relevant legislative and regulatory requirements. An audit is conducted at all sites across the group every six months with action plans implemented where necessary.



Pharmacy/CA/2025-26/02

Key: Adherence ⩾ 80% | Adherence 60% – 79% | Adherence ⩽ 59%

	Daily checks have been completed (missed no more than 5 times in 6 month period)	Weekly checks have been completed (missed no more than 5 times in 6 month period)	Page titles are fully complete with drug name.	Page titles are fully complete with drug strength.	Page titles are fully complete with ampoule/vial size.	Page titles are fully complete with drug form.	Page titles are fully complete with drug expiry date
2025/26	93%	88%	99%	100%	98%	100%	96%
2024/25	94%	93%	99%	99%	96%	99%	67%
2023/24	93%	93%	100%	97%	95%	97%	91%
2022/23	93%	84%	98%	98%	98%	97%	93%
2021/22	92%	79%	97%	95%	94%	97%	94%
2020/21	87%	80%	95%	97%	95%	98%	97%
2019/20	90%	80%	99%	100%	98%	96%	95%

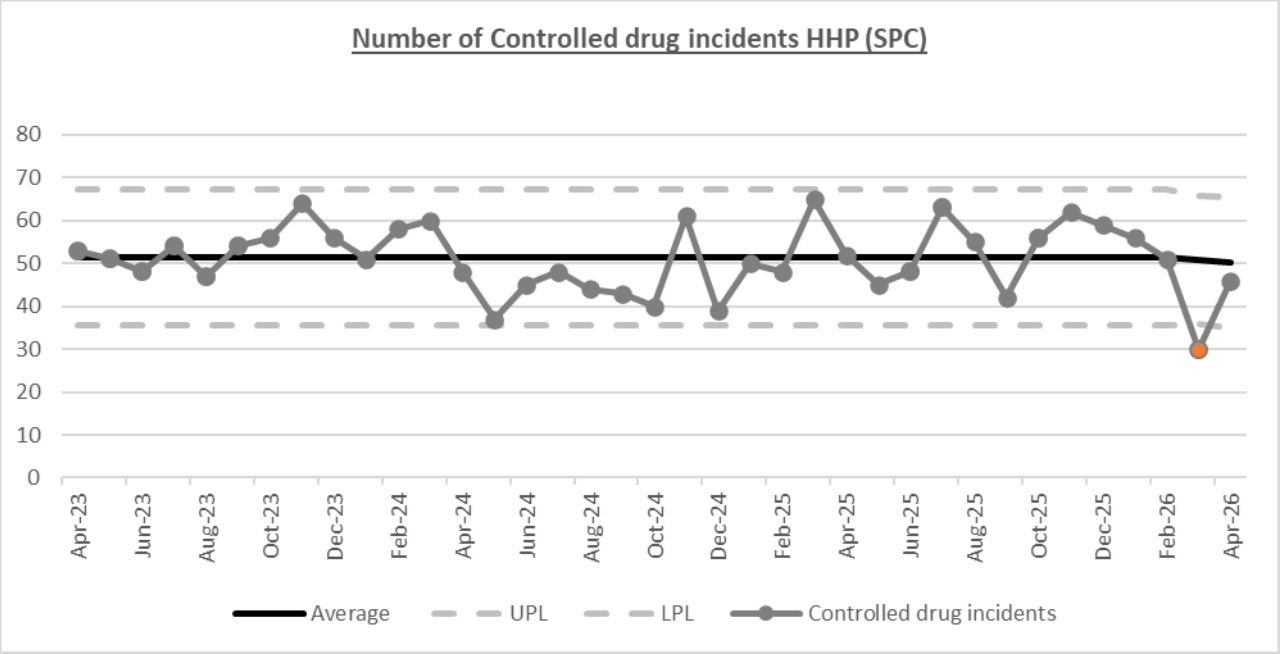
The Chief Pharmacist is the Accountable Officer for controlled drugs and attends and shares learning with the regional and national controlled drug intelligence networks. Quarterly occurrence reports of controlled drug incidents were submitted to NHS England Controlled Drug Accountable Officer (CDAO) in accordance with regulatory requirements.

Across the HHP there is a monthly Accountable Officer Controlled Drug meeting. Attendance at these meetings is from pharmacy, nursing and security colleagues and this group reports into the HHP Safer Medication Group.

In HUTH, in 2025-26 there were 333 controlled drug related incidents, an increase from 256 the previous year and 300 controlled drug related incidents were reported at NLAG. No incidents were rated moderate or above, with 89% no harm/near miss and 11% rated as low harm. Medication administration errors accounted for 26% errors, documentation errors 13%, prescribing errors 14% and dispensing errors 11%.

The controlled drug annual report and recommendations will be presented to SMG in June 2026.

Please see the annual Controlled Drug report for further information on controlled drug management at HUTH. This report will be aligned with NLaG and a joint HHP report prepared for the next annual report.

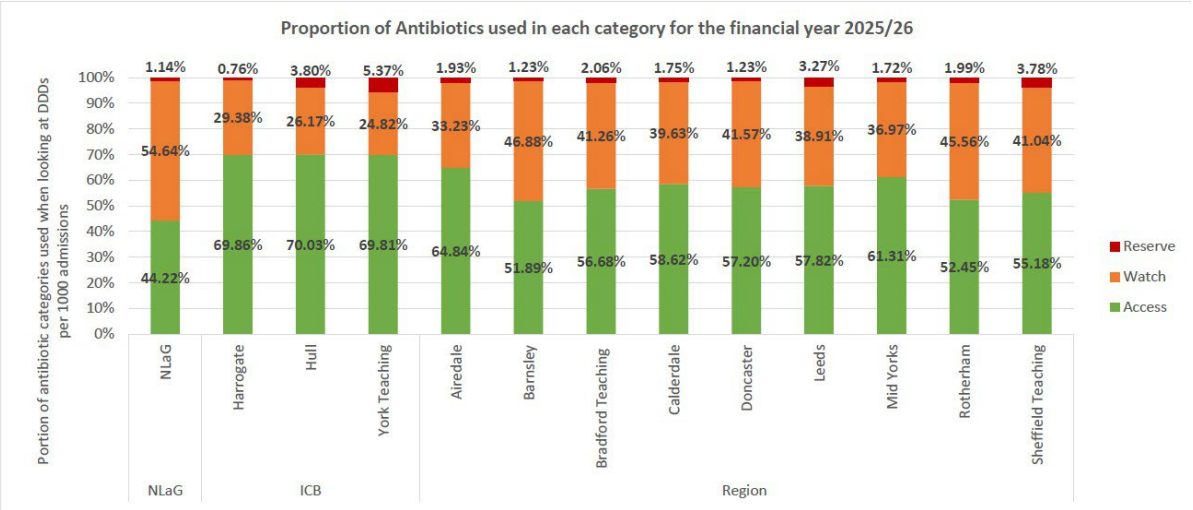


4.3. Antimicrobial Stewardship

The NHS National Contract for 26/27 aligns the antimicrobial usage targets with the National Action Plan 2024-29. The two main areas of focus are to increase the proportion of ACCESS agents to 70% and reduce overall antibiotic use by 5% (compared to the 2019 baseline). ACCESS agents are narrower spectrum agents or agents with a reduced likelihood for driving antibiotic resistance.

Over 25/26, the proportion of ACCESS agents used in HUTH was just over 70% (figure below). Broad spectrum antibiotic use in HUTH (WATCH and RESERVE agents) has reduced by 22.5%, compared to usage in 2019. Total antibiotic use, however, has increased relative to the baseline and at the end of 25/26, HUTH was using 2.5% more antibiotics than in 2019. This is largely due to a higher number of agents being used in HUTH for a particular infection in order to achieve the ACCESS target. For example, in intra-abdominal infections the 1st line regimen in HUTH is three ACCESS agents (as opposed to one WATCH agent). From an AMR point of view, increasing use of ACCESS agents reduces the drive for resistance but the consequence is an increase in the overall usage. HUTH is also a higher user of IV antibiotics within the region, partially due to the acute nature of the patients presenting but also partially due to the guideline choices to promote multiple ACCESS agents over a single WATCH/ RESERVE agent, with aim of conserving future treatment options.

Proportion of Antibiotics used within each Category - expressed through % usage - Regional Trust Comparison

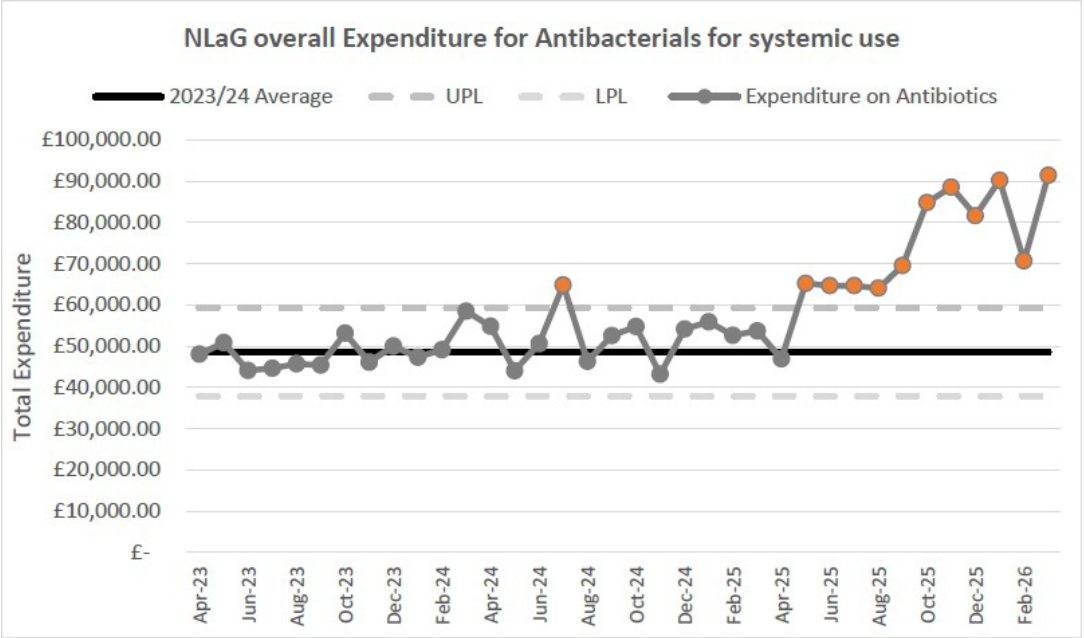


NLaG underperforms significantly against national AMS (Antimicrobial Stewardship) targets, ranking worst in Humber and North Yorkshire, showing as a high user of broad-spectrum antibiotics. It has failed to achieve its 5% reduction and failed to submit IVOS and blood culture pathway data in previous financial years. The UK Antimicrobial Resistance National Action Plan 2024/29 expects all Trusts to achieve 70% of antimicrobial use from the Access category by 2029. At the end of 2025/26 financial year, NLaG are at 44.22% and lowest Trust in the region (worst).

Due to the CPE (Carbapenemase Producing Enterobacterales) outbreak at NLaG, the focus of interventions was on Carbepenem prescribing, antimicrobial guidance review, the establishment of a pharmacy AMS team and engagement with clinicians. NLAG has failed to continue submitting IVOS data and blood culture pathway (BCP) data due to lack of resources. Overall performance from NHSE AMR data packs shows that NLAG is not performing well but is improving.

	Hospital antimicrobial stewardship assurance			UK AMR NAP 2024-29			NHS Standard Contract			UK AMR NAP 2024-29		National Medicines Optimisation Opportunities 2024-25		NHS Standard Contract	
Regio	ICB Region	Trust Code	Trust Name	Total AB (DDDs/1000adm) 2019-20 UKHSA	Total AB (DDDs/1000adm incl DC) 12mth	% difference in total AB vs 2019 (DDDs/1000adm incl DC) RX-info Target -5% by 2029	rolling 12mthvs baseline (DDD/1000adm) to Q2 25-	% differenc e in WaRe vs baseline (DDDs/1000ad	Trend WaRe vs 2019-20 baseline (DDDs/1000adm)	% Access (2025 list) Jul-25 RX-info) - Target 70%+ by 202	Trend	2024-25 % IV AB RX-info - NMOO to reduce in 2024-5	Trend since last q	% on IV AB meeting IVOS FY2526 (target <15%)	% on IV AB meeting IVOS - Q3 25-26 (target <15%)
Data Source				UKHSA reports to be published on Future NHS A				Future NHS AMR		Report - Define Reports		Report - Define Reports			
Data date				2019 baseline	to Q2 25-26	to Q2 25-26	Q3 2425 to Q2 2526	rolling 12mth to Q2 FY2526	Trend to Q2 FY2526	Dec-25	vs Jul-25	Dec-25	trend Jul-25	2025-26 YTD	Q3 2526
Target			target			-5%			decrease	70%+		lower is better		<15%	<15%
HNY	NHS HUMBER AND NORTH YORK	RWA	Hull University Teaching Hospitals NHS	4319	4262	-1.3%	1313	-23.4%	DECREASING	69.9%	0.4%	28%	0%	no submission	no submission
HNY	NHS HUMBER AND NORTH YORK	RCB	York and Scarborough Teaching Hospita	3647	3770	3.4%	1203	0.3%	INCREASING	69.2%	0.1%	24%	0%	no submission	no submission
HNY	NHS HUMBER AND NORTH YORK	RCD	Harrogate and District NHS Foundation	3621	4140	14.3%	1233	4.5%	INCREASING	70.1%	0.5%	17%	-1%	13%	10%
HNY	NHS HUMBER AND NORTH YORK	RJL	Northern Lincolnshire and Goole NHS F	4930	4595	-6.8%	2570	-9.4%	DECREASING	44.8%	0.6%	20%	0%	no submission	no submission

Delivering on the AMS agenda at NLAG has been challenged by the lack of staffing resources, leading to limitations to implement AMS activities, address the gaps in audit, data and education, and reduce the increased expenditure on antimicrobials due to the CPE outbreak, which resulted in more complex infections requiring expensive intravenous (IV) antimicrobials and increased length of stay. High usage of ciprofloxacin and increase in cost had a significant increase (October 2025) in total antimicrobial expenditure as per graph below.



SPC Trend Status	Statistically Increasing

The lack of early investment for an AMS team has not been financially beneficial to the Trust as the consequences of this has resulted in a CPE outbreak which the Trust was struggling to control. The NLAG team have just successfully recruited to an AMS advanced pharmacist and higher level pharmacy technician and out patient antimicrobial therapy (OPAT) advanced pharmacist and we will demonstrate the benefit of this investment going forwards.

Eolas is an app that clinical staff can access antimicrobial guidelines easily on their smartphone or laptop. This was implemented and widely promoted across NLaG and HUTH clinical teams.

Please find attached NLAG Antimicrobial Stewardship position summary report for the 2025/26 financial year for further information.

Antibiotic Stewardship Position

5. Pharmacy Workforce

Pharmacy recruitment and retention across the group has remained well below the 10% turnover target for the 2025-26 period. All vacant Band 6 pharmacist posts across the group have now been offered with some pharmacists now in post and other posts offered to current trainees who are due to start between July and September subject to professional registration.

The Trust continues to participate in the annual NHS Benchmarking Networks Pharmacy and Medicines Optimisation. The aim is to compare pharmacy services and medicines optimisation metrics with providers across the country. The 2025 results show that our pharmacy team establishments at both trusts are in the lower quartile for pharmacists when

compared to other organisations. Our pharmacy staff survey results show that our team members are struggling with their workload and wellbeing.

WTE per 100 beds

	median	HUTH	NLaG
Pharmacists	8.3	6.6	6.9
Pharmacy Technicians	7.4	6.7	6.7
Pharmacy Assistant	4.7	5.6	5.7

Our establishment for the pharmacy team does not support the current workload expected and we are often working at priority (reduced service level) across the group. Over recent years we have implemented services on the promise of funding which has not been forthcoming, and we cannot continue to cover all areas to the level requested without additional resource. Digital solutions do not always support our team fully and access to data to support our work is difficult. Whilst NLaG benefit from some efficiencies such as the newer stores robot and closed loop dispensing, further work is required to ensure the pharmacy service is right sized for the organisation.

The GPhC launched the Chief Pharmacist standards in January 2025. The standards were developed following new legislation which removes the threat of criminal sanctions for inadvertent preparation and dispensing errors by pharmacy staff working in hospitals and similar settings. These defences already apply to pharmacy staff working in registered pharmacies. This will provide consistency across the sector and encourage the reporting of incidents and subsequently learning from errors.

To benefit from the defences, the hospital must have a Chief Pharmacist or equivalent in post, who must be a registered pharmacist with the appropriate skills, training, and experience; and who must meet the standards for Chief Pharmacists.

HHP pharmacy team have three consultant pharmacist posts and the postholders are currently undergoing the credentialling process with the Royal Pharmaceutical Society. They will support our patients and teams in their clinical, teaching and research roles within their specialities.

The pharmacy profession continues to innovate and transform to help meet the challenges the NHS faces. In January 2021, the General Pharmaceutical Council (GPhC) published the revised Standards for the Initial Education and Training of Pharmacists. These new learning outcomes enable pharmacists to be independent prescribers at the point of registration from 2026. In order to respond to this change we increased the number of undergraduate placements we offer so undergraduate trainees can develop the necessary skills and confidence to provide clinical services expected by patients and the NHS. We have increased the number Designated Prescribing Practitioners to support Foundation Trainee Pharmacists across our region to achieve professional registration.

Alongside this we need to invest in the training of our Pharmacy Technicians who will need to take on additional clinical roles, as well as training our Pharmacy Support Workers so they can provide ward based technical support to improve the way medicines are managed. This

transformation of the pharmacy workforce can release nursing and clinician time by improving the multidisciplinary skill mix for patient care and support the ethos that each profession should be focussed on the aspects of care only they can deliver.

6. Summary

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

Key achievements:

- Medication safety dashboard for the group working well and shared through care groups
- Single system Area Prescribing Committee and single formulary approach in place
- Trainee pharmacist programme means new pharmacists will now qualify as independent prescribers
- Retention and development of the pharmacy team across the group improved
- Commitment to new ePR/ ePMA for HHP
- Development of the ideal ward standard for medicines management
- Biosimilar switches made as medicines become available
- New policy for management of unaccounted loss of controlled drugs
- Groupwide task and finish groups for Insulin safety, intravenous to oral switch of medicines and discharge medication ongoing

Key areas of concern:

- Lorenzo ePMA concerns around product alert notices, reporting functionality and integration with other systems at HUTH
- Antimicrobial usage at NLaG
- Insulin never event at NLaG
- Controlled drug incidents – unaccounted losses
- Medicines reconciliation rates across the partnership

Key plans for next year

- Support the quality priority to improve insulin safety across HHP
- Orbis U ePMA roll out across HHP
- Nitrous oxide pipeline decommissioning at NLaG
- Review pharmacy services across the group and consolidate where appropriate. Explore the option of a single procurement, store, aseptic unit, clinical trials and medicines information service for the group based at Castle Hill site.
- Share learning on successful antimicrobial strategies to ensure appropriate prescribing and use at NLaG
- Review safe storage of medicines across the group and explore the use of automated cabinets and electronic keys
- Continue to review and standardise medication related policies across the group

Recommendation to the Board

This report is presented for the Board's assurance and approval.

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)207

Name of Meeting	**Trust Boards-in-Common (meeting held in Public)**
Date of the Meeting	10 September 2026
Director Lead	Dr Peter Sedman, Deputy Medical Officer
Contact Officer / Author	Dr Harish Lad, Clinical Lead for Organ Donation
Title of Report	**Organ Donation Annual Report – for Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)**
Executive Summary	The purpose of this report is to explain how HUTH and NLaG have contributed to UK's deceased donation programme. HUTH & NLaG each have organ donation programmes which are well established and supported by the NHS Blood and Transplant (NHSBT). Levels of organ donation vary from year to year but each side are broadly in line with expectations. **Alert** The paper details the current performance of the local organ donation team and their awareness, activities and advice to Board. **Assure** The UK Organ Donation Service has an agreement in place that requires the Trust to support and promote organ donation practices across appropriate clinical areas. **Advise** This report is to advise the Committees-in-Common as to current practice against last year. **Recommendations** N/A
Background Information and/or Supporting Document(s) (if applicable)	Copy of data attached
Prior Approval Process	Quality & Safety Committees-in-Common meeting held on 23 July 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:

Organ Donation

HUTH / NLaG Organ Donation

April 2025– March 2026

NHS
Hull University Teaching Hospitals
NHS Trust

Level 1 Centre

> 12 Donors per year

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Level 3 Centre

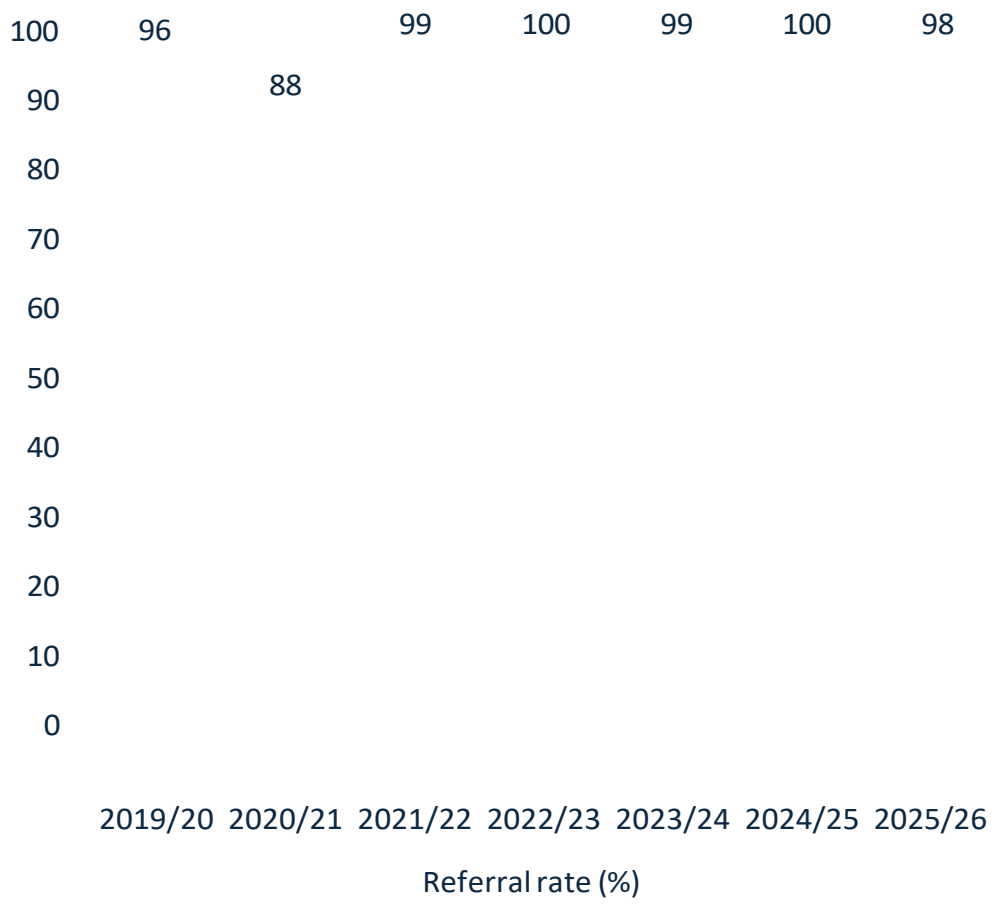
> 3 but < 6 donors per year

NHSBT Goals

Every patient who meets referral criteria should be referred to Organ donation service

A Specialist Nurse should be present during formal approach for organ donation

HUTH Referral rate (%)

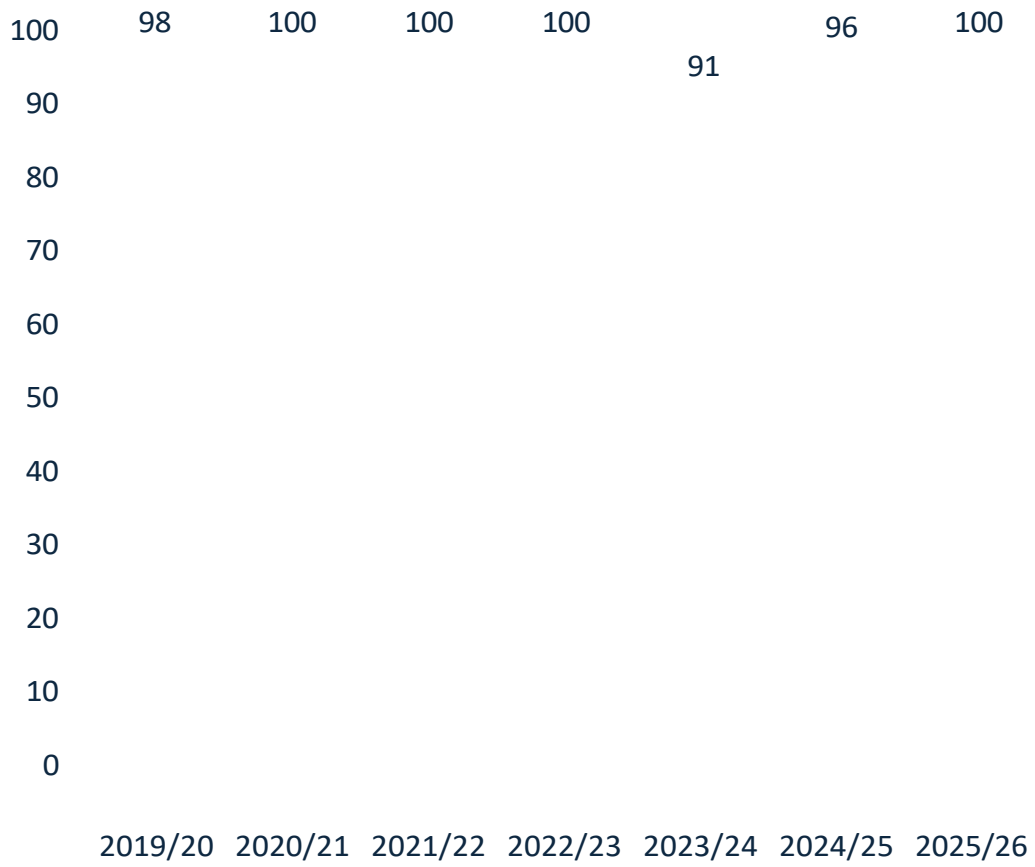


NLaG Referral rate (%)

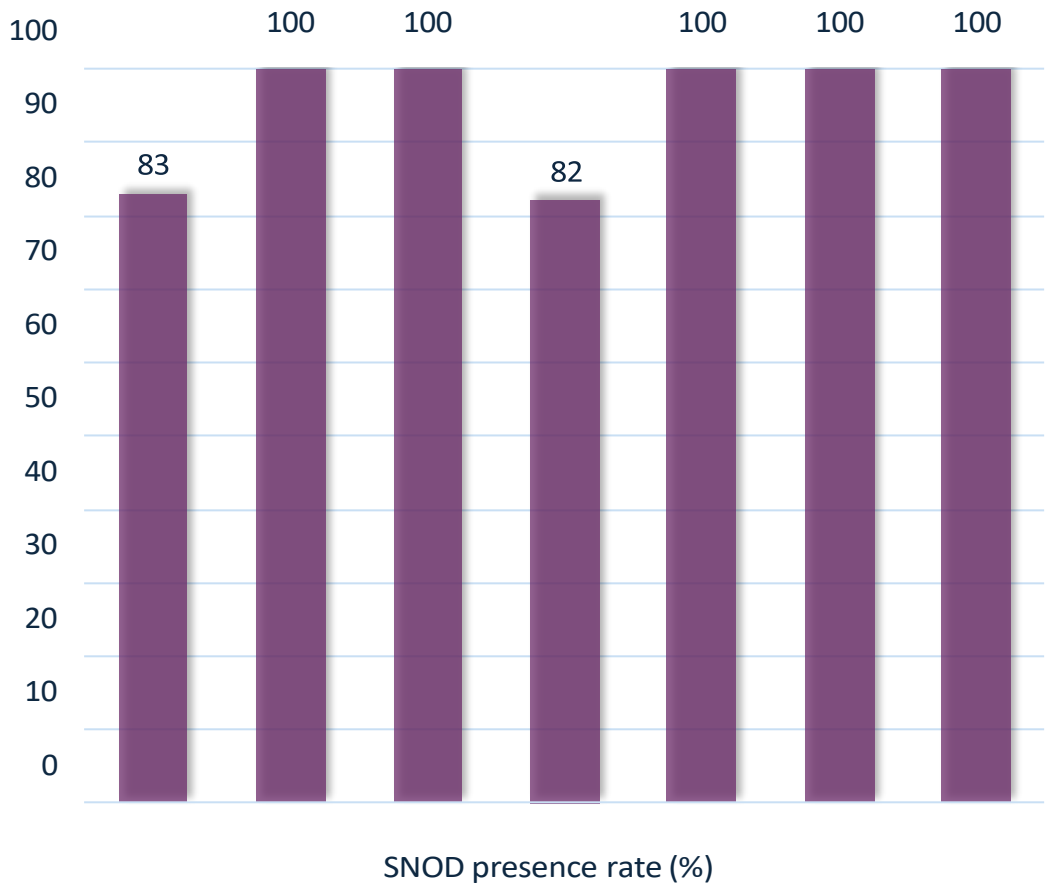
National referral rate 25/26 – 95%

Specialist Nurse in Organ Donation(SNOD)

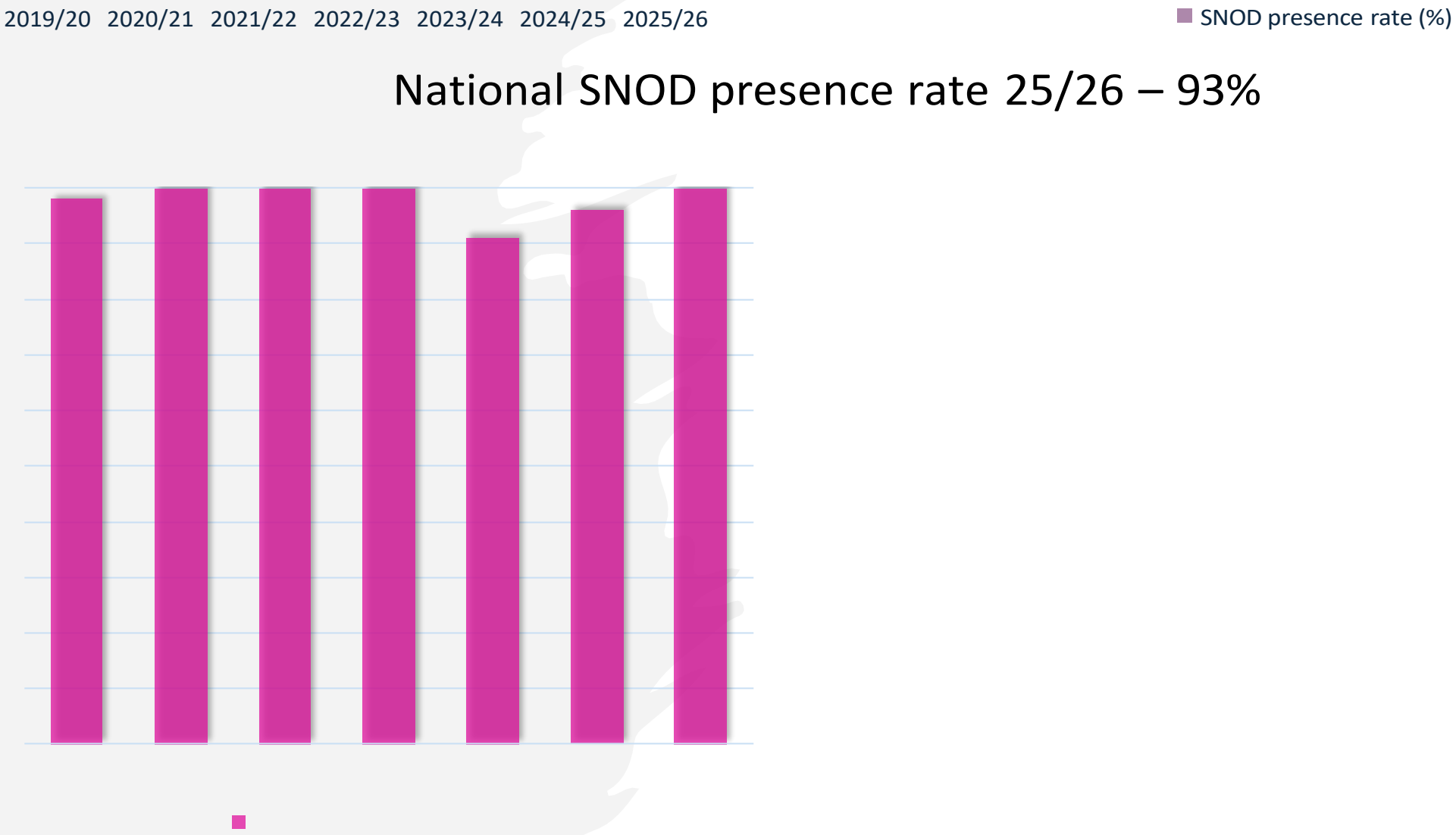
HUTH SNOD presence rate (%)



NLaG SNOD presence rate (%)



National SNOD presence rate 25/26 – 93%

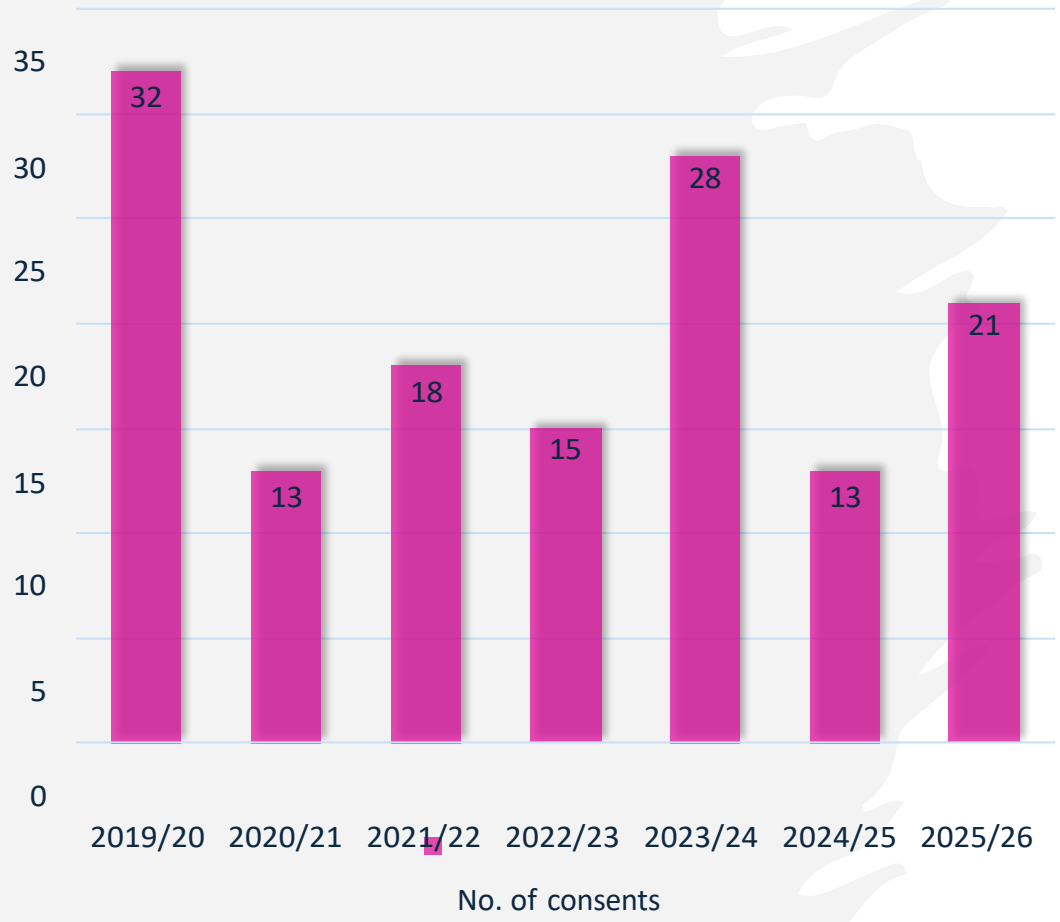


SNOD presence for organ donation decision – consent rate (%)

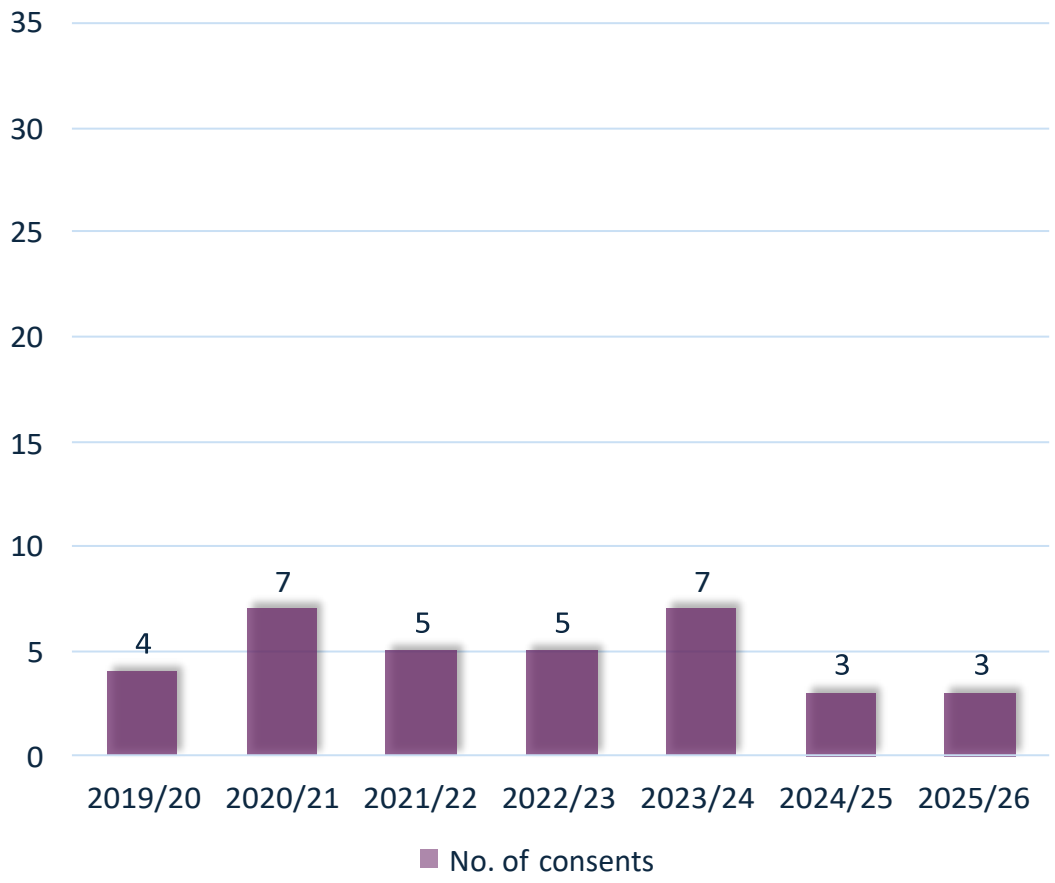
- Consent rate with <u>SNOD NOT present</u> 22%
- Consent rate with <u>SNOD present</u> 65%

NHSBT PDA data 2022-23

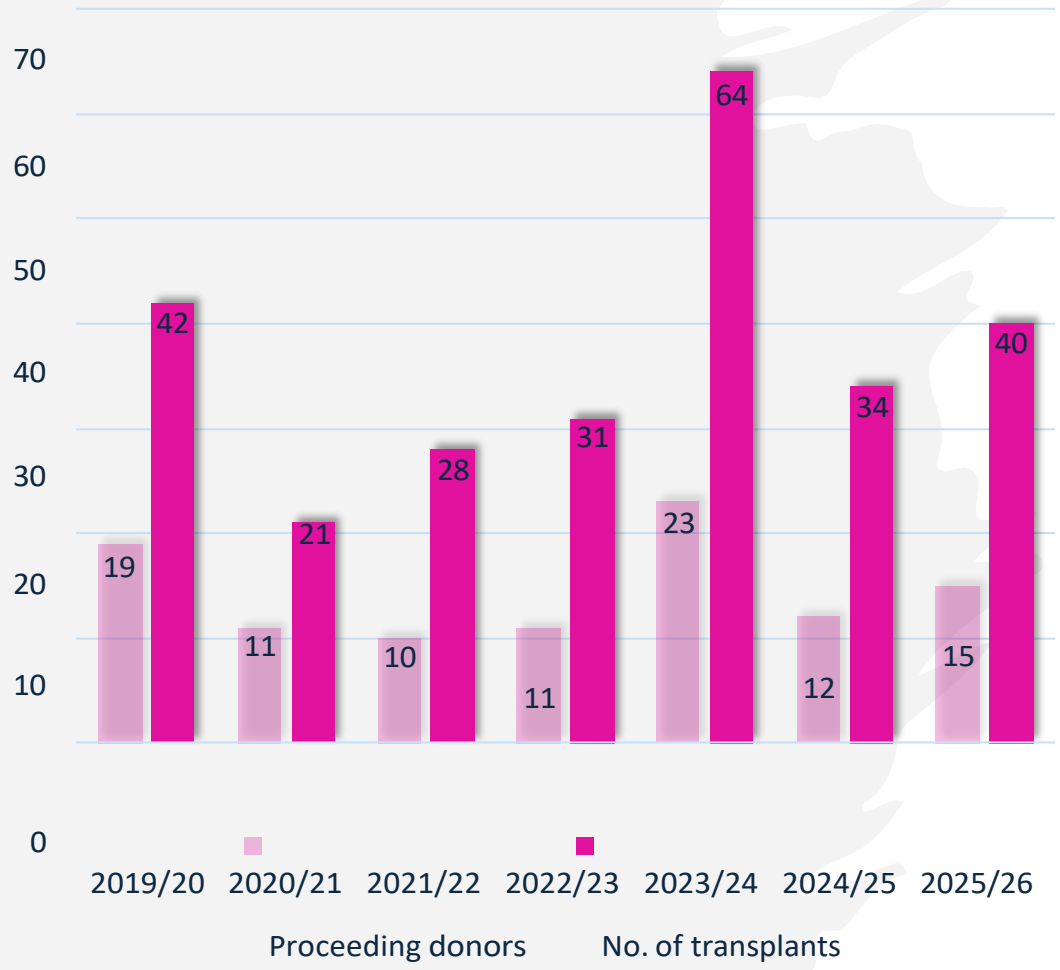
HUTH – No. of consents for donation



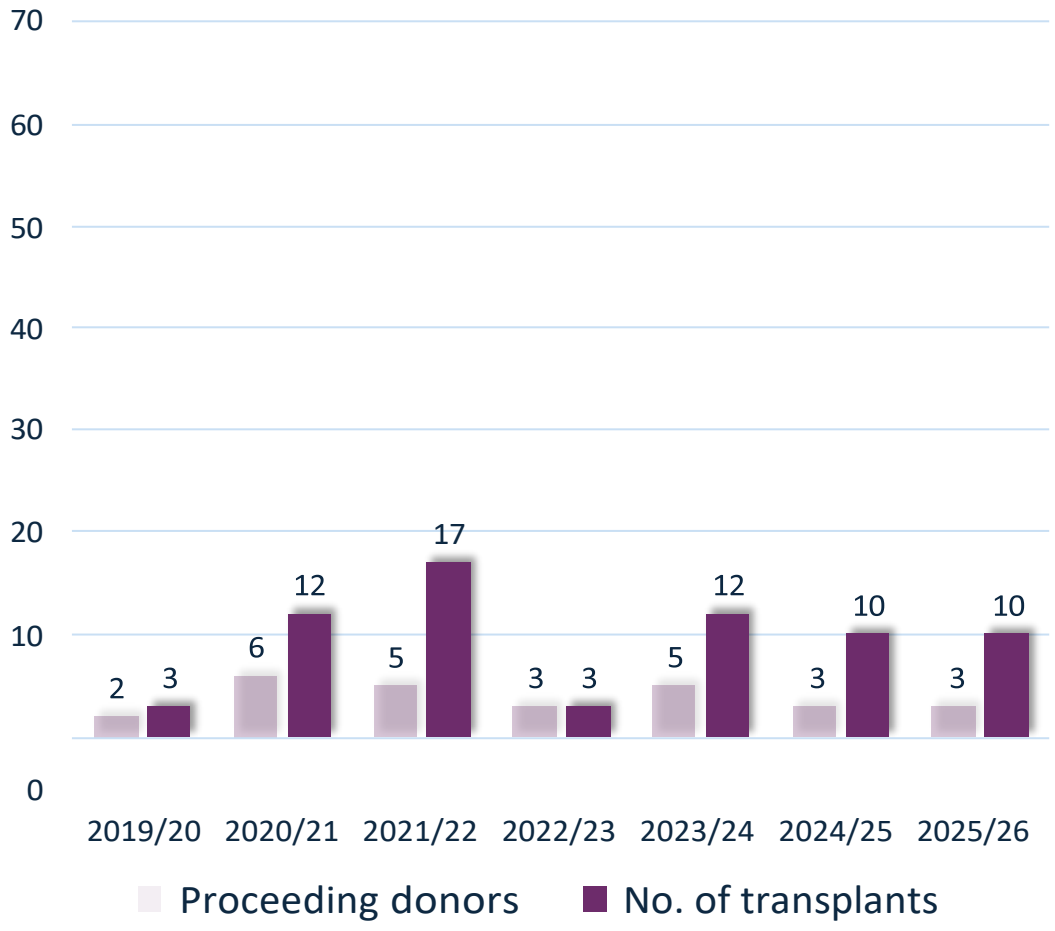
NLaG – No. of consents for donation



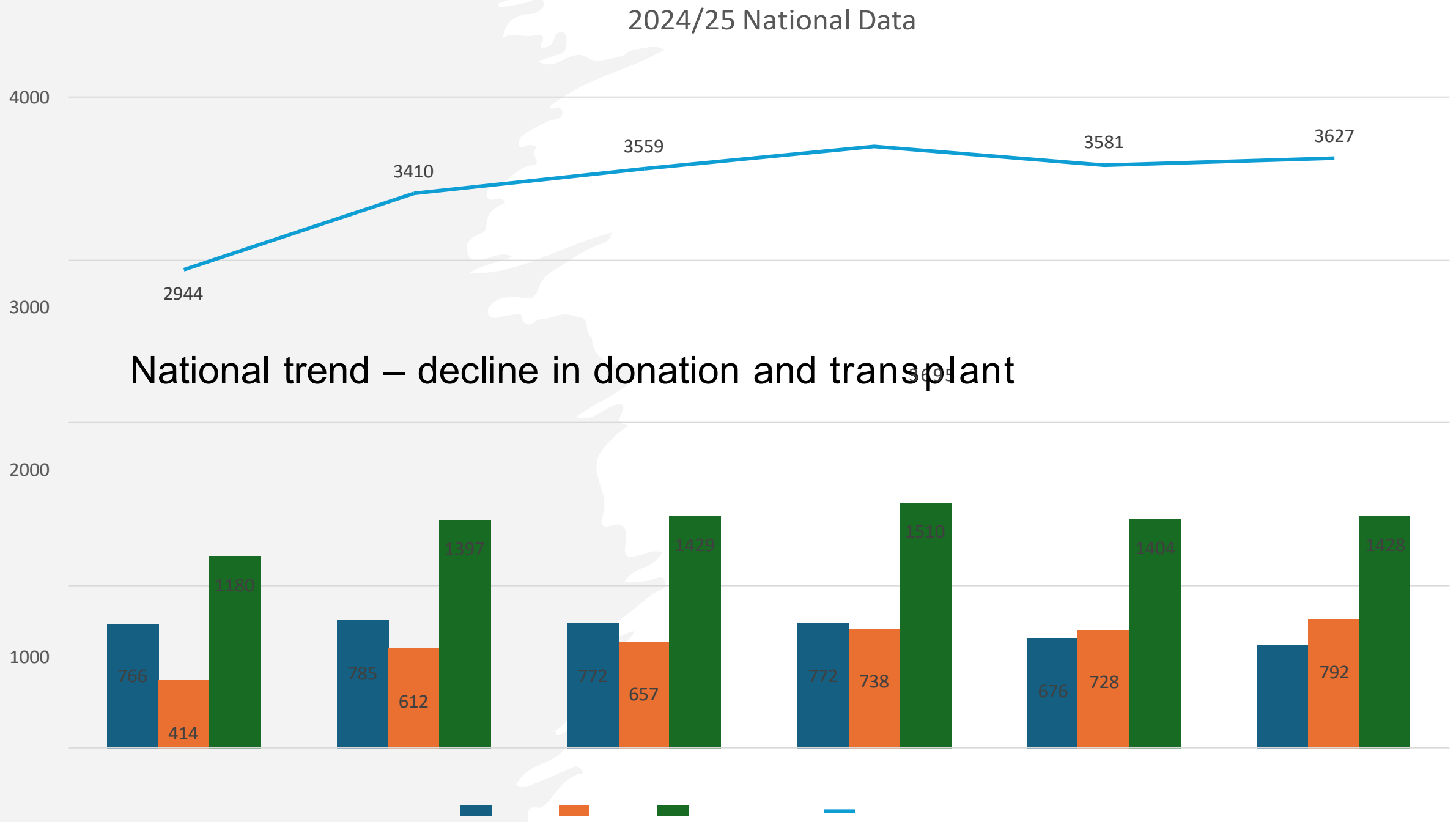
HUTH – Proceeding donors and transplants



NLaG – Proceeding donors and transplants



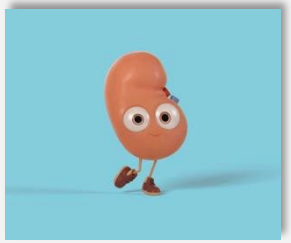
National trend – decline in donation and transplant



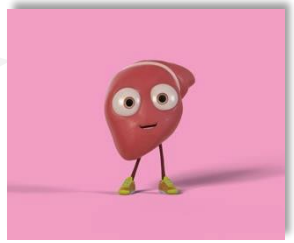
0

2020/21 2021/22 2022/23 2023/24 2024/25 2025/26

DBD DCD Total Donors Organ transplants

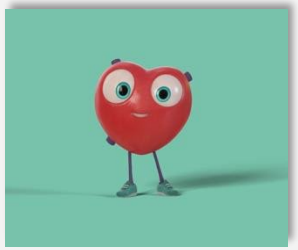


Kidneys		
	24/5	25/6
HUTH	22	24
NLaG	6	6
Total	28	30



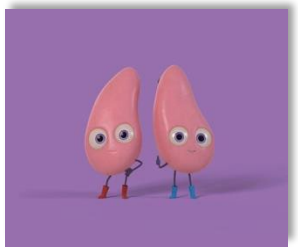
Liver		
	24/5	25/6
HUTH	8	6
NLaG	3	3
Total	11	9

Small Bowel		
	24/5	25/6
HUTH	0	0
NLaG	0	0
Total	0	0



Heart		
	24/5	25/6
HUTH	3	5
NLaG	0	1
Total	3	6

Pancreas		
	24/5	25/6
HUTH	3	1
NLaG	0	1
Total	3	2



Lungs		
	24/5	25/6
HUTH	0	4
NLaG	2	0
Total	2	4

Successes

- **Promotion**

- Organ Donation Awareness Week
- Hull City Council pink
- Staff and public engagement
- Stand in HRI foyer and DPOW canteen
- Hindu religious event in Cottingham – Oct 25
- Presentation at temple in Bradford – 100 people
- Ultra marathon in honour of donor families

Successes

- **Education**
  - Virtual regional nurse study day
  - Traumatic Brain Injury study day – Neurosurgery nurses
  - Theatre teaching sessions
  - ODP annual teaching
  - ICU nurse training
  - Hull University - Nursing, Physio, Paediatric, Mental Health students
  - Palliative Care meetings
  - ED meeting

The Future

- **Education**

- Tissue Promotion
- YODELS course – Organ Donation Simulation Course
  - Observe 14/7/25
  - 1st session 09/07/2026
- Nursing and physio students Hull University
- Foundation in Critical care training
- ACCP DCD raining September 2026

The Future

- Community involvement/promotion
  - Rangoli radio show interview – May 2026
  - Potential talks at temples around the UK
- Collaboration with Malta to assist in setting up DCD organ donation

Organ Donation

Thank You

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)208

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	10 September 2026
Director Lead	**Emma Sayner, Group Chief Financial Officer**
Contact Officer / Author	**Philippa Russell, Group Deputy Director of Finance** **Brian Shipley, Operational Director of Finance**
Title of Report	**Finance Report – Month 4**
Executive Summary	This report highlights the reported financial position for July 2026
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	Presented at Performance, Estates & Finance Comittees-in-Common 1 September 2026
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓Information ☐ Assurance ☐ Other – please detail below:

V2

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committees-in-Common Front Sheet

Agenda Item No: CIC(26)4.7

Name of Meeting	**Performance, Estates & Finance Committees-in-Common**
Date of the Meeting	**1 September 2026**
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Philippa Russell, Group Deputy Director of Finance Brian Shipley, Operational Director of Finance
Title of Report	**Group Finance Report Month 4**
Executive Summary	The purpose of this report is to highlight the reported financial position for July 2026. Also attached is a highlight report from the August Cash Committee meeting. **Alert** • The Group reported a year-to-date deficit of (£41.8m), (£13.3m) adverse to plan. This position includes (£1.5m) of expenditure relating to Industrial Action cover which will have to be mitigated internally. • Whilst the Group is formally forecasting a plan compliant position, the forecast includes an unidentified and unmitigated gap of (£36.0m) and this is currently assessed to be the best-case scenario. Mid-case forecast is currently assessed to be a (£116.8m) deficit, a (£53.8m) adverse variance to plan. • Year to date adverse variance and slippage on identification of CIP is adversely impacting the cash forecast. For H1 (Apr- Sep) the Group has requested Revenue Support PDC of £57.8m, which is £26.92m higher than planned for H1 and will have to be recovered in H2. • Based on the mid-case forecast, Revenue Support PDC requirement for Q3 is assessed as follows:

Revenue Support PDC	Q3 (£m)	Q1-3 (£m)
HUTH	18.7	54.0
NLAG	10.9	21.5
Total	29.6	75.5

	Q3 value assumes that September request is approved in full, if it is not the Q3 value may need to increase to compensate. Actual cash requirements will be reassessed every month and will be managed within the Q1-3 envelope shown above. • August cash allocation was lower than requested and this is impacting on the Group's ability to pay suppliers promptly. NHS England finance colleagues have indicated that plan plus any further adverse variance in Creditor values would be considered for funding, and cash forecasts continue to come under significant scrutiny. **Assure** Financial Recovery Plan progress: - Agreed a targeted 30% / £30m reduction in variable pay with associated Care Group targets – the majority of Care Groups have developed plans to achieve this target, but further work required to deliver with c. 10% reduction YTD. - Weekly monitoring of variable pay where data is available - shared weekly with Care Groups. - Introduced vacancy pause – implemented 6th July. - Approved expansion of Locum's Nest digital solution which will facilitate electronic approval for variable pay including Extra Contractual Payments – implemented 1st July 2026 - Full escalation process is to be agreed: Recovery Action Plan's escalated to Performance & Finance Committee for the Care Groups' of greatest concern (see attached report). - At this stage plans to reduce headcount are the least developed but remains a key area of focus and scrutiny. Business Case in-development for Voluntary Redundancy programme. - Finance training to be included in LISA programme being developed to support operational managers. - Enhanced communications strategy to support ownership of the finance agenda. - Alignment with clinical priorities through the Integrated Recovery Plan – action plans signed off 30th June 2026. - Strengthened CIP development & support delivery - Appointment of Grant Thornton & Keith Pringle - Financial Improvement Director. Grant Thornton are directly supporting the 8 most challenged Care Groups to deliver their CIP and financial plans. -

	Advise • Request for external cash support for both HUTH and NLAG for September is pending approval. • Underlying deficit position of £127.0m. • Awaiting response to request to reprofile Capital Tower Block expenditure across 2 year programme. • Capital expenditure behind plan at Month 4 with delays in progressing HRI SDEC and Tower Block schemes and the ITU at DPOW. **Recommendations** The Committee is asked to approve the overall Quarter 3 Revenue Support PDC cash requirement of £29.6m, (£75.5m Q1-3 cumulative).
Background Information and/or Supporting Document(s) (if applicable)	**Attached:** M4 Finance Report Cash Committee Highlight Report
Prior Approval Process	Not applicable
Financial Implication(s) (if applicable)	As detailed in the report
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**-**
Recommended action(s) required	✓ Approval by CiC ☐ Information ☐ Endorse for approval by Trust Board(s) ✓ Assurance ☐ Other – please detail below:

BAF to which the paper relates:	**Tick all those appropriate**
Our Patients - Access	☐
Our Patients - Safety	☐
Our People	☐
Our Partnerships	☐
Our Pioneers	☐
Our Public Purse	✓

NHS
Humber Health
Partnership

Finance Report Month 4
July – 2026/27

Finance Overview

In-month I&E Performance – page 3 to 8

(£3.1m)

The Group reported an in-month deficit for month 4 of (£8.9m), (£3.1m) adverse to plan.

Year to Date I&E Performance – page 3 to 8

(£13.3m)

The Group reported a year-to-date deficit of (£41.8m), (£13.3m) adverse to plan. The position includes (£1.5m) of expenditure relating to Industrial Action cover.

I&E Forecast Outturn & Risk – page 9 to 11

(£36.0m)

The Group is formally forecasting a plan compliant position. However, an adjusted straight-line projection would give a deficit of (£139.6m). Mitigating actions reduce the deficit leaving an unidentified gap of (£36.0m).

YTD Cost Improvement Plan – page 12 to 13

(£18.7m)

The Group has delivered £13.5m in CIP against a YTD target of £32.2m, (£18.7m) behind target.
The Group are forecasting CIP delivery of £79.3m, (£39.8m) adverse to plan.

Underlying I&E – page 14

(£127.0m)

The Group's underlying position is estimated at a deficit of circa (£127.0m). In year recurrent CIP delivery will be the key driver of its underlying financial position.

System Performance – page 15

(£25.8m)

The ICS reported a YTD deficit of (£68.8m), (£25.8m) adverse to plan at month 4. The ICS is forecasting a (£100.9m) deficit for the year in line with plan.

Capital Expenditure – page 16

(£7.4m)

The Group has spent £8.1m on capital expenditure against a plan of £15.6m, (£7.4m) behind plan.

Balance Sheet & Cash – pages 17 to 18

£47.4m

The Group's cash balance at the end of month 4 was £47.4m. The Group continues to require additional external cash support. At the end of month 4 the Group has drawn down £14.9m in cash support.

Variable Pay – pages 19 to 25

£4.0m

The Group has spent £32.1m on variable pay, £4.0m less than the same period in 2025/26. This includes (£1.9m) of gross IA expenditure. Variable pay remains significantly behind the 30% Target reduction.

Key Risks

- High value of unidentified CIP and high-risk CIP opportunities.
- Variable Income Risk - CDC under-performance claw back.
- Inflation above Tariff assumptions.
- Further Industrial Action.
- Slippage on Capital Expenditure profile
- Requirement for additional Revenue Cash Support.

Key Actions

- Reducing cost pressures: reliance on premium variable pay; minimising escalation beds; and greater control of non-pay expenditure.
- Maximising planned care activity within core capacity, reducing reliance on Independent Sector (IS) and Waiting List Initiative (WLI) premium costs.
- Delivering a challenging CIP programme – conversion of non-recurrent savings into recurrent delivery schemes and identifying additional schemes to close the gap to target.

Financial Performance Summary

The Group ended month 4 with a year-to-date (YTD) deficit of (£41.8m), (£13.3m) 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	76.4	78.1	1.8	303.1	305.5	2.4	47.2	46.9	(0.3)	187.8	186.4	(1.4)	123.6	125.0	1.4	490.9	491.9	1.0
Other Income	6.2	6.1	(0.1)	24.5	24.5	(0.0)	4.5	4.9	0.4	18.0	18.8	0.8	10.7	11.0	0.3	42.5	43.3	0.8
Total Operating Income	**82.5**	**84.2**	**1.7**	**327.6**	**330.0**	**2.4**	**51.7**	**51.8**	**0.1**	**205.8**	**205.2**	**(0.6)**	**134.3**	**136.0**	**1.7**	**533.4**	**535.2**	**1.8**
Pay Costs																		
Clinical Pay	(41.2)	(42.6)	(1.3)	(166.5)	(170.6)	(4.1)	(30.1)	(29.1)	1.0	(119.4)	(117.6)	1.8	(71.3)	(71.7)	(0.4)	(286.0)	(288.2)	(2.3)
Other Pay	(8.8)	(8.7)	0.2	(35.0)	(34.7)	0.3	(7.2)	(7.3)	(0.1)	(29.0)	(29.2)	(0.2)	(16.0)	(16.0)	0.1	(64.0)	(63.8)	0.1
Total Pay Costs	**(50.1)**	**(51.2)**	**(1.2)**	**(201.5)**	**(205.3)**	**(3.8)**	**(37.3)**	**(36.4)**	**0.9**	**(148.4)**	**(146.8)**	**1.6**	**(87.3)**	**(87.6)**	**(0.3)**	**(349.9)**	**(352.1)**	**(2.1)**
Clinical Non Pay	(19.6)	(21.8)	(2.2)	(79.7)	(84.2)	(4.5)	(8.3)	(8.3)	(0.0)	(32.6)	(33.6)	(1.0)	(27.9)	(30.1)	(2.2)	(112.3)	(117.8)	(5.6)
Other Non Pay	(11.8)	(13.3)	(1.5)	(47.9)	(53.3)	(5.4)	(5.8)	(7.2)	(1.4)	(23.5)	(27.6)	(4.1)	(17.6)	(20.5)	(2.9)	(71.4)	(80.9)	(9.5)
Total Non Pay Costs	**(31.4)**	**(35.1)**	**(3.6)**	**(127.6)**	**(137.5)**	**(9.9)**	**(14.2)**	**(15.6)**	**(1.4)**	**(56.1)**	**(61.2)**	**(5.1)**	**(45.6)**	**(50.6)**	**(5.1)**	**(183.7)**	**(198.7)**	**(15.0)**
Total Operating Expenditure	**(81.5)**	**(86.3)**	**(4.8)**	**(329.1)**	**(342.8)**	**(13.7)**	**(51.4)**	**(52.0)**	**(0.6)**	**(204.5)**	**(208.0)**	**(3.5)**	**(132.9)**	**(138.3)**	**(5.4)**	**(533.6)**	**(550.8)**	**(17.2)**
EBITDA	**1.0**	**(2.1)**	**(3.2)**	**(1.5)**	**(12.8)**	**(11.3)**	**0.3**	**(0.2)**	**(0.5)**	**1.3**	**(2.8)**	**(4.1)**	**1.4**	**(2.3)**	**(3.7)**	**(0.2)**	**(15.6)**	**(15.4)**
Depreciation	(2.7)	(2.7)	0.0	(10.8)	(10.6)	0.1	(2.3)	(1.8)	0.5	(9.4)	(7.2)	2.1	(5.0)	(4.5)	0.5	(20.1)	(17.9)	2.2
Non Operating Items	(1.6)	(1.5)	0.0	(6.1)	(6.2)	(0.0)	(0.7)	(0.6)	0.1	(2.7)	(2.3)	0.4	(2.3)	(2.2)	0.1	(8.8)	(8.5)	0.4
Surplus/(Deficit)	**(3.2)**	**(6.3)**	**(3.1)**	**(18.4)**	**(29.6)**	**(11.2)**	**(2.7)**	**(2.6)**	**0.1**	**(10.7)**	**(12.3)**	**(1.5)**	**(5.9)**	**(8.9)**	**(3.0)**	**(29.2)**	**(41.9)**	**(12.8)**
NHSE Allowable Adjustments	0.0	(0.0)	(0.0)	0.0	(0.2)	(0.2)	0.2	0.1	(0.1)	0.6	0.3	(0.3)	0.2	0.1	(0.1)	0.6	0.1	(0.5)
Adjusted Surplus / (Deficit)	**(3.2)**	**(6.3)**	**(3.1)**	**(18.4)**	**(29.9)**	**(11.4)**	**(2.5)**	**(2.5)**	**0.0**	**(10.1)**	**(12.0)**	**(1.9)**	**(5.8)**	**(8.9)**	**(3.1)**	**(28.5)**	**(41.8)**	**(13.3)**

- **The Group reported a (£8.9m) deficit in month, (£3.1m) adverse to plan. The Group has incurred (£1.5m) to cover Industrial Action in April.**
- The Group is behind on its CIP programme by (£18.7m). This is only partly mitigated through vacancy factors and other underspends.
- The Group cash balance decreased by (£3.9m) in month to £47.4m (£20.0m HUTH / £27.5m NLAG). £14.9m of additional external cash support (Revenue Support Public Dividend Capital (PDC)) has been drawn down at the end of Month 4. The Group requested £11.9m of cash support for August but has only gained approval of £9.4m putting further pressure on cash balances and timely creditor payments, resulting in an increased September request of £21.6m still awaiting NHSE approval.

See Appendix A on Page 27 to 28 for Detailed I&E Position

Financial Performance Summary: By Care Group

Directorate	Directorate 2	Care Group	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	In Month Variance £'000's	% Overspend	% CIP Identified (Forecast)	Escalate	% Overspend movement M4
Central Income			500,816	498,651	(2,165)	(213)	-0.4%			↑
Corporate Directorates			(86,081)	(86,111)	(29)	1,057	0.0%	46.6%		↑
Finance Technical			(29,691)	(26,928)	2,763	419				
Operations	Operations North	Acute And Emergency Medicine North	(15,099)	(16,818)	(1,719)	(480)	-11.4%	51.2%	Y	↓
		Cancer Network	(3,005)	(3,011)	(6)	7	-0.2%	7.7%	N	↑
		Cardiovascular	(17,651)	(19,084)	(1,433)	176	-8.1%	129.3%	Monitor	↑
		Chief Delivery Officer	(337)	(517)	(180)	3	-53.4%	0.0%	Monitor	↑
		Digestive Diseases	(23,200)	(25,987)	(2,786)	(435)	-12.0%	40.4%	Y	↑
		Head & Neck	(19,455)	(19,559)	(105)	(77)	-0.5%	86.3%	N	↑
		Patient Services	(15,250)	(15,574)	(324)	(102)	-2.1%	31.7%	Monitor	↓
		Specialist Cancer And Support Services	(97,550)	(100,431)	(2,880)	(736)	-3.0%	46.7%	Y	↓
		Theatres, Anaesthetics And Critical Care	(43,836)	(45,505)	(1,670)	(393)	-3.8%	58.5%	Y	↓
	Operations North Total		**(235,383)**	**(246,485)**	**(11,102)**	**(2,037)**	-4.7%			
	Operations South	Acute And Emergency Medicine South	(23,067)	(23,898)	(830)	(124)	-3.6%	68.9%	N	↑
		Chief Delivery Officer	(311)	(284)	27	5	8.6%	0.0%	N	↓
		Community, Frailty & Therapy	(30,090)	(31,763)	(1,673)	(167)	-5.6%	44.2%	Y	↑
		Family Services	(39,622)	(40,970)	(1,349)	(236)	-3.4%	46.2%	Y	↑
		Neuroscience	(13,167)	(13,713)	(546)	(47)	-4.1%	43.9%	Monitor	↑
		Pathology Network Group	(17,459)	(17,571)	(112)	(47)	-0.6%	71.8%	N	↓
		Site Management & Discharge Teams	(2,495)	(2,575)	(80)	(3)	-3.2%	38.9%	Monitor	↑
		Specialist Medicine	(24,943)	(26,034)	(1,090)	(300)	-4.4%	22.9%	Y	↑
		Specialist Surgery	(22,491)	(23,358)	(867)	(167)	-3.9%	63.7%	Monitor	↑
	Operations South Total		**(173,645)**	**(180,166)**	**(6,521)**	**(1,085)**	-3.8%			
Operations Total			**(409,028)**	**(426,651)**	**(17,623)**	**(3,122)**	-4.3%			
Reserves			(5,214)	(884)	4,330	(1,121)				
Grand Total			**(29,198)**	**(41,923)**	**(12,725)**	**(2,979)**				
Adjusted Financial Performance			656	78	(578)	(129)				
Adjusted Financial Performance (surplus / (deficit)			**(28,542)**	**(41,845)**	(13,303)	(3,108)				

See Appendix A on Page 28 for Detailed I&E Position

Care Group Escalations: Acute & Emergency Medicine North M4 Financial Position

A&EM North and Major Trauma (Financial Position £000)	YTD (M4)
Budget Allocation	15,099
Expenditure	16,818
Variance	(1,719)

Variance made up of:

CIP non delivery	A&EM £837k ; Major Trauma £38k	(875)
Vacancy factor	A&EM £81k ; Major Trauma (£33k)	(48)
Medical Staff	Unfunded IA strike costs	(336)
	Unfunded Towerblock on call rota changes	(53)
	ED : unfunded deanery +6wte	(179)
	ED : additional wte worked	(174)
	Acute : vacancy premium	(17)
Major Trauma	Pay : excludes IA & CIP & VF	(6)
Nursing Pay	Emergency Dept	(117)
	AMU & wards	(8)
NonPay		94
		(1,719)

A&EM : £88k CIP delivered YTD - £837k adverse ; VF variance - £81k adverse = Total £917k deficit

MT : £15k CIP delivered YTD - £38k adverse ; VF variance - £33k favourable = Total £5k deficit

£336k unfunded IA medical staff costs

Medical Pay cost pressures continue covering gaps with locums & agency. Acute pressures are due to vacancy cover premium (6wte consultant) & covering weekends at Extra Contractual Rates. x4 substantive consultant posts start in August.

ED medics continue to staff above budgeted levels & includes 6wte unfunded deanery posts.

The ED Nursing is now working at the uplifted SNCT levels. Agency & overtime has reduced but is still used to cover vacancies (15 RN & 3 HCA) & sickness (7%). Recruitment is key to mitigate this use.

There are still no plans to mitigate the external changes made to the Tower block oncall rotas. The expected annual pressure to cover Acute TG staff with locums is £160k.

Digestive Diseases – M4 Financial Position

Reason	Current Month Variance £k	Year to Date £k	Forecast £k
CIP including mitigating actions	-203	-863	-2,155
Consultant Additional Sessions before mitigations	-209	-478	-1,433
Endoscopy CHH & HRI Clinical Supplies Expense Category overspends	-76	-303	-908
Exec historically approved Allam Build Recruitment (CHH Endoscopy Unit cost centre pay)	-30	-124	-371
Bowel screening consumables	70	-30	-91
Resident Doctors - over established (rota expansion)	-82	-272	-816
Agency GIM rota costs consultant and CT3 level - exact WTE/amount TBC, before mitigations	-5	-91	-123
Nursing - maternity leave, redeploymnets due, long-term sickness, historically agreed spec nurses requiring business case due to saving consultant spend	41	-124	-372
Nursing OT Pressure - Premium element estimate	-13	-69	-207
Industrial Action Cover	-4	-171	-171
Technical issues/adjustments - Drugs national switch from high cost to tariff, insourcing/outsourcing	-183	-389	
Business cases requiring approval, and the £128k workforce redesign as this is a cost increase that will also require a case/approval			1,248
Other	259	128	0
TOTAL	**-435**	**-2,786**	**-5,400**

The Care Group was forecasting a deficit of £5.4m at the end of month 4. This includes some mitigating actions totalling at least £1.5m, subject to further work and calculations.

31% of the year to date overspend is driven by the CIP position, which at the point of reporting had a forecast variance of £2.2m.

Other significant cost pressures are mainly connected with waiting lists, the staffing for the new Allam building and historical resident doctor allocations, all of which require business cases to agree the run-rate expenditure and budget going forward.

Specialist Cancer and Support Services – M4 Financial Position

	(£,000s)		
	Current Month	Year-To-Date	Forecast
CIP Delivery	(494)	(2,529)	(5,012)
IRT consumables overtrade/Excluded devices	(90)	(417)	(1,058)
Medical Equipment Repair Costs	9	(13)	(33)
Medical Gasses Usage	(23)	(30)	(90)
Radiopharmacy isotopes	50	(108)	(341)
CT Contrast	(11)	(108)	(323)
OPAT drugs	8	(16)	(39)
MT expansion	-	-	(400)
Passthrough drugs block (over)/under trade	(185)	(478)	(1,598)
Trust Wide Maintenance Contracts	(19)	(74)	(173)
EMIS Contract	(56)	(74)	(222)
RT Maintenance	(28)	(93)	(281)
Industrial Action	-	(44)	(44)
Drug Wastage	47	(253)	(253)
Dr Doctor	(108)	(108)	(324)
P2P Income under recovery	26	-	-
Vacancies above NR VF (incl CDC)	494	1,151	2,775
Lung Cancer Screening Programme undertrade	13	90	269
Onc & Haem consumables	244	244	681
Other non-pay	(610)	(19)	(15)
	(733)	(2,879)	(6,481)

At the end of M4, the Care Group is forecasting a year-end deficit of £6.5m. This excludes £0.4m of technical adjustments for NHSE MT funding yet to be allocated.

The main driver of the overspend is unidentified CIP (£5m). The M4 forecast projects 47% of the Care Group's total target will be delivered in 26/27.

Other key issues include consumable overtrade on IRT (£1.1m) linked to higher activity levels and increased cost per case from the new consultant cohort. A degree of this overspend may be recovered from NHSE Devices funding with a detailed reconciliation underway.

Pass-through drugs are currently forecasting a block overtrade of £1.6m with growth above funded levels. Of this, £1.1m relates to unfunded 25/26 OT.

One-off events (£0.3m) are included in the YTD overspend related to industrial action and overspend on drug waste. No further increase is anticipated as part of the forecast.

Care Group Escalations: Community, Frailty & Therapies – M4 Financial Position

	Current Month Variance £'k	Year to Date £'k	Forecast £'k
CIP non delivery	142	- 1,399	- 2,651
Ward Staffing pressures in Frailty	- 54	- 326	- 879
H1 and FSDEC	-	- 156	- 156
CHH C20 and Medical Cover	- 60	- 240	- 720
Industrial action		- 80	- 80
Medical staffing pressures incl Sickness & Goole	- 10	- 59	- 227
District Nursing Sickness Cover	20	- 16	- 48
Wheelchair Services	- 5	- 11	- 33
Non Pay/income	67	281	236
Additional Vacancies	- 267	332	708
Recovery Action Plan			680
TOTAL	-167	-1674	-3170

At this early stage of the financial year, the Care Group is forecasting a deficit of £3.17m. 83.6% of this is driven by the CIP position, which at the point of reporting had a risk adjusted forecast variance of £2.6m.

Other significant cost pressures are connected with Medical staff cover both at CHH and Goole as well high levels of sickness. The Nursing position is equally challenged with staffing pressures on the Frailty wards and high levels of sickness within District Nursing, however in month the latter has improved considerably.

The Care Group is continuing to actively manage the sickness and reduce cover wherever safe to do so. Further CIP schemes are being developed to close the efficiency gap and a recovery action plan has been put in place.

Care Group Escalations: Family Services – M4 Financial Position

Reason	Current Month Variance £k	Year to Date £k	Forecast £k
CIP including mitigating actions	-281	-1,358	-4,074
VF	308	1,122	3,366
Med staff	-139	-614	-2,305
Nursing	-56	-293	-878
Drugs	-45	-97	-387
Clinical supplies	-23	71	129
Other Non Pay	-32	70	200
Income	30	114	300
Industrial Action Cover	0	-363	-363
TOTAL	**-238**	**-1,348**	**-4,012**

At this stage of the financial year, the Care Group was forecasting a deficit of £4.0m at the end of month 04. This excludes some mitigating plans, subject to further work and calculations.

101% of the year to date overspend is driven by the CIP position, which at the point of reporting had a forecast variance of £4.0m.

Other significant cost pressures are mainly connected with Medical staffing Extra Contractual Payments, Nursing staff bank and OT costs.

Drug costs forecast a cost pressure across Paediatrics (£204k); maternity (£77k); Neonates (£31k) & Gynae FP10s (£45k)

Care Group Escalations: Specialist Medicine M4 Financial Position

Specialist Medicine (Financial Position £000)	YTD (M4)
Budget Allocation	24,943
Expenditure	26,034
Variance	(1,091)

Variance made up of:

CIP non delivery		(817)
Vacancy Factor		253
Medical Staff	Unfunded IA strike costs	(73)
	HUTH Rheumatology	(70)
	NLG Respiratory	(57)
Activity Pressures	Renal : CAPD Fluids / MSSE	(45)
	Renal : Fresenius Contract	(109)
	Respiratory : Home Ventilation	66
	Respiratory : CPAP consumables	(274)
Lung Cancer Screening	IS : actual < plan	72
Nursing Wards	Pay	(56)
	NonPay	12
Misc Other		7
		(1,091)

- CIP non-delivery = 75% of YTD variance
  YTD = £189k delivered against a target of £1,006k
- Unfunded £73k IA strike medical staff costs
- HUTH Rheumatology medical staff
  2.5wte worked WTE > funded WTE
- NLG Respiratory medical staff
  4.0wte consultant vacancy premium
- Non-pay pressures
  CPAP (£274k) ; Renal fluids/MSSE £45k)
  Renal Fresenius contract (£109k)
- Ward Pay pressures
  (H70 £38k ; H50 £11k ; Wd25 £7k)
- NLG Lung Cancer Screening £72k IS underspent based on activity phasing. A forecast balanced variance is expected.

Financial Performance – Forecast Outturn (FOT)

The Group is forecasting a deficit of (£125.5m) based on a straight-line projection. Seasonal costs, planned investments, CIP delivery and other mitigating actions are expected to reduce the deficit leaving an unidentified gap of (£36.0m) across the Group.

The Group continues to forecast delivery of the planned deficit, but there remains a significant level of risk to delivery due to the challenging £119.1m efficiency target (6.8% including FYEs), which at the point of reporting had a risk adjusted forecast of just £58.3m, a gap of £60.8m.

A straight-line forecast based on the YTD deficit position would leave the group with a £125.5m deficit by year end. When adjusted for seasonality, expenditure that has not yet started and non recurrent slippage in the year-to-date position, this deficit increases to £139.6m, an improvement of £5.1m versus M3.

To bring back the forecast deficit to the planned level the Group needs to:

- **Deliver forecast improved efficiency of at least £35.5m** including currently undeveloped opportunities of c.£15m.
- **Identify further mitigations of £36m** to close the unidentified efficiency gap and cover other cost pressures and risks including the unplanned cost of industrial action.

The forecast also assumes a level of mitigation through additional non recurrent income that would routinely be expected to be allocated later in the year.

	Current Month			Previous Month			Movement		
Forecast Bridge (Group)	HUTH £'m	NLAG £'m	HHP £'m	HUTH £'m	NLAG £'m	HHP £'m	HUTH £'m	NLAG £'m	HHP £'m
YTD deficit (M4)	(29.9)	(12.0)	(41.8)	(23.5)	(9.5)	(33.0)	(6.4)	(2.5)	(8.9)
Straight line forecast	**(89.6)**	**(36.0)**	**(125.5)**	**(94.0)**	**(37.8)**	**(131.8)**	**4.4**	**1.9**	**6.3**
Seasonality	(1.6)	(1.5)	(3.1)	(0.8)	(1.5)	(2.3)	(0.8)	-	(0.8)
Industrial Action	2.2	0.7	2.9	3.3	1.0	4.4	(1.1)	(0.3)	(1.5)
Investment Expenditure Profile	(3.4)	(3.1)	(6.5)	(3.6)	(4.0)	(7.6)	0.2	0.9	1.1
Expected changes to run-rate	(2.0)	(3.3)	(5.3)	(2.3)	(2.7)	(5.0)	0.3	(0.6)	(0.3)
Depreciation, Interest Received & PDC	-	(2.1)	(2.1)	-	(2.3)	(2.3)	-	0.2	0.2
Adjusted Run Rate	**(94.4)**	**(45.2)**	**(139.6)**	**(97.5)**	**(47.2)**	**(144.7)**	**3.1**	**2.0**	**5.1**
Forecast CIP delivery (improvement in run-rate)	25.9	9.6	35.5	26.4	8.8	35.2	(0.5)	0.9	0.3
Additional Non Recurrent (Technical)		3.0	3.0			-	-	3.0	3.0
Additional Non Recurrent Income	2.0		2.0	4.6	-	4.6	(2.6)	-	(2.6)
Forecast deficit	**(66.5)**	**(32.6)**	**(99.1)**	**(66.4)**	**(38.5)**	**(104.9)**	**(0.1)**	**5.9**	**5.8**
Plan	**(39.4)**	**(23.7)**	**(63.1)**	**(39.4)**	**(23.7)**	**(63.1)**	**-**	**-**	**-**
Unmitigated Variance	**(27.1)**	**(8.9)**	**(36.0)**	**(27.0)**	**(14.8)**	**(41.8)**	**(0.1)**	**5.9**	**5.8**

Financial Performance – Forecast Scenarios

The Group has a significant amount of risk to its core Best Case forecast deficit of £99.1m, particularly CIP forecast delivery.

Forecast Bridge (Group)	HUTH £'m	NLAG £'m	Group £'m
Best Case			
Reported Forecast (as per Forecast Bridge)	(39.40)	(23.7)	(63.1)
Less Unidentified Mitigation	(27.09)	(8.91)	(36.0)
Forecast deficit	**(66.5)**	**(32.6)**	**(99.1)**
Variance	**(27.1)**	**(8.9)**	**(36.0)**
Mid Case			
Reported Forecast (as per Forecast Bridge)	(39.40)	(23.67)	(63.1)
Less Unidentified Mitigation	(27.09)	(8.91)	(36.0)
CIP adjusted to reflect current risk adjusted forecast	(14.23)	(3.6)	(17.8)
Forecast deficit	**(80.7)**	**(36.1)**	**(116.8)**
Variance	**(41.3)**	**(12.5)**	**(53.8)**
Worst Case			
Reported Forecast (as per Forecast Bridge)	(39.40)	(23.67)	(63.1)
Less Unidentified Mitigation	(27.09)	(8.91)	(36.0)
No further improvement in CIP delivery vs run-rate	(25.90)	(9.6)	(35.5)
Variable Income Risk	(2.00)	(1.4)	(3.4)
Winter Pressures / Growth Risk	(0.60)	(0.4)	(1.0)
Inflationary Risks		(0.7)	(0.7)
Other risks			0.0
Forecast deficit	**(95.0)**	**(44.7)**	**(139.7)**
Variance	**(55.6)**	**(21.0)**	**(76.6)**

The Group has adopted the Provider Assurance Model (PAM) for assessing risk to its financial forecast.

This essentially uses the CIP forecast risk as the key variable to its core finance forecast presenting the following scenario's:

- Best Case – (£99.1m) deficit, (£36.0m) adverse to plan
- Mid Case - £116.8m) deficit, (£53.8m) adverse to plan
- Worst Case – (£139.7m) deficit, (£76.6m) adverse to plan

Financial Performance – Recovery Plan

Focus on workforce, given the growth in both pay costs and headcount in recent years, with particular attention to two key elements: variable pay reduction and headcount reduction.

- Agreed a targeted 30% / £30m reduction in variable pay with associated Care Group targets – the majority of Care Groups have developed plans to achieve this target, but further work required to deliver with c. 10% reduction YTD.
- Weekly monitoring of variable pay where data is available - shared with Care Groups.
- Introduced vacancy pause – **implemented 6th July.** CEO escalation process underpinned with a revised vacancy control process supported by a new form and tracker – **implemented.**
- Approved expansion of Locum's Nest digital solution which will facilitate electronic approval for variable pay including Extra Contractual Payments – **implemented 1st July 2026**
- Full escalation process is to be agreed: Recovery Action Plan's escalated to Performance & Finance Committee for the Care Groups' of greatest concern.
- At this stage plans to reduce headcount are the least developed but remains a key area of focus and scrutiny. Business Case in-development for Voluntary Redundancy programme.
- Finance training to be included in LISA programme being developed to support operational managers.
- Enhanced communications strategy to support ownership of the finance agenda.
- Alignment with clinical priorities through the Integrated Recovery Plan – action plans signed off 30th June 2026.
- Strengthened CIP development & support delivery - Appointment of Grant Thornton & Keith Pringle - Financial Improvement Director

Financial Performance – CIP Delivery

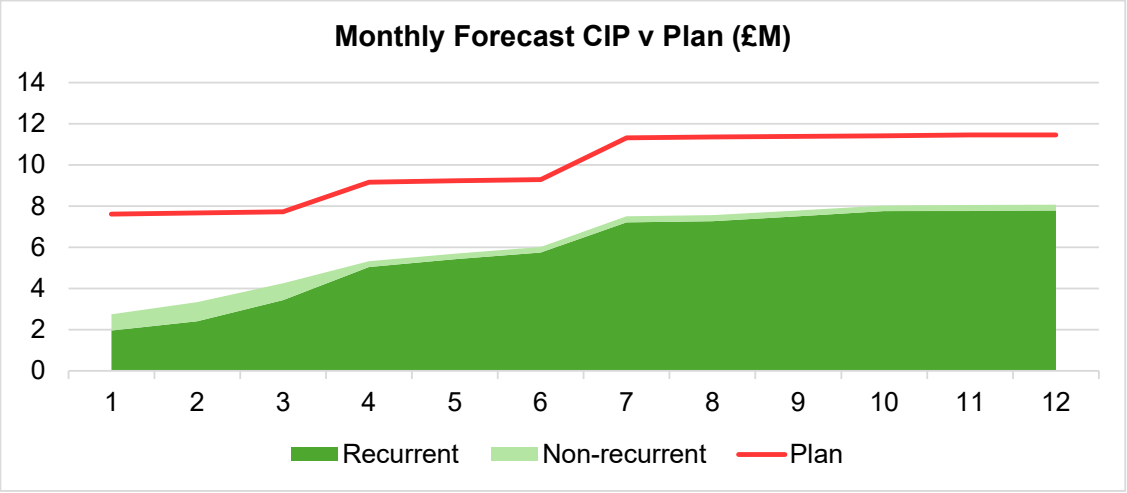
The Group has delivered £13.5m CIP year-to-date against a target of £32.2m, (£18.7m) adverse. The Group is forecasting CIP delivery of £79.3m (£39.8m) adverse to plan.

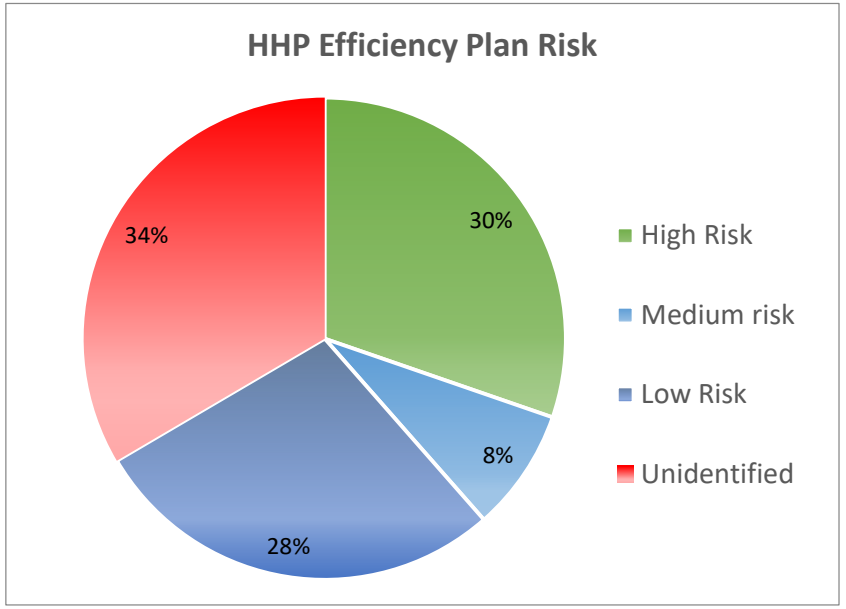
		HUTH						NLAG						HHP					
		Year to Date			Forecast Year-end			Year to Date			Forecast Year-end			Year to Date			Forecast Year-end		
£000		Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Operations	Acute and Emergency Medicine North	924	87	(837)	2,771	1,419	(1,352)	0	0	0	0	0	0	924	87	(837)	2,771	1,419	(1,352)
	Acute and Emergency Medicine South	0	0	0	0	0	0	1,721	904	(817)	5,163	3,556	(1,607)	1,721	904	(817)	5,163	3,556	(1,607)
	Cancer Network	68	9	(60)	205	26	(179)	44	0	(44)	133	0	(133)	112	9	(104)	337	26	(311)
	Cardiovascular	707	172	(535)	2,122	3,059	937	179	129	(51)	538	381	(157)	887	301	(586)	2,661	3,441	780
	Chief Delivery Officer	18	0	(18)	54	0	(54)	19	0	(19)	58	0	(58)	37	0	(37)	112	0	(112)
	Community, Frailty & Therapy	721	127	(594)	2,163	1,080	(1,083)	862	60	(802)	2,586	1,018	(1,568)	1,583	187	(1,396)	4,749	2,098	(2,651)
	Digestive Diseases	599	143	(455)	1,796	896	(900)	606	164	(441)	1,818	563	(1,255)	1,205	308	(897)	3,614	1,459	(2,155)
	Family Services	1,006	299	(706)	3,017	1,603	(1,413)	1,020	368	(652)	3,060	1,201	(1,859)	2,025	668	(1,358)	6,076	2,805	(3,272)
	Head & Neck	660	565	(95)	1,981	1,653	(328)	426	338	(89)	1,279	1,162	(117)	1,087	903	(184)	3,260	2,815	(445)
	Major Trauma Network	54	15	(38)	161	50	(111)	0	0	0	0	0	0	54	15	(38)	161	50	(111)
	Neuroscience	444	163	(280)	1,331	617	(714)	209	21	(188)	628	243	(385)	653	184	(468)	1,958	859	(1,099)
	Pathology Network Group	212	221	9	635	666	31	683	166	(516)	2,048	1,260	(789)	894	387	(507)	2,683	1,926	(757)
	Patient Services	380	98	(282)	1,140	477	(662)	324	23	(301)	972	193	(780)	704	121	(583)	2,112	670	(1,442)
	Site Management & Discharge Teams	56	11	(45)	169	72	(97)	73	22	(51)	218	79	(140)	129	33	(96)	387	150	(236)
	Specialist Cancer And Support Services	1,840	383	(1,457)	5,521	1,901	(3,620)	1,292	219	(1,072)	3,875	2,484	(1,391)	3,132	603	(2,529)	9,396	4,384	(5,011)
	Specialist Medicine	579	64	(514)	1,736	225	(1,511)	428	124	(303)	1,283	465	(818)	1,006	189	(817)	3,019	690	(2,328)
	Specialist Surgery	708	229	(479)	2,123	967	(1,156)	484	383	(101)	1,452	1,309	(143)	1,192	612	(580)	3,575	2,276	(1,299)
	Theatres, Anaesthetics And Critical Care	1,337	185	(1,153)	4,012	2,545	(1,468)	906	128	(778)	2,719	1,392	(1,326)	2,244	313	(1,930)	6,731	3,937	(2,794)
Total Operations		10,312	2,772	(7,540)	30,936	17,256	(13,680)	9,276	3,051	(6,225)	27,829	15,306	(12,523)	19,588	5,823	(13,765)	58,764	32,561	(26,203)
Corporate	Chief Executive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Chief Medical Officer	240	67	(174)	721	200	(521)	67	0	(67)	201	0	(201)	307	67	(241)	922	200	(722)
	Chief Nurse	201	36	(165)	602	320	(282)	188	44	(144)	565	508	(57)	389	80	(309)	1,166	828	(339)
	Director Of Assurance	8	12	3	25	83	58	18	9	(9)	53	44	(9)	26	20	(6)	78	127	49
	Director Of People	255	0	(254)	764	316	(447)	213	0	(213)	638	376	(262)	467	0	(467)	1,402	693	(709)
	Finance - E&F	1,713	607	(1,106)	5,138	2,860	(2,279)	1,051	69	(981)	3,152	1,267	(1,885)	2,763	676	(2,087)	8,290	4,126	(4,164)
	Finance - Finance	96	43	(53)	289	129	(160)	80	56	(24)	239	169	(70)	176	99	(77)	527	298	(230)
	Finance - Procurement	41	0	(41)	124	0	(124)	29	0	(29)	87	0	(87)	71	0	(71)	212	0	(212)
	Finance - S & P	132	0	(132)	397	27	(370)	78	42	(36)	233	124	(109)	210	42	(169)	630	151	(479)
	Strategy, Partnerships and Digital	287	5	(283)	862	149	(713)	239	57	(182)	718	383	(335)	527	62	(465)	1,580	532	(1,048)
Total Corporate		2,974	769	(2,205)	8,921	4,084	(4,838)	1,962	277	(1,685)	5,886	2,871	(3,015)	4,936	1,046	(3,890)	14,807	6,954	(7,853)
Total Allocated CIPCore Programme		13,286	3,541	(9,745)	39,857	21,339	(18,518)	11,238	3,328	(7,910)	33,714	18,177	(15,538)	24,524	6,869	(17,655)	73,572	39,516	(34,056)
Trustwide	Reserves	0	646	646	0	727	727	0	1,324	1,324	0	3,449	3,449	0	1,970	1,970	0	4,176	4,176
	Technical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Unallocated	2,789	0	(2,789)	22,043	19,591	(2,452)	217	0	(217)	9,486	1,976	(7,509)	3,006	0	(3,006)	31,528	21,567	(9,961)
	Full Year Effects	3,660	3,664	4	10,981	10,981	0	1,008	1,006	(2)	3,023	3,023	0	4,668	4,670	2	14,004	14,004	0
Total Technical & Unallocated		6,449	4,310	(2,139)	33,024	31,298	(1,725)	1,225	2,330	1,106	12,509	8,448	(4,060)	7,674	6,640	(1,034)	45,532	39,747	(5,786)
TOTAL		19,735	7,851	(11,884)	72,881	52,637	(20,244)	12,463	5,658	(6,805)	46,223	26,625	(19,598)	32,198	13,509	(18,689)	119,104	79,262	(39,842)

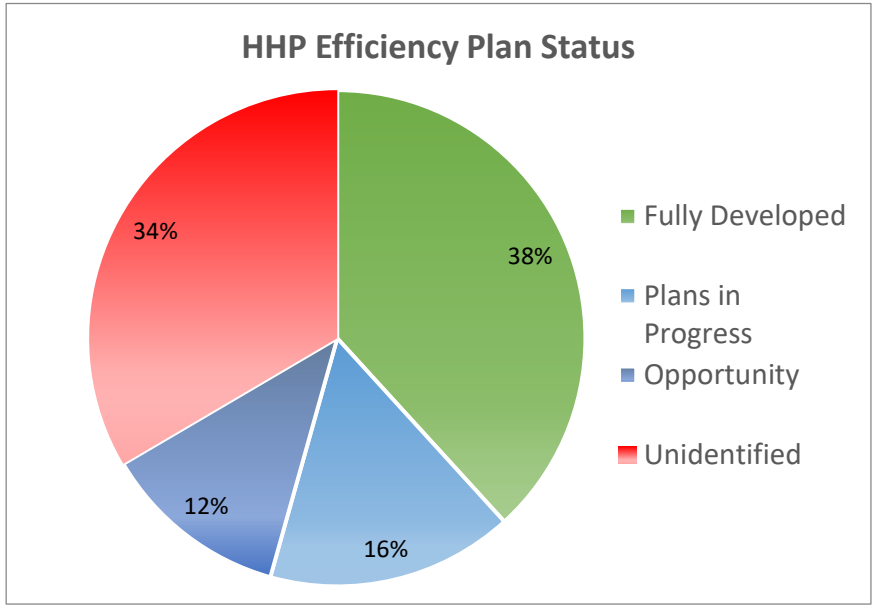
Financial Performance – CIP

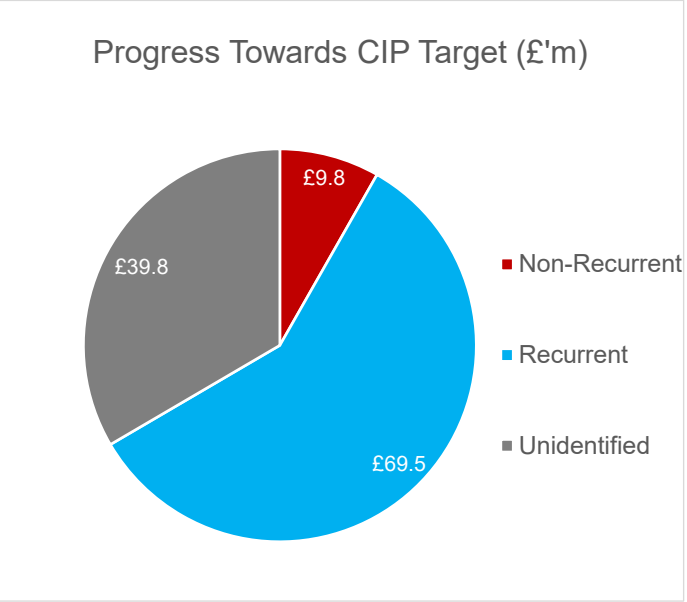
Efficiency Forecast Risk	HUTH	NLAG	HHP
High Risk	18,924	17,153	36,076
Medium risk	5,511	4,291	9,802
Low Risk	28,203	5,181	33,384
Unidentified	20,244	19,598	39,842
TOTAL	**72,881**	**46,223**	**119,104**

Efficiency Forecast Status	HUTH	NLAG	HHP
Fully Developed	25,508	20,033	45,541
Plans in Progress	12,841	6,351	19,192
Opportunity	14,289	241	14,530
Unidentified	20,244	19,598	39,842
TOTAL	**72,881**	**46,223**	**119,104**









Underlying Position

The Group's underlying financial position is estimated at a deficit of (£127.0m)

Bridging from the (£63.1m) planned deficit for 2026-27 the below are the main drivers:

1. The Group is in receipt of specific Non-Recurrent Income and associated Expenditure totalling (£9.5m).
2. The Group currently has unidentified and non recurrent CIP of (£68.7m).
3. The in year CIP schemes have a potential FYE of £26.6m if delivered in full in year.
4. The Group has incurred £1.5m of Industrial Action costs (net of pay reductions).
5. The Groups has committed investments with a full year effect of (£8.5m).
6. The Group is forecasting to deliver £5.4m of NR Technical balance sheet support.

This position assumes that CIP opportunities including high risk schemes will be delivered recurrently and in full. Delivery of these schemes will be the key driver for the Trust's underlying financial position both in year and the potential full year effects of in year schemes.

£million	NLAG	HUTH	HHP
2026/27 - Planned Surplus/(Deficit)	**(23.7)**	**(39.4)**	**(63.1)**
Non-recurrent Adjustments			
NR Additional Income & Costs	1.3	(10.8)	(9.5)
NR CIP (Forecast incl Unidentified & Risk)	(22.0)	(46.7)	(68.7)
FYE 26/27 CIP (Risk Adjusted)	4.8	21.8	26.6
NR Indutrial Action	0.3	1.1	1.5
FYE 26/27 Investments	(3.0)	(5.4)	(8.5)
NR Technical & Other	(4.1)	(1.3)	(5.4)
Underlying Deficit	**(46.3)**	**(80.7)**	**(127.0)**

System Financial Performance – Month 4, July 2026

The ICS reported a YTD deficit of (£68.8m), (£25.8m) adverse to plan. The ICS is forecasting a (£100.9m) plan compliant deficit at the year end.

			Surplus / (Deficit) Including DSF					
Code	Name	ICB / Provider	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s
Humber and North Yorkshire								
QOQ	NHS Humber and North Yorkshire ICB	ICB	0	0	0	0	0	0
RCD	Harrogate and District NHS Foundation Trust	Provider	(6,764)	(14,827)	(8,063)	(15,279)	(15,279)	0
RWA	Hull University Teaching Hospitals NHS Trust	Provider	(18,414)	(29,858)	(11,444)	(39,400)	(39,400)	0
RV9	Humber Teaching NHS Foundation Trust	Provider	0	0	0	0	0	0
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Provider	(10,126)	(11,984)	(1,858)	(23,665)	(23,665)	0
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Provider	(7,685)	(12,161)	(4,476)	(22,646)	(22,646)	0
Humber and North Yorkshire Provider Total		**QOQ**	**(42,989)**	**(68,830)**	**(25,841)**	**(100,990)**	**(100,990)**	**0**
Humber and North Yorkshire Total		**QOQ**	**(42,989)**	**(68,830)**	**(25,841)**	**(100,990)**	**(100,990)**	**0**

			Total Efficiencies					
Code	Name	ICB / Provider	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s
Humber and North Yorkshire								
QOQ	NHS Humber and North Yorkshire ICB	ICB	23,667	23,392	(275)	81,468	81,468	(0)
RCD	Harrogate and District NHS Foundation Trust	Provider	9,327	4,815	(4,512)	32,000	32,000	0
RWA	Hull University Teaching Hospitals NHS Trust	Provider	19,735	7,851	(11,884)	72,881	72,881	(0)
RV9	Humber Teaching NHS Foundation Trust	Provider	4,701	4,732	30	14,353	14,353	0
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Provider	12,463	5,658	(6,805)	46,223	46,223	(0)
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Provider	19,546	15,885	(3,661)	61,640	61,640	(0)
Humber and North Yorkshire Provider Total		**QOQ**	**65,772**	**38,940**	**(26,832)**	**227,097**	**227,097**	**0**
Humber and North Yorkshire Total		**QOQ**	**89,440**	**62,332**	**(27,107)**	**308,565**	**308,565**	**0**

Capital Expenditure

The Group has spent £8.1m year to date on capital expenditure against a plan of £15.6m plan, (£7.4m) behind plan.

£million	NLAG Year to Date			HUTH Year to Date			HHP Year to Date		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
Estates Major Schemes									
Ward/Department Refurbishment/Development	2.0	0.0	(2.0)	0.0	0.0	0.0	2.0	0.0	(2.0)
Constitutional Standards	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates Safety Funding	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.1
Theatre upgrades and ventilation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HRI Tower Block	0.0	0.0	0.0	3.0	0.1	(2.9)	3.0	0.1	(2.9)
SDEC	0.0	0.0	0.0	4.0	0.3	(3.7)	4.0	0.3	(3.7)
Total Estates Major Schemes	**2.0**	**0.1**	**(1.9)**	**7.0**	**0.5**	**(6.5)**	**9.0**	**0.5**	**(8.5)**
Other Estates Schemes	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0	0.0	(0.0)
IM&T Programme	0.5	0.2	(0.4)	0.1	0.3	0.3	0.6	0.5	(0.1)
EPR	1.9	2.3	0.4	0.1	1.9	1.8	2.0	4.3	2.2
Equipment Renewal	0.2	0.0	(0.2)	0.5	0.2	(0.3)	0.7	0.2	(0.5)
Facilities Maintenance	0.5	0.2	(0.2)	0.3	0.4	0.1	0.8	0.6	(0.1)
Other Capital Expenditure	0.1	0.3	0.1	2.3	1.8	(0.5)	2.4	2.1	(0.3)
Total Capital Programme	**5.2**	**3.0**	**(2.2)**	**10.3**	**5.1**	**(5.2)**	**15.5**	**8.1**	**(7.4)**
Funded By:									
Internally Generated	5.0	2.1	(2.9)	3.3	5.1	1.8	8.3	7.2	(1.2)
PDC Funded	0.1	0.7	0.6	7.0	0.0	(7.0)	7.1	0.7	(6.4)
Donated	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
IFRS16	0.1	0.2	0.1	0.0	0.0	0.0	0.1	0.2	0.1
Disposals - Net Book Value	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**5.2**	**3.0**	**(2.2)**	**10.3**	**5.1**	**(5.2)**	**15.6**	**8.1**	**(7.4)**

Key areas of slippage in Month 4 continue to relate to HRI: the reconfiguration required to facilitate SDEC and the Tower Block improvements. A start date has now been agreed for enabling works for the Lansdown building, planning permission is 6 months late and has just been confirmed on 14.08.27. Building Safety Regulation (BSR) for SDEC configuration is waiting approval, this has been extended to 10th August

The Trust has submitted a revised profile to NHSE for the Tower Block funding to reduce the expenditure in 26/27 and is awaiting approval.

Delayed spend on new ITU at DPoW, the CCU demolition started on 11 May, phase 1 is progressing, however phase 2, old medical records has been delayed due to bitumen adhesive being found under the floor. Planned work to strip all asbestos prior to phase 2 start.

Ward C6 at DPoW is now fully live and progressing well on site.

For both Trusts, Business cases are progressing for the Constitutional standards schemes, these are yet to be approved.

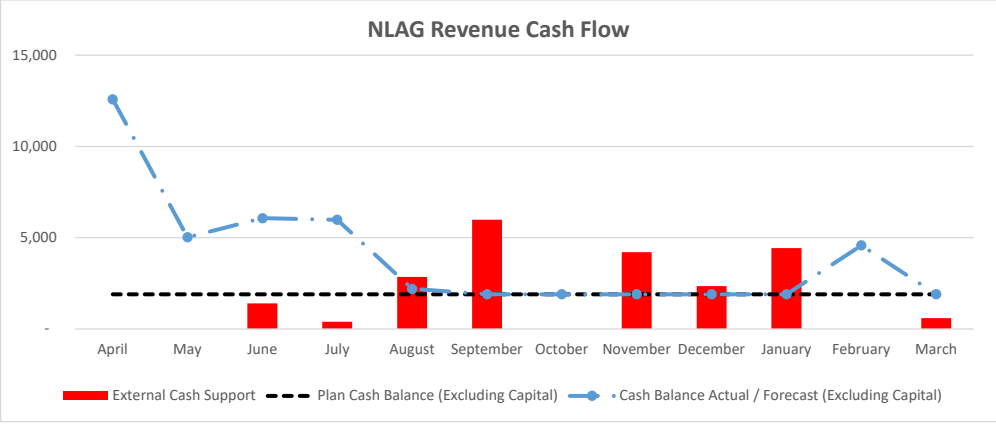
Balance Sheet

£ million	NLAG			HUTH			HHP		
	Actual 30-Jun-26	Actual 31-Jul-26	In month movement	Actual 30-Jun-26	Actual 31-Jul-26	In month movement	Actual 30-Jun-26	Actual 31-Jul-26	In month movement
Fixed Assets	310.0	308.6	(1.4)	542.3	540.8	(1.5)	852.3	849.4	(2.9)
Other Investments	0.0	0.0	0.0	0.6	0.6	0.0	0.6	0.6	0.0
Current Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Inventories	4.8	5.1	0.2	19.6	19.6	0.0	24.5	24.7	0.2
Trade and Other Debtors	18.9	19.4	0.5	42.4	44.6	2.2	61.3	64.0	2.7
Cash	30.7	27.5	(3.2)	20.6	20.0	(0.7)	51.3	47.4	(3.9)
Total Current Assets	**54.4**	**51.9**	**(2.5)**	**82.7**	**84.2**	**1.5**	**137.1**	**136.1**	**(1.0)**
Current Liabilities									
Trade and Other Creditors	(69.2)	(62.4)	6.8	(76.7)	(84.1)	(7.3)	(145.9)	(146.5)	(0.5)
Accruals	(24.7)	(26.1)	(1.4)	(49.4)	(39.0)	10.4	(74.1)	(65.1)	9.0
Other Current Liabilities	(7.7)	(11.8)	(4.1)	(20.7)	(27.6)	(6.9)	(28.5)	(39.4)	(11.0)
Total Current Liabilities	**(101.6)**	**(100.3)**	**1.4**	**(146.9)**	**(150.7)**	**(3.8)**	**(248.5)**	**(251.0)**	**(2.5)**
Net Current Liabilities	**(47.3)**	**(48.4)**	**(1.1)**	**(64.2)**	**(66.5)**	**(2.3)**	**(111.5)**	**(114.9)**	**(3.4)**
Debtors Due > 1 Year	0.7	0.7	0.0	2.0	2.0	0.0	2.7	2.7	0.0
Creditors Due > 1 Year	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Loans > 1 Year	(2.9)	(2.9)	0.0	(3.1)	(3.1)	0.0	(6.0)	(6.0)	0.0
Finance Lease Obligations > 1 Year	(6.7)	(6.4)	0.3	(69.4)	(69.1)	0.3	(76.1)	(75.5)	0.6
Provisions - Non Current	(3.3)	(3.3)	0.0	(2.2)	(2.2)	0.0	(5.5)	(5.5)	0.0
Total Assets/(Liabilities)	**250.5**	**248.3**	**(2.2)**	**406.0**	**402.4**	**(3.5)**	**656.4**	**650.7**	**(5.8)**
TOTAL CAPITAL & RESERVES	**250.5**	**248.3**	**(2.2)**	**406.0**	**402.4**	**(3.5)**	**656.4**	**650.7**	**(5.8)**

Cash Flow

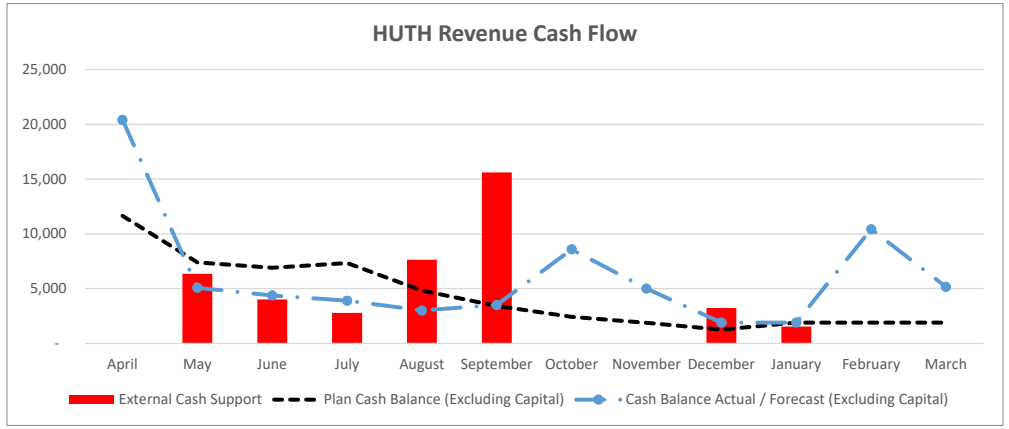
The Group cash balance decreased by (£3.9m) in month to £47.4m. £14.9m of additional external cash support has been drawn down at the end of Month 4. The Group requested £11.9m of cash support for August but has only gained approval of £9.4m putting further pressure on cash balances and timely creditor payments, resulting in an increased September request of £21.6m still awaiting NHSE approval.

NLAG



£m	AP01	AP02	AP03	AP04	AP05	AP06	Total YTD
Planned Drawdown	-	-	1.40	0.39	1.84	5.12	8.75
Requested Drawdown	-	-	1.40	3.11	2.85	5.98	13.35
Confirmed Drawdown (TBC)	-	-	1.40	0.39	2.85	5.98	10.62

HUTH



£m	AP01	AP02	AP03	AP04	AP05	AP06	Total YTD
Planned Drawdown	-	6.89	5.07	-	7.14	3.03	22.13
Requested Drawdown	-	6.35	6.68	6.80	9.01	15.61	44.45
Confirmed Drawdown (TBC)	-	6.35	4.00	2.78	6.56	15.61	35.30

2026-27 Combined ICB and Provider Summary

Month 4

BPPC Summary

			YTD					
			Percentage of bills paid within target			Percentage of bills paid within target		
			Current YTD by Number			Current YTD by Value £000s		
Code	Name	Provider Type	Non NHS %	NHS %	Total %	Non NHS %	NHS %	Total %
Humber and North Yorkshire								
RCD	Harrogate and District NHS Foundation Trust	Acute	14.5%	15.7%	14.6%	38.6%	7.1%	34.6%
RWA	Hull University Teaching Hospitals NHS Trust	Acute	70.4%	74.1%	70.5%	60.5%	75.6%	63.0%
RV9	Humber Teaching NHS Foundation Trust	Mental Health	99.0%	89.0%	98.3%	96.5%	98.8%	97.1%
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Acute	55.8%	61.8%	56.0%	77.6%	64.1%	76.4%
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Acute	90.2%	70.2%	89.7%	88.4%	62.2%	84.9%

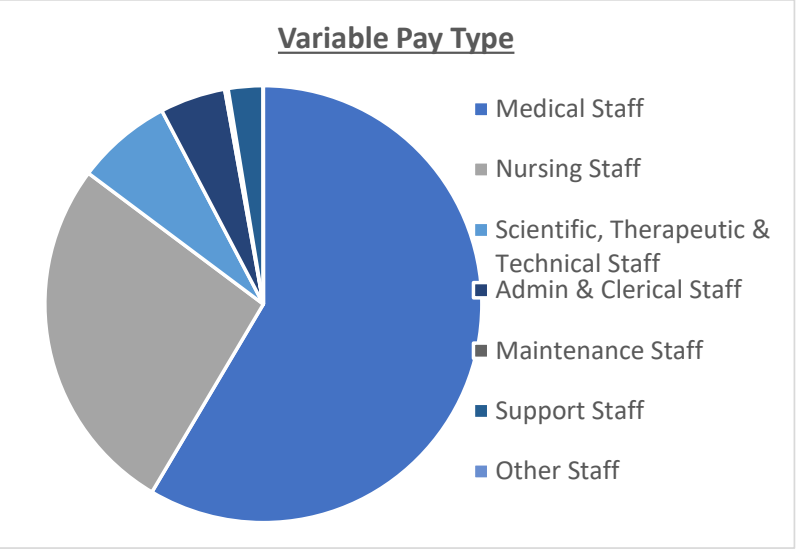
Variable Pay Summary

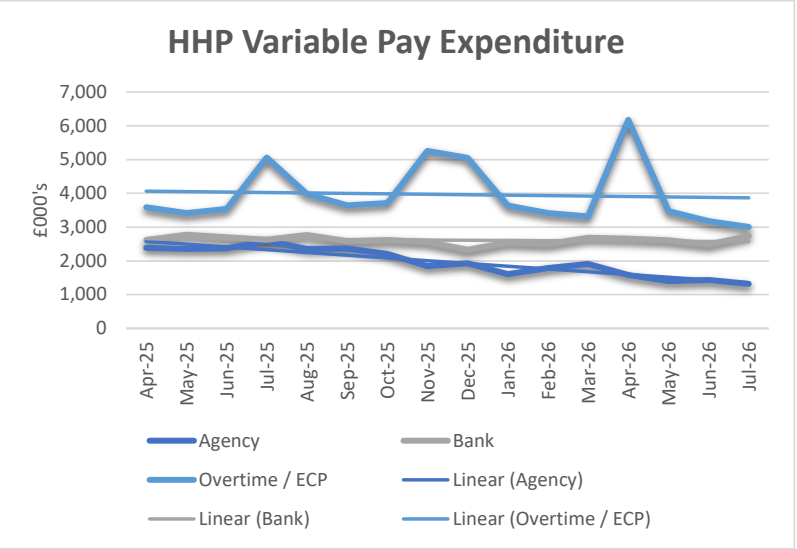
The Group has spent £32.1m on variable pay YTD. This is £4.0m less than the same period in 2025/26. The position includes £1.9m of expenditure covering Industrial Action.

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Type	Subjective Sub category	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Agency	Medical Staff	2,962	1,667	1,294	4,423	2,877	1,547	7,385	4,544	2,841
	Nursing Staff	430	407	23	1,175	311	864	1,606	718	887
	Scientific, Therapeutic & Technical Staff	91	87	4	568	387	181	659	474	185
	Admin & Clerical Staff	(7)	2	(8)	35	0	35	28	2	26
	Maintenance Staff	0	0	0	0	1	(1)	0	1	(1)
	Support Staff	0	0	0	0	0	0	0	0	0
	Other Staff	26	0	26	2	2	(1)	28	2	25
Agency Total		3,502	2,163	1,339	6,203	3,578	2,625	9,705	5,741	3,964
Bank	Medical Staff	1,495	1,581	(86)	869	806	63	2,364	2,387	(23)
	Nursing Staff	1,470	1,441	29	4,128	4,313	(185)	5,597	5,753	(156)
	Scientific, Therapeutic & Technical Staff	231	155	77	522	434	88	753	588	165
	Admin & Clerical Staff	360	396	(36)	687	734	(47)	1,048	1,130	(83)
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	55	33	22	903	599	304	958	632	326
	Other Staff	0	0	0	0	0	0	0	0	0
Bank Total		3,611	3,605	6	7,109	6,886	223	10,719	10,491	229
Overtime / ECP's	Medical Staff	5,965	6,478	(513)	4,861	5,352	(491)	10,826	11,830	(1,004)
	Nursing Staff	2,012	1,710	302	667	380	287	2,679	2,090	589
	Scientific, Therapeutic & Technical Staff	744	757	(14)	500	451	49	1,244	1,209	35
	Admin & Clerical Staff	404	334	70	105	89	16	509	423	86
	Maintenance Staff	65	57	7	21	24	(3)	85	81	4
	Support Staff	204	162	42	55	32	23	259	194	65
	Other Staff	0	0	0	0	0	0	0	0	0
Overtime / ECP's Total		9,394	9,499	(106)	6,208	6,328	(120)	15,602	15,827	(226)
Grand Total		16,507	15,267	1,239	19,520	16,792	2,728	36,026	32,059	3,967

Agency Spend v's Agency CAP									
Bank Spend v's Bank CAP									

	HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Subjective Sub category	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Medical Staff	10,422	9,726	696	10,153	9,035	1,118	20,575	18,761	1,814
Nursing Staff	3,912	3,558	354	5,970	5,003	966	9,881	8,562	1,320
Scientific, Therapeutic & Technical Staff	1,065	999	67	1,590	1,272	318	2,656	2,271	385
Admin & Clerical Staff	758	732	26	827	823	4	1,585	1,555	30
Maintenance Staff	65	57	7	21	25	(4)	85	82	3
Support Staff	259	195	64	958	631	327	1,217	826	391
Other Staff	26	0	26	2	2	(1)	28	2	25
Grand Total	16,507	15,267	1,239	19,520	16,792	2,728	36,026	32,059	3,967





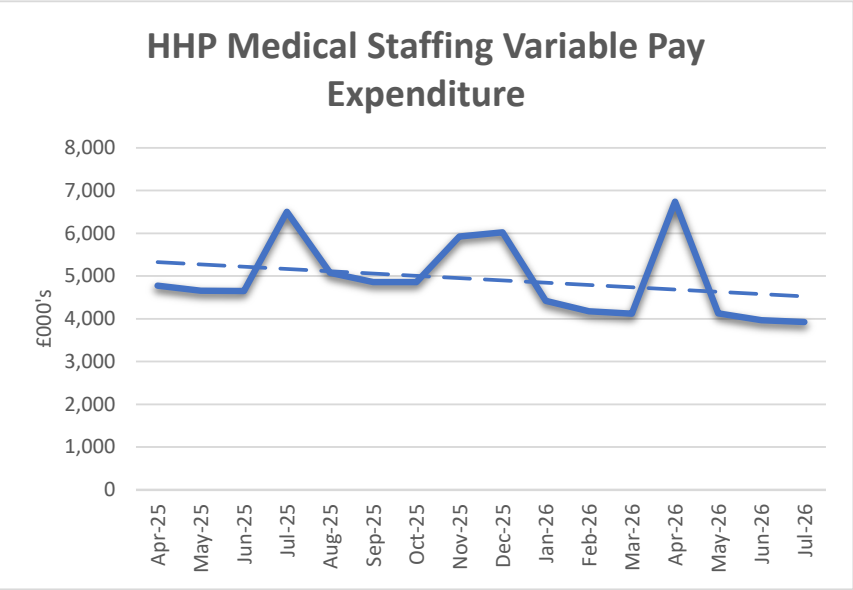
Variable Pay Summary – Directorate / Care Group

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	3,154	3,230	(76)	0	13	(13)	3,154	3,243	(89)
	Acute and Emergency Medicine (South)	0	0	0	5,064	4,732	331	5,064	4,732	331
	Cancer Network	75	13	62	30	12	18	105	25	80
	Cardiovascular	977	943	35	200	261	(62)	1,177	1,204	(27)
	Chief Delivery Officer	7	0	6	12	18	(6)	19	19	(0)
	Community, Frailty & Therapy	1,496	1,332	164	1,173	1,130	43	2,669	2,461	207
	Digestive Diseases	855	966	(111)	960	1,354	(394)	1,816	2,320	(505)
	Family Services	1,583	1,868	(285)	2,159	1,998	161	3,742	3,865	(124)
	Head & Neck	1,074	623	451	1,288	771	516	2,361	1,394	968
	Neuroscience	601	440	161	562	484	78	1,163	924	239
	Pathology Network Group	75	36	39	423	292	131	498	328	171
	Patient Services	524	543	(18)	435	397	38	960	940	20
	Site Management & Discharge teams	216	78	138	97	123	(27)	313	201	111
	Specialist Cancer and Support Services	1,705	1,856	(151)	1,613	1,322	291	3,319	3,178	141
	Specialist Medicine	599	511	87	1,269	895	374	1,867	1,406	461
	Specialist Surgery	989	826	164	1,093	570	524	2,083	1,395	687
	Theatres, Anaesthetics and Critical Care	2,094	1,582	512	1,972	1,630	342	4,066	3,213	854
Total Operations		**16,024**	**14,845**	**1,179**	**18,350**	**16,003**	**2,347**	**34,374**	**30,848**	**3,526**
Corporate	Corporate Directorates	483	423	60	1,170	789	381	1,653	1,211	441
Total Corporate		**483**	**423**	**60**	**1,170**	**789**	**381**	**1,653**	**1,211**	**441**
Grand Total		**16,507**	**15,267**	**1,239**	**19,520**	**16,792**	**2,728**	**36,026**	**32,059**	**3,967**

Variable Pay Summary – Medical Staffing

The Group has spent £18.8m on Medical Staffing agency variable pay YTD. This is £1.8m less than the same period in 2025/26 but does include £1.9m of Industrial Action Cover.

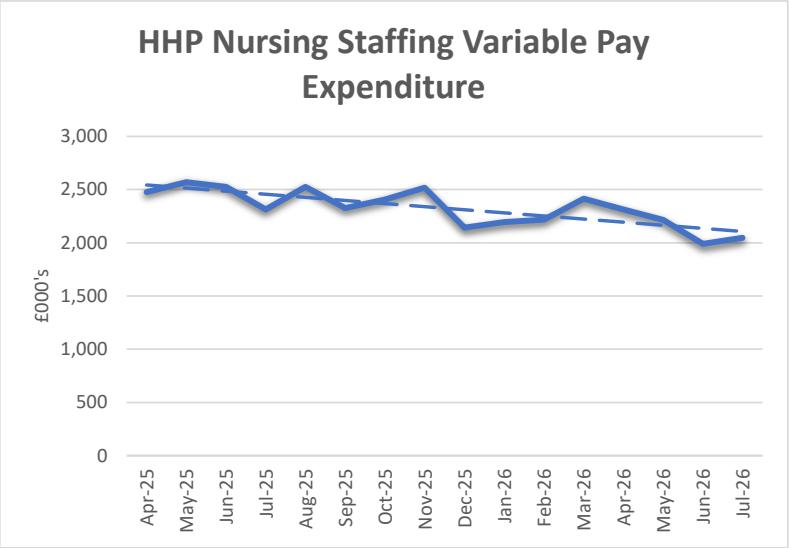
		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	2,372	2,386	(14)	0	0	0	2,372	2,386	(14)
	Acute and Emergency Medicine (South)	0	0	0	3,126	2,988	139	3,126	2,988	139
	Cancer Network	0	0	0	0	0	0	0	0	0
	Cardiovascular	728	649	78	60	79	(19)	788	729	60
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	811	677	134	500	430	70	1,311	1,107	204
	Digestive Diseases	506	634	(128)	506	931	(425)	1,012	1,565	(553)
	Family Services	1,050	1,264	(215)	852	1,164	(312)	1,901	2,428	(527)
	Head & Neck	983	552	431	1,079	595	484	2,061	1,147	914
	Neuroscience	375	280	95	259	232	26	633	513	121
	Pathology Network Group	66	17	49	118	106	12	184	123	60
	Patient Services	0	0	0	0	0	0	0	0	0
	Site Management & Discharge teams	0	0	0	0	0	0	0	0	0
	Specialist Cancer and Support Services	755	897	(142)	649	427	222	1,404	1,324	80
	Specialist Medicine	397	293	104	814	516	297	1,211	809	402
	Specialist Surgery	796	687	109	883	420	463	1,678	1,106	572
	Theatres, Anaesthetics and Critical Care	1,583	1,376	207	1,305	1,145	160	2,888	2,521	367
Total Operations		**10,421**	**9,714**	**707**	**10,150**	**9,034**	**1,117**	**20,571**	**18,747**	**1,824**
Corporate	Corporate Directorates	1	13	(11)	3	1	2	4	14	(10)
Total Corporate		**1**	**13**	**(11)**	**3**	**1**	**2**	**4**	**14**	**(10)**
Grand Total		**10,422**	**9,726**	**696**	**10,153**	**9,035**	**1,118**	**20,575**	**18,761**	**1,814**



Variable Pay Summary - Nursing

The Group has spent £8.6m on Nursing variable pay YTD. This is £1.3m less than the same period in 2025/26.

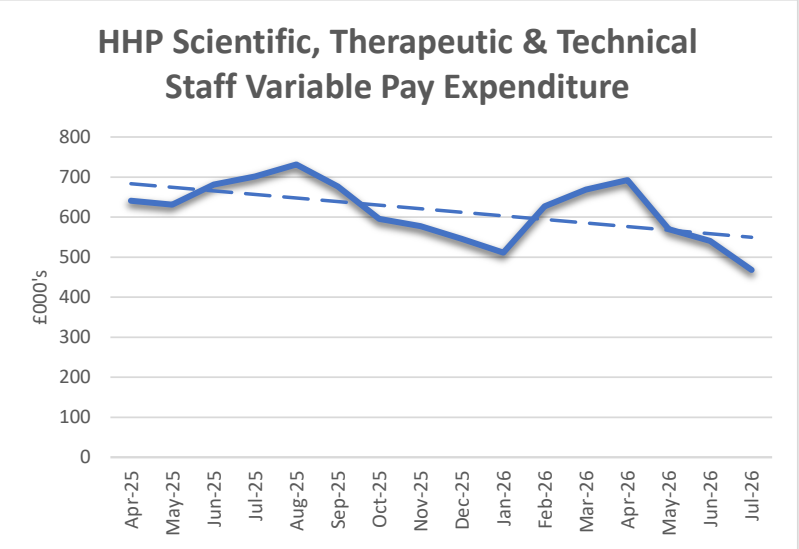
		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	762	828	(66)	0	0	0	762	828	(66)
	Acute and Emergency Medicine (South)	0	0	0	1,878	1,686	191	1,878	1,686	191
	Cancer Network	1	3	(2)	3	0	3	4	4	0
	Cardiovascular	176	223	(46)	116	138	(22)	292	361	(69)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	552	548	4	512	540	(28)	1,064	1,088	(24)
	Digestive Diseases	332	319	14	454	423	32	787	741	45
	Family Services	529	600	(72)	1,306	826	480	1,835	1,427	408
	Head & Neck	49	42	7	24	39	(15)	73	81	(8)
	Neuroscience	213	158	56	269	228	42	483	385	97
	Pathology Network Group	2	1	1	0	1	(1)	2	1	1
	Patient Services	8	8	1	57	4	54	66	11	54
	Site Management & Discharge teams	205	70	135	95	120	(25)	300	190	110
	Specialist Cancer and Support Services	297	232	65	67	94	(26)	364	325	39
	Specialist Medicine	195	210	(15)	433	364	69	629	574	55
	Specialist Surgery	186	131	55	211	150	61	397	281	116
	Theatres, Anaesthetics and Critical Care	371	171	200	513	372	141	884	543	341
Total Operations		**3,878**	**3,542**	**336**	**5,939**	**4,983**	**956**	**9,817**	**8,525**	**1,292**
Corporate	Corporate Directorates	34	16	18	30	20	10	64	36	28
Total Corporate		**34**	**16**	**18**	**30**	**20**	**10**	**64**	**36**	**28**
Grand Total		**3,912**	**3,558**	**354**	**5,970**	**5,003**	**966**	**9,881**	**8,562**	**1,320**



Variable Pay Summary – Scientific, Therapeutic & Technical Staff

The Group has spent £2.3m on AHP variable pay YTD. This is £0.4m less than the same period in 2025/26.

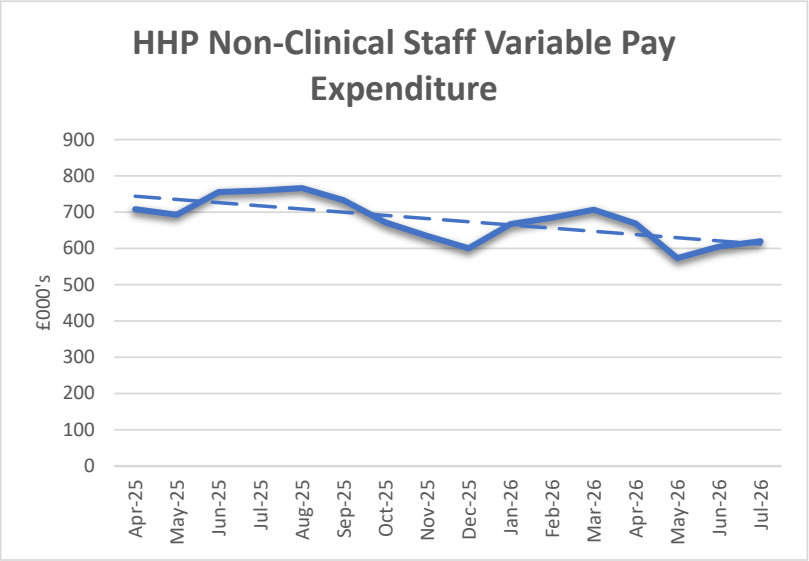
		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	0	0	0	0	0	0	0	0	0
	Acute and Emergency Medicine (South)	0	0	0	0	0	0	0	0	0
	Cancer Network	44	0	44	0	0	0	44	0	44
	Cardiovascular	71	65	7	23	43	(20)	94	107	(13)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	124	93	31	99	70	29	223	163	60
	Digestive Diseases	0	3	(2)	0	0	(0)	0	3	(3)
	Family Services	1	2	(1)	0	0	0	1	2	(1)
	Head & Neck	39	25	14	152	120	32	191	145	46
	Neuroscience	8	1	7	31	16	14	38	17	21
	Pathology Network Group	7	18	(10)	288	180	109	296	197	98
	Patient Services	0	0	(0)	0	0	0	0	0	(0)
	Site Management & Discharge teams	0	0	0	0	0	0	0	0	0
	Specialist Cancer and Support Services	590	689	(99)	851	721	130	1,441	1,410	32
	Specialist Medicine	6	4	2	6	3	3	11	7	4
	Specialist Surgery	5	8	(3)	0	0	0	5	8	(3)
	Theatres, Anaesthetics and Critical Care	139	35	105	129	105	25	269	140	129
Total Operations		**1,036**	**942**	**93**	**1,579**	**1,258**	**321**	**2,614**	**2,200**	**414**
Corporate	Corporate Directorates	30	56	(27)	11	15	(3)	41	71	(30)
Total Corporate		**30**	**56**	**(27)**	**11**	**15**	**(3)**	**41**	**71**	**(30)**
Grand Total		**1,065**	**999**	**67**	**1,590**	**1,272**	**318**	**2,656**	**2,271**	**385**



Variable Pay Summary – Non-Clinical Staff

The Group has spent £2.5m on Non-Clinical variable pay YTD. This is £0.4m less than the same period in 2025/26.

		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	20	16	3	0	13	(13)	20	29	(10)
	Acute and Emergency Medicine (South)	0	0	0	60	59	1	60	59	1
	Cancer Network	30	9	21	27	12	15	57	21	36
	Cardiovascular	2	6	(4)	1	1	(0)	3	7	(4)
	Chief Delivery Officer	7	0	6	12	18	(6)	19	19	(0)
	Community, Frailty & Therapy	9	13	(4)	62	90	(28)	71	103	(32)
	Digestive Diseases	16	11	6	0	0	0	16	11	6
	Family Services	4	1	3	1	7	(7)	5	9	(4)
	Head & Neck	3	3	(1)	33	18	15	36	21	15
	Neuroscience	5	1	4	3	8	(5)	9	9	(0)
	Pathology Network Group	0	0	0	17	5	12	17	5	12
	Patient Services	516	534	(18)	378	394	(16)	894	928	(34)
	Site Management & Discharge teams	11	8	3	2	3	(1)	13	11	1
	Specialist Cancer and Support Services	63	38	25	46	80	(35)	109	118	(9)
	Specialist Medicine	1	5	(4)	16	11	5	16	16	1
	Specialist Surgery	2	0	2	0	0	0	2	0	2
	Theatres, Anaesthetics and Critical Care	1	0	1	25	9	16	26	9	16
Total Operations		**690**	**647**	**43**	**682**	**728**	**(47)**	**1,371**	**1,375**	**(4)**
Corporate	Corporate Directorates	418	337	80	1,125	753	373	1,543	1,090	453
Total Corporate		**418**	**337**	**80**	**1,125**	**753**	**373**	**1,543**	**1,090**	**453**
Grand Total		**1,107**	**984**	**123**	**1,807**	**1,481**	**326**	**2,914**	**2,465**	**449**



Variable Pay v's 30% Target Reduction

The Group has seen a marginal decrease in its variable pay expenditure once adjusting for industrial Action expenditure. However, this falls well short of the 30% targeted reduction. A straight-line projection would be (£19.8m) higher than target.

HHP Variable Pay £k (excluding IA)

Directorate / Care Group	Annual Target	Monthly Target	July	Variance to Target	YTD Target	YTD Actual (exc IA)	YTD Variance to Target	YTD Straight-line	Forecast Variance to Target
Acute And Emergency Medicine North	5,754	479	698	(218)	1,918	2,870	(952)	8,609	(2,855)
Acute And Emergency Medicine South	10,912	909	1,090	(181)	3,637	4,622	(985)	13,867	(2,955)
Cancer Network	126	10	4	6	42	25	17	75	51
Cardiovascular	2,068	172	181	(9)	689	1,029	(340)	3,087	(1,019)
Chief Delivery Officer	0	0	3	(3)	0	19	(19)	56	(56)
Community, Frailty & Therapy	5,468	456	554	(98)	1,823	2,340	(518)	7,021	(1,553)
Digestive Diseases	4,395	366	463	(97)	1,465	2,123	(658)	6,369	(1,973)
Family Services	7,552	629	846	(217)	2,517	3,457	(940)	10,372	(2,820)
Head & Neck	4,262	355	273	82	1,421	1,357	64	4,072	191
Neuroscience	2,222	185	212	(27)	741	878	(138)	2,635	(414)
Pathology Network Group	1,060	88	72	17	353	328	26	983	78
Patient Services	1,583	132	241	(109)	528	940	(412)	2,820	(1,237)
Site Management & Discharge Teams	633	53	51	2	211	201	10	604	29
Specialist Cancer And Support Services	6,621	552	700	(149)	2,207	3,097	(890)	9,291	(2,669)
Specialist Medicine	3,211	268	325	(57)	1,070	1,301	(230)	3,902	(691)
Specialist Surgery	3,571	298	276	21	1,190	1,264	(73)	3,791	(220)
Theatres, Anaesthetics And Critical Care	7,665	639	769	(130)	2,555	3,097	(542)	9,292	(1,627)
Sub Total Operations	**67,103**	**5,592**	**6,760**	**(1,168)**	**22,368**	**28,948**	**(6,580)**	**86,844**	**(19,741)**
Chief Executive	13	1	14	(13)	4	19	(15)	58	(45)
Chief Medical Officer	20	2	1	1	7	11	(4)	33	(12)
Chief Nurse Office	181	15	16	(1)	60	77	(17)	232	(51)
Director of Assurance	0	0	-	0	0	-	0	-	0
Director of People	227	19	13	5	76	63	12	190	37
Director of Finance, Estates & Facilities	3,038	253	244	9	1,013	961	51	2,884	154
Strategy and Partnerships	133	11	14	(3)	44	78	(34)	234	(101)
Sub Total Operations	**3,613**	**301**	**302**	**(1)**	**1,204**	**1,210**	**(6)**	**3,631**	**(18)**
TOTAL	**70,716**	**5,893**	**7,062**	**(1,169)**	**23,572**	**30,158**	**(6,586)**	**90,474**	**(19,758)**

Appendices

Appendix A – Trust I&E & Divisional Budgetary Performance

£million	HUTH £m						NLAG £m						HHP £m					
	CM			YTD			CM			YTD			CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income																		
Clinical Income	75.3	76.0	0.7	150.6	151.5	0.9	46.7	46.6	(0.2)	93.5	92.7	(0.9)	122.1	122.6	0.5	244.1	244.1	(0.0)
Other Income	6.1	6.0	(0.1)	12.2	11.9	(0.4)	4.5	4.6	0.0	9.0	9.2	0.2	10.6	10.5	(0.1)	21.2	21.1	(0.2)
Total Operating Income	**81.4**	**82.0**	**0.6**	**162.9**	**163.3**	**0.5**	**51.3**	**51.1**	**(0.1)**	**102.5**	**101.8**	**(0.7)**	**132.7**	**133.1**	**0.4**	**265.4**	**265.2**	**(0.2)**
Pay Costs																		
Medical Staff	(17.4)	(18.4)	(1.0)	(34.8)	(37.6)	(2.7)	(10.6)	(10.7)	(0.1)	(21.2)	(21.4)	(0.2)	(27.9)	(29.1)	(1.1)	(56.0)	(58.9)	(2.9)
Nursing Staff	(16.7)	(16.5)	0.2	(33.2)	(33.0)	0.3	(13.6)	(13.4)	0.2	(27.2)	(26.4)	0.8	(30.3)	(29.9)	0.4	(60.4)	(59.4)	1.0
Scientific Therapeutic & Technical Staff	(7.5)	(7.3)	0.2	(14.9)	(14.6)	0.4	(5.5)	(5.5)	(0.0)	(10.9)	(11.0)	(0.1)	(13.0)	(12.8)	0.2	(25.8)	(25.6)	0.3
Total Clincial Pay	**(41.6)**	**(42.2)**	**(0.6)**	**(83.0)**	**(85.1)**	**(2.1)**	**(29.6)**	**(29.6)**	**0.0**	**(59.2)**	**(58.8)**	**0.4**	**(71.2)**	**(71.8)**	**(0.5)**	**(142.2)**	**(143.9)**	**(1.6)**
Admin & Clerical Staff	(6.5)	(6.6)	(0.1)	(13.2)	(13.0)	0.2	(5.4)	(5.2)	0.2	(10.8)	(10.6)	0.2	(11.9)	(11.8)	0.1	(23.9)	(23.6)	0.4
Maintenance Staff	(0.3)	(0.3)	0.0	(0.7)	(0.6)	0.0	(0.2)	(0.2)	0.0	(0.3)	(0.3)	0.0	(0.5)	(0.5)	0.0	(1.0)	(1.0)	0.0
Support Staff	(1.6)	(1.6)	(0.0)	(3.3)	(3.3)	(0.0)	(1.6)	(1.6)	(0.1)	(3.1)	(3.2)	(0.2)	(3.2)	(3.3)	(0.1)	(6.4)	(6.5)	(0.2)
Other Staff	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.0)	0.0
Apprentice Levy	(0.2)	(0.2)	(0.0)	(0.3)	(0.4)	(0.1)	(0.1)	(0.1)	(0.0)	(0.3)	(0.3)	(0.0)	(0.3)	(0.4)	(0.0)	(0.6)	(0.7)	(0.1)
Total Other Pay	**(8.6)**	**(8.7)**	**(0.1)**	**(17.5)**	**(17.3)**	**0.1**	**(7.3)**	**(7.2)**	**0.1**	**(14.6)**	**(14.5)**	**0.1**	**(15.9)**	**(15.9)**	**0.0**	**(32.0)**	**(31.8)**	**0.2**
Total Pay Costs	**(50.2)**	**(50.9)**	**(0.7)**	**(100.5)**	**(102.4)**	**(2.0)**	**(37.0)**	**(36.8)**	**0.2**	**(73.8)**	**(73.3)**	**0.5**	**(87.2)**	**(87.7)**	**(0.5)**	**(174.3)**	**(175.7)**	**(1.4)**
Drugs	(11.4)	(13.3)	(1.9)	(22.7)	(24.7)	(2.0)	(3.4)	(3.6)	(0.3)	(6.8)	(7.1)	(0.4)	(14.7)	(16.9)	(2.2)	(29.5)	(31.9)	(2.4)
Clinical Supplies & Services	(8.7)	(8.2)	0.5	(17.4)	(16.6)	0.8	(4.8)	(5.0)	(0.3)	(9.5)	(9.7)	(0.3)	(13.5)	(13.3)	0.2	(26.8)	(26.3)	0.5
Total Clinical Non Pay	**(20.1)**	**(21.5)**	**(1.4)**	**(40.1)**	**(41.3)**	**(1.3)**	**(8.1)**	**(8.7)**	**(0.5)**	**(16.2)**	**(16.9)**	**(0.6)**	**(28.2)**	**(30.2)**	**(2.0)**	**(56.3)**	**(58.2)**	**(1.9)**
Admin & Clerical Staff - Non Execs	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.0)	0.0
General Supplies & Services	(2.0)	(2.1)	(0.1)	(4.0)	(4.2)	(0.2)	(0.7)	(0.7)	0.0	(1.3)	(1.3)	0.0	(2.7)	(2.8)	(0.1)	(5.3)	(5.5)	(0.2)
Establishment Expenses	(0.3)	(0.5)	(0.2)	(0.6)	(0.9)	(0.2)	(0.3)	(0.4)	(0.1)	(0.7)	(0.6)	0.0	(0.6)	(0.9)	(0.2)	(1.3)	(1.5)	(0.2)
Establishment Expenses Op Lease	0.0	0.0	0.0	0.0	0.0	0.0	(0.1)	(0.0)	0.0	(0.1)	(0.1)	(0.0)	(0.1)	(0.0)	0.0	(0.1)	(0.1)	(0.0)
Establishment Expenses Transport	(0.2)	(0.2)	(0.1)	(0.4)	(0.5)	(0.1)	(0.3)	(0.2)	0.0	(0.5)	(0.5)	0.0	(0.4)	(0.5)	(0.0)	(0.9)	(1.0)	(0.1)
Other Establishment Costs	(0.2)	(0.3)	(0.1)	(0.4)	(0.6)	(0.2)	(0.1)	(0.1)	(0.0)	(0.2)	(0.2)	(0.1)	(0.3)	(0.4)	(0.1)	(0.5)	(0.8)	(0.2)
Other Establishment Costs Clinical Negligence	(2.5)	(2.4)	0.0	(4.9)	(4.7)	0.2	(1.6)	(1.5)	0.0	(3.1)	(3.1)	0.0	(4.0)	(3.9)	0.1	(8.1)	(7.8)	0.2
Premises and Fixed Plant	(3.2)	(3.0)	0.2	(6.5)	(5.9)	0.5	(0.2)	(0.3)	(0.0)	(0.5)	(0.5)	(0.0)	(3.4)	(3.2)	0.2	(6.9)	(6.5)	0.5
Premises and Fixed Plant - Rates	(0.4)	(0.4)	(0.0)	(0.8)	(0.9)	(0.1)	(1.9)	(1.9)	0.0	(3.9)	(3.7)	0.2	(2.3)	(2.3)	(0.0)	(4.7)	(4.6)	0.1
Purchase of Healthcare Services NHS and other DHSC bodies	(1.9)	(2.0)	(0.1)	(3.7)	(4.0)	(0.3)	(0.3)	(0.3)	0.0	(0.6)	(0.5)	0.1	(2.2)	(2.3)	(0.1)	(4.4)	(4.6)	(0.2)
Purchase of Healthcare Services Non NHS	(0.9)	(1.8)	(1.0)	(1.7)	(3.6)	(1.9)	(0.2)	(1.0)	(0.8)	(0.3)	(2.0)	(1.6)	(1.0)	(2.8)	(1.8)	(2.1)	(5.6)	(3.5)
Miscellaneous Expenditure	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)	(0.1)	(0.2)	(0.0)	(0.3)	(0.3)	0.0
Miscellaneous Expenditure Statutory Audit	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Education Expenditure	(0.5)	(0.4)	0.1	(1.0)	(0.9)	0.2	(0.2)	(0.2)	0.0	(0.4)	(0.3)	0.1	(0.7)	(0.6)	0.2	(1.5)	(1.2)	0.3
Consultancy Expenditure	0.0	(0.2)	(0.2)	0.0	(0.1)	(0.1)	(0.0)	(0.2)	(0.1)	(0.0)	(0.2)	(0.1)	(0.0)	(0.3)	(0.3)	(0.0)	(0.3)	(0.3)
Total Other Non Pay	**(12.0)**	**(13.4)**	**(1.4)**	**(24.2)**	**(26.4)**	**(2.2)**	**(5.9)**	**(6.8)**	**(0.9)**	**(12.0)**	**(13.4)**	**(1.4)**	**(17.9)**	**(20.2)**	**(2.3)**	**(36.2)**	**(39.8)**	**(3.6)**
Total Non Pay Costs	**(32.1)**	**(34.9)**	**(2.8)**	**(64.3)**	**(67.7)**	**(3.4)**	**(14.0)**	**(15.5)**	**(1.4)**	**(28.2)**	**(30.2)**	**(2.0)**	**(46.1)**	**(50.4)**	**(4.3)**	**(92.5)**	**(97.9)**	**(5.5)**
Total Operating Expenditure	**(82.3)**	**(85.8)**	**(3.5)**	**(164.7)**	**(170.1)**	**(5.4)**	**(51.0)**	**(52.2)**	**(1.3)**	**(102.0)**	**(103.5)**	**(1.5)**	**(133.3)**	**(138.1)**	**(4.8)**	**(266.7)**	**(273.6)**	**(6.9)**
EBITDA	**(0.9)**	**(3.8)**	**(2.9)**	**(1.9)**	**(6.8)**	**(4.9)**	**0.3**	**(1.1)**	**(1.4)**	**0.6**	**(1.7)**	**(2.2)**	**(0.6)**	**(4.9)**	**(4.3)**	**(1.3)**	**(8.4)**	**(7.1)**
Depreciation	(2.7)	(2.7)	0.0	(5.4)	(5.3)	0.1	(2.3)	(1.8)	0.5	(4.7)	(3.6)	1.1	(5.0)	(4.5)	0.6	(10.1)	(8.9)	1.1
Non Operating Items	(1.5)	(1.5)	(0.0)	(3.0)	(3.1)	(0.0)	(0.7)	(0.5)	0.1	(1.4)	(1.1)	0.2	(2.2)	(2.1)	0.1	(4.4)	(4.2)	0.2
Surplus/(Deficit)	**(5.1)**	**(8.0)**	**(2.9)**	**(10.3)**	**(15.2)**	**(4.9)**	**(2.7)**	**(3.4)**	**(0.7)**	**(5.5)**	**(6.4)**	**(0.9)**	**(7.8)**	**(11.5)**	**(3.6)**	**(15.8)**	**(21.6)**	**(5.8)**
NHSE Allowable Adjustments	(0.0)	0.0	0.0	0.0	(0.0)	(0.0)	0.2	0.1	(0.1)	0.3	0.2	(0.2)	0.1	0.1	(0.1)	0.3	0.1	(0.2)
Adjusted Surplus / (Deficit)	**(5.1)**	**(8.0)**	**(2.9)**	**(10.3)**	**(15.2)**	**(4.9)**	**(2.5)**	**(3.3)**	**(0.8)**	**(5.1)**	**(6.2)**	**(1.1)**	**(7.7)**	**(11.4)**	**(3.7)**	**(15.5)**	**(21.4)**	**(6.0)**

Appendix A – Trust I&E & Divisional Budgetary Performance

		HUTH (£m)						NLAG (£m)						HHP (£m)					
		CM			YTD			CM			YTD			CM			YTD		
Directorate	Care Group	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operations	Acute and Emergency Medicine (North)	(3.7)	(4.0)	(0.2)	(7.4)	(8.3)	(0.9)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(3.7)	(4.0)	(0.2)	(7.4)	(8.3)	(0.9)
	Acute and Emergency Medicine (South)	0.0	0.0	0.0	0.0	0.0	0.0	(5.7)	(5.9)	(0.2)	(11.4)	(11.8)	(0.4)	(5.7)	(5.9)	(0.2)	(11.4)	(11.8)	(0.4)
	Cancer Network	(0.5)	(0.5)	(0.0)	(1.0)	(1.0)	(0.0)	(0.3)	(0.3)	(0.0)	(0.5)	(0.5)	(0.0)	(0.8)	(0.8)	(0.0)	(1.5)	(1.5)	(0.0)
	Cardiovascular	(3.5)	(3.8)	(0.4)	(6.9)	(7.8)	(0.8)	(0.9)	(0.9)	(0.0)	(1.8)	(1.8)	0.0	(4.3)	(4.7)	(0.4)	(8.7)	(9.5)	(0.8)
	Chief Delivery Officer	(0.1)	(0.1)	(0.1)	(0.1)	(0.3)	(0.1)	(0.1)	(0.1)	(0.0)	(0.2)	(0.1)	0.0	(0.1)	(0.2)	(0.1)	(0.3)	(0.4)	(0.1)
	Community, Frailty & Therapy	(3.5)	(3.9)	(0.4)	(7.0)	(7.8)	(0.8)	(4.0)	(4.2)	(0.2)	(7.9)	(8.3)	(0.3)	(7.5)	(8.1)	(0.6)	(14.9)	(16.0)	(1.1)
	Digestive Diseases	(3.1)	(3.4)	(0.4)	(6.2)	(7.2)	(1.0)	(2.6)	(2.9)	(0.2)	(5.3)	(5.4)	(0.2)	(5.7)	(6.3)	(0.6)	(11.4)	(12.6)	(1.2)
	Family Services	(5.0)	(5.3)	(0.3)	(10.0)	(10.8)	(0.8)	(4.8)	(4.7)	0.0	(9.5)	(9.4)	0.1	(9.8)	(10.0)	(0.2)	(19.5)	(20.2)	(0.7)
	Head & Neck	(3.4)	(3.4)	(0.1)	(6.7)	(6.9)	(0.1)	(1.3)	(1.4)	(0.0)	(2.7)	(2.8)	(0.2)	(4.7)	(4.8)	(0.1)	(9.4)	(9.7)	(0.3)
	Neuroscience	(2.4)	(2.4)	(0.0)	(4.7)	(4.8)	(0.1)	(0.9)	(1.0)	(0.1)	(1.8)	(1.9)	(0.1)	(3.3)	(3.4)	(0.1)	(6.5)	(6.7)	(0.2)
	Pathology Network Group	(2.2)	(2.1)	0.1	(4.1)	(4.2)	(0.1)	(2.2)	(2.3)	(0.1)	(4.5)	(4.5)	(0.0)	(4.4)	(4.4)	0.0	(8.6)	(8.7)	(0.1)
	Patient Services	(2.2)	(2.3)	(0.1)	(4.4)	(4.5)	(0.1)	(1.6)	(1.6)	(0.0)	(3.2)	(3.3)	(0.0)	(3.8)	(3.9)	(0.1)	(7.6)	(7.7)	(0.1)
	Site Management & Discharge teams	(0.3)	(0.3)	(0.0)	(0.5)	(0.6)	(0.0)	(0.3)	(0.4)	(0.0)	(0.7)	(0.7)	(0.0)	(0.6)	(0.7)	(0.0)	(1.2)	(1.3)	(0.0)
	Specialist Cancer and Support Services	(18.3)	(19.4)	(1.1)	(36.6)	(38.3)	(1.6)	(5.9)	(6.1)	(0.2)	(11.8)	(12.1)	(0.3)	(24.2)	(25.5)	(1.3)	(48.4)	(50.4)	(2.0)
	Specialist Medicine	(4.1)	(4.3)	(0.2)	(8.1)	(8.7)	(0.5)	(2.1)	(2.2)	(0.2)	(4.2)	(4.3)	(0.2)	(6.2)	(6.5)	(0.4)	(12.3)	(13.0)	(0.7)
	Specialist Surgery	(3.7)	(3.8)	(0.1)	(7.4)	(7.5)	(0.1)	(1.9)	(2.0)	(0.1)	(3.7)	(3.8)	(0.1)	(5.6)	(5.8)	(0.2)	(11.1)	(11.3)	(0.2)
	Theatres, Anaesthetics and Critical Care	(7.3)	(7.6)	(0.3)	(14.6)	(15.3)	(0.8)	(4.1)	(4.2)	(0.1)	(8.3)	(8.6)	(0.3)	(11.4)	(11.9)	(0.5)	(22.8)	(23.9)	(1.1)
Total Operations		**(63.1)**	**(66.7)**	**(3.6)**	**(125.8)**	**(133.7)**	**(7.9)**	**(38.7)**	**(40.1)**	**(1.4)**	**(77.3)**	**(79.4)**	**(2.1)**	**(101.8)**	**(106.8)**	**(5.0)**	**(203.2)**	**(213.1)**	**(9.9)**
Corporate	Chief Executive	(0.1)	(0.2)	(0.1)	(0.2)	(0.4)	(0.2)	(0.1)	(0.2)	(0.1)	(0.2)	(0.4)	(0.1)	(0.2)	(0.4)	(0.2)	(0.5)	(0.8)	(0.3)
	Chief Medical Officer	(0.4)	(0.5)	(0.1)	(0.9)	(0.9)	(0.1)	(0.6)	(0.7)	(0.0)	(1.3)	(1.3)	0.0	(1.1)	(1.2)	(0.1)	(2.1)	(2.2)	(0.1)
	Chief Nurse Office	(3.3)	(3.1)	0.1	(6.5)	(6.4)	0.1	(2.4)	(2.4)	0.1	(4.9)	(4.8)	0.1	(5.7)	(5.5)	0.2	(11.4)	(11.1)	0.2
	Director of Assurance	(0.0)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)	(0.1)
	Director of People	(0.9)	(0.9)	(0.0)	(1.8)	(1.9)	(0.1)	(0.7)	(0.8)	(0.1)	(1.5)	(1.5)	0.0	(1.6)	(1.7)	(0.1)	(3.3)	(3.4)	(0.0)
	Director of Finance, Estates & Facilities	(6.2)	(6.4)	(0.1)	(12.6)	(12.7)	(0.2)	(4.1)	(4.4)	(0.3)	(8.3)	(8.7)	(0.4)	(10.3)	(10.8)	(0.5)	(20.9)	(21.4)	(0.5)
	Strategy and Partnerships	(0.9)	(1.0)	(0.1)	(1.9)	(1.8)	0.0	(0.7)	(0.6)	0.1	(1.5)	(1.4)	0.1	(1.7)	(1.6)	0.1	(3.4)	(3.3)	0.1
Total Corporate		**(11.9)**	**(12.3)**	**(0.4)**	**(23.9)**	**(24.3)**	**(0.4)**	**(8.9)**	**(9.1)**	**(0.3)**	**(17.9)**	**(18.2)**	**(0.3)**	**(20.7)**	**(21.4)**	**(0.7)**	**(41.8)**	**(42.4)**	**(0.7)**
Central Income, Reserves & Technical	Central Income	76.3	76.2	(0.1)	152.7	152.6	(0.1)	48.4	47.8	(0.6)	96.8	95.8	(1.0)	124.7	124.1	(0.7)	249.5	248.4	(1.1)
	Central Technical	(4.6)	(4.9)	(0.2)	(9.0)	(9.1)	(0.1)	(2.9)	(1.8)	1.1	(5.8)	(4.3)	1.5	(7.5)	(6.7)	0.8	(14.8)	(13.4)	1.4
	Reserves	(1.8)	(0.4)	1.4	(4.2)	(0.7)	3.6	(0.6)	(0.2)	0.5	(1.3)	(0.3)	1.0	(2.5)	(0.6)	1.9	(5.5)	(1.0)	4.5
Total Central Income, Reserves & Technical		**69.9**	**70.9**	**1.0**	**139.4**	**142.8**	**3.4**	**44.9**	**45.8**	**1.0**	**89.7**	**91.2**	**1.4**	**114.7**	**116.7**	**2.0**	**229.1**	**234.0**	**4.8**
Surplus / (Deficit)		**(5.1)**	**(8.0)**	**(2.9)**	**(10.3)**	**(15.2)**	**(4.9)**	**(2.7)**	**(3.4)**	**(0.7)**	**(5.5)**	**(6.4)**	**(0.9)**	**(7.8)**	**(11.5)**	**(3.6)**	**(15.8)**	**(21.6)**	**(5.8)**
Adjustments to adjusted financial performance		(0.0)	0.0	0.0	0.0	(0.0)	(0.0)	0.2	0.1	(0.1)	0.3	0.2	(0.2)	0.1	0.1	(0.1)	0.3	0.1	(0.2)
Adjusted financial performance Surplus / (Deficit)		**(5.1)**	**(8.0)**	**(2.9)**	**(10.3)**	**(15.2)**	**(4.9)**	**(2.5)**	**(3.3)**	**(0.8)**	**(5.1)**	**(6.2)**	**(1.1)**	**(7.7)**	**(11.4)**	**(3.7)**	**(15.5)**	**(21.4)**	**(6.0)**

Recovery Action Plan

Care Group:	HUTH Acute & Emerg Med & Major Trauma	£'000
Forecast Variance as at:	M4 (July-26)	(3,362)

Recovery Schemes	**Details of actions / decisions required**	**Expected Forecast Improvement - Current Year (£'000)**	**Progress status**	**Recurrent / Non-Recurrent**
Acute Consultant appointments (5wte) - over & above the £460k in M3 CIP plan	start dates in August	in forecast	actioned	Rec
Reduce x2 RN 24/7 covering corridor care	wef Sept	in forecast	Plans In Development	Rec
Cease In-Reach doctors (consultant & registrar)	wef Aug	442	actioned	Rec
Reduce additional support into ECA = overtime (work towards safe dept. numbers c40)	wef November (£20k a month)	100	Plans In Development	Rec
re-align Wd5 resources following closure	nonpay wef Sept. Review w/c 6th July to confirm	20	Plans In Development	Rec
re-align Wd5 resources following closure	Consultant to cease wef Nov	100	Plans In Development	Rec
rebanding of MT co-ordinators	to review in December	TBC	Plans In Development	Rec
Adjusted Forecast / Recovery Gap		**(2,700)**		

Recovery Action Plan

Care Group:	Digestive Diseases	£'000
Forecast Variance as at:	End of July 2026	(7,138)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
£250k Nurse Endoscopy workforce model	Consultation, agree new workforce model.	63	250	01-Jan-27	Scoping	Med	Sarah Clarke	Recovery action - to reduce current expenditure	Rec
Workforce redesign. Run rate reduction	Consultation, agree new workforce model.	(128)	130	01-Jan-27	Scoping	Med	Sarah Clarke	Recovery action - to reduce current expenditure	Rec
WLI controls further details needed for £k calculation. RR reduction	Additional internal care group controls and process changes. Then a potentially material savings amount can be forecasted. Locum cons interview july 14th gastro north. Flexible job plan for first year to fill more vacant lists and reduce WLIs. Two endoscopy fellows north intervew 18th with flexible job plann HRI and CHH. Forecast 30pc reduction in forecast from recruitment dates. Consultant start end of August. Two registrars starting end of Sept. INcrease in number of people able to do fixed lists by funding the 6th room - this will reduce the number of vacant lists that are published i.e. fewer WLIs.	TBC	TBC	01-Sep-26	Scoping	Med	George Abouda, Peter Grant	Recovery action - to reduce current expenditure	Rec
£34k Reduce budget WTE on wards on the south bank	Rotas and budgets permanently changed.	34	34	01-Sep-26	Plans in development	Low	Sarah Clarke	Recovery action - to reduce current expenditure	Rec
£18k PEG service income from CHCP.	Process for capturing and rechargning costs set up.	11	18	01-Sep-26	Plans in development	Low	Tracey Davies	Recovery action - to reduce current expenditure	Rec
£40k endoscopy – switch from pre-made to loaded syringes.	Switch date confirmation. Chase lisa gadd. Emailed Lisa again June 30th	23	40	01-Aug-26	Plans in development	Med	Procurement	Recovery action - to reduce current expenditure	Rec
£9k Endoscopy on-call nursing requirements GI bleed rota.	linked to Humber GI job planning review	5	9	01-Sep-26	Scoping	Med	Sarah Clarke	Recovery action - to reduce current expenditure	Rec
Technical / budget improvements - mainly outstanding business cases requiring submission and budget award	Mainly outstanding business cases requiring submission and budget award	1,375	3,300	01-Oct-26	Plans in development	Med	Several Care Group Staff	Budget transfer	Rec
UNPALATABLE - stop GIM rota agency cover. THIS HAS STOPPED.	Needs trust-wide agreement. Consultant stopped but consultant review costs 2.5 PAs per week (2 hours per day mon to fri £80 per hour). CT3 end of Aug onwards replaced by substantive.	150	300	Sep-26	Scoping	High	George Abouda, Peter Grant	Recovery action - to reduce current expenditure	Rec
Back to basics exercise – review of all job plans and long-term vacancies underway	Review of all job plans and long-term vacancies underway	TBC	TBC	01-Sep-26	Scoping	Med	Tri	Recovery action - to reduce current expenditure	Rec
Other	minor improvements/adjustments across several areas / balancing figure to forecast	206							
Adjusted Forecast / Recovery Gap		**(5,400)**	**(3,057)**						

Recovery Action Plan
Care Group:
Forecast Variance as at:

	£'000
M4	(6,481)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
Clinical Engineering Repairs	Ceasing repairs and support on equipment over 10 years in age - eQIA completed and supported	11	85		Agreed / Approved	Low		Recovery action - to deliver CIP	Rec
Radiation Protection Income Margin	Increase income margin of private work	10	20		Agreed / Approved	Low		Recovery action - to deliver CIP	Rec
Onc & Haem External Testing Review	Challenge the bredth of external specialist testing and review what isn't necessary and what can be downgraded to local labs instead	TBC	TBC		Scoping	Med		Recovery action - to deliver CIP	Rec
HCD Income Recovery	Embed group-wide income recovery process to align NLAG recovery with HUTH	194	388		Scoping	High		Recovery action - to deliver CIP	Rec
Dispensary closures	Would require assessment of stock/staffing release	TBC	TBC		Scoping	High			
Centralised pharmacy +/- aseptic	Would require capital investment to facilitate single site provision	0	90		Scoping	High		Recovery action - to deliver CIP	Rec
Cessation of Homecare Deliveries	EQIA Being developed/ Would for part of 27/28 contract award	0	300		Plans in development	Med		Recovery action - to deliver CIP	Rec
Biosimilar Gains Share	Negotiate gains share arrangements with ICB/NHSE around biosimilar switches	TBC			Plans in development	Med		Additional Income allocation	NR
Reducing Imaging footprint across HHP	Review of delivery site requirements I.e. CDC	0	75		Scoping	High		Recovery action - to deliver CIP	Rec
Reviewing our Clinical Engineering footprint/exploration of arms length delivery model	Work through alternative delivery models and sites.	TBC	TBC		Scoping	High		Recovery action - to deliver CIP	Rec
Manufacturer review in IR	Looking to standardise/rationalise product options	20	40		Plans in development	Low		Recovery action - to reduce forecast expenditure	Rec
IRT Stock Management	Ensuring stock processes, including regular stock takes, Scan4Safety, and consignment are actively supporting the financial position	100	100		Plans in development	Med		Recovery action - to reduce current expenditure	Rec
Breast Tissue Consumables	Product switch to be reviewed for cost effectiveness and clinical appropriateness	25	50		Plans in development	Low		Recovery action - to deliver CIP	Rec
Ultrasound Probe Maintenance	Review scope of maintenance contracts and risk appetite for probe cover	18	72		Scoping	Med		Recovery action - to deliver CIP	Rec
Breast Postage	Reduce letter usage as part of Dr Doctor contract	50	100		Scoping	High		Recovery action - to reduce current expenditure	Rec
Shadow On-Call Review		7	28		Scoping	Med		Recovery action - to deliver CIP	Rec
Implement Reporting Productivity Model	National tool now available, reviewing to identify opportunity to implement	150	360		Scoping	High		Recovery action - to deliver CIP	Rec
OPAT Drugs	Support transition to 7 day model to reduce premium drugs expenditure	75	150		Plans in development	Med		Recovery action - to reduce current expenditure	Rec
MT Additional Income	Technical adjustment to capture additional £400k NHSE allocation	400	400		Agreed / Approved	Low		Budget transfer	Rec
Not extending MT service beyond current hours	£1m cost avoidance on current draft staffing model/requirement	0	0		Scoping	High		Recovery action - to remove forecast risk	Rec
Variable pay minisuction (Pharmacy)	Enforce cut off times for IDL	40	75		Scoping	High		Recovery action - to deliver CIP	Rec
Vacancy Hold	Support Group-wide vacancy freeze by holding non-essential vacancies which don't adversely impact variable pay - estimated at 10wte being held	300	0		Plans in development	High		Recovery action - to reduce forecast expenditure	NR
Ceasing all Imaging outsourcing	Stop outsourcing	3,033	5,200		Scoping	High		Recovery action - to reduce forecast expenditure	Rec
Ceasing Radiologist extra sessional reporting	1M NLAG/£0.65n HUTH	963	1,650		Scoping	High		Recovery action - to reduce forecast expenditure	Rec
Ceasing all NOUS locums	Release of Agency workers supporting NOUS at the detriment of NLAG DM01 performance	592	1,014		Scoping	High		Recovery action - to reduce forecast expenditure	Rec
Adjusted Forecast / Recovery Gap		(494)	**3,716**						

Recovery Action Plan

Care Group:	TACC	£'000
Forecast Variance as at:	Month 4	(4,647)

Recovery Schemes	**Details of actions / decisions required**	**Expected Forecast Improvement - Current Year (£'000)**	**Expected Financial Improvement - Full Year Effect (£'000)**	**Action to be completed by (date)**	**Progress status**	**RAG Rating**	**Responsible Officer**	**Category**	**Recurrent / Non-Recurrent**
		+ve	+ve						
CRES Unidentified- HUTH	Improved delivery of CIP	2,600		ASAP	Plans in Development		TACC Tri		Recurrent
Acute Latent Sessions Cease	Cease unfunded sessions	310	460	Oct-27	Plans in Development		TACC Tri		Recurrent
F2 MT Transfer - HUTH	Agree Transfer Between MT & TACC. Discussed at TACC Exec M3	260	260	Sep-26	Scoping		Hayley Briggs, Caroline Hibbert, Lorraine Laws		Recurrent
HUTH Drugs	Understand reasons for and seek control of Drugs position	250	400	Jan-27	Scoping		Rob Bourne		Recurrent
CRES Unidentified - NLAG	Improved delivery of CIP	1,792		ASAP	Plans in Development		TACC Tri		Recurrent
F2 Pressure NLAG	Do not renew	33	67	Apr-27	Plans in Development		Sophie Fisher		Recurrent
Adjusted Forecast / Recovery Gap		**598**	**0**						

Recovery Action Plan

Care Group:	Community, Frailty & Therapies	£'000
Forecast Variance as at:	Month 3	(3,170)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
Improvement on CIP since Month 2	Deliver on plans - Included IN FORECAST								Rec
NCTR Capacity	Exec decision on option paper submitted				Plans in development	High	Exec	Recovery action - to reduce forecast expenditure	Rec
Review of CHCP/HUTH Palliative care medical staff	Approval of Business model by CHCP	20	50	30-Sep-26	Plans in development	Med	Care Group Board	Recovery action - to deliver CIP	Rec
CHH Overnight Hospital at Night	Revert to previous model on CHH Med cover - requires Exec Approval	99	170	31-Aug-26	Plans in development	High	Exec	Recovery action - to reduce current expenditure	Rec
Active Sickness Management	Targetted actions to reduce high levels of sickness - IN FORECAST				In delivery	Low			Rec
Ward Staffing - review of levels and funding	remove additional nurse staff on rotas until funding starts in October - ACTIONED _ IN FORECAST	180	0	30-Jun-26	In delivery	Low	Care Group Board	Recovery action - to reduce current expenditure	NR
Secure deanery funding	Funding request to be approved - ACTIONED - IN FORECAST				In delivery	Low			
Increased Variable pay reductions	Further stretch challenge re variable pay reductions - IN FORECAST				In delivery	Low			
Adjusted Forecast / Recovery Gap		(2,871)	(2,950)						

Recovery Action Plan

Care Group:	Family Services Care Group	£'000
Forecast Variance as at:	Month 04	(4,011)

Recovery Schemes	**Details of actions / decisions required**	**Expected Forecast Improvement - Current Year (£'000)**	**Expected Financial Improvement - Full Year Effect (£'000)**	**Action to be completed by (date)**	**Progress status**	**RAG Rating**	**Responsible Officer**	**Category**	**Recurrent / Non-Recurrent**
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
Uncosted CIP Schemes	A&G templates being rolled out to reduce acceptance of non commissioned pathways. EG Sleep. This will reduce the melatonin medication spend	100	200	01-Sep-26	Agreed / Approved	Low	Lisa Pearce	Recovery action - to reduce forecast expenditure	Rec
ADHD Medication	Reduction in ADHD medication overspend	30	65	01-Sep-26	Agreed / Approved	Low	Lisa Pearce	Recovery action - to reduce forecast expenditure	Rec
Cease use of Agency staff	Phase out usage of agency medical staff as we recruit to med staff expansion bus case	180	480	31-Mar-27	Plans in development	Med	Lisa Pearce	Recovery action - to deliver CIP	Rec
Paediatric Surgery Consultant Costs	Removal of cost pressure - end of Cons locum contract	50	0	01-Oct-26	Agreed / Approved	Low	Lisa Pearce	Recovery action - to reduce current expenditure	NR
Hospital at Home - NLAG	Decommission Hospital at Home service model - NLAG	230	350	01-Sep-26	Plans in development	Med	Debbie Bray	Non Recurrent benefit	Rec
Reduction of ECP	Workforce expansion will support additional ECP reduction via flexi job planning with consultant expansion across gynaecology and paed/neonates	100	360	01-Mar-26	Plans in development	Med	Clinical Leads and Clinical Director	Recovery action - to deliver CIP	Rec
Neonatal Critical Care Review	Outcome of the regional NCCR to be implemented. It is anticipated that this will reduce the status of the SGH service from LNU to a SCU leading to an HHP neonatal configuration of NICU HUTH L3, LNU DPoW L2, SCU SGH L1. At present efficiences are unknown given the large scale transformation and likely formal public consultation that will be required to deliver the change. NB The fallout of the NCCR will require reconfiguration of the matenrity pathways which may have financial efficiences, however these are unknown at this time	0	tbc	Unknown NHSE / Spec Comm / ODN led exercise	Plans in development	Med	NHSE	Recovery action - to reduce current expenditure	Rec
Site consolidation of Gynaecology services NLAG	Undertake a scoping exercise to review the options regarding gynaecolgoy elective and non elective pathways, IP and OP across NLAG	0	tbc		Scoping	High	QUAD	Recovery action - to reduce current expenditure	Rec
Paediatric Critical Care Service HUTH	Undertake a review of the service model and commissioning of critical care service model at HUTH - Income v's cost.	0	tbc	2027	Scoping	High	Debbie Bray	Recovery action - to reduce current expenditure	Rec
Paediatric Neonatal Surgery Senate	Outcome of the Neonatal Surgery Senate to be implemented. This may deliver some savings, however this will be unknown until the recommendations are received	0	tbc		Plans in development	Med		Recovery action - to reduce current expenditure	Rec
Drug Review	Undertake a further deep dive with pharmacy colleagues to explore any medication / prescribing efficiencies or standardisation of practice	20	60	01-Oct-26	Scoping	Med	QUAD	Recovery action - to reduce forecast expenditure	Rec
Reusable Bottles	Replace disposable bottles with reusable bottles - North bank (already in place south bank)	5	10	01-Oct-26	Agreed / Approved	Low	Yvonne McGrath	Recovery action - to reduce forecast expenditure	Rec
Conversion of community clinic Gynae NLAG	Convert the community based clinic on site to DPOW, this is due to the lack of efficiency and use of the community clinic. Currently pay rent and taxi fare to transport staff. Bi weekly clinic - Louth and Mablethorpe - 2 rooms, travel in work time so clinic capacity is compromised.	5	10	01-Oct-26	Scoping	High	Clinical Lead DPOW	Recovery action - to deliver CIP	Rec
Adjusted Forecast / Recovery Gap		(3,291)	(2,476)						

Recovery Action Plan

Care Group:	Specialist Medicine	£'000
Forecast Variance as at:	Month 4 (July-26)	(3,097)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Progress status	Recurrent / Non-Recurrent
vacancy pause	to review vacanct posts & impact on activity / waiting lists	20	Agreed / Approved	NR
reduce NLG Respiratory Agency (from 3 to 2 posts covered)	decision TBC = impact on activity/WL - (Oct-Dec)	71	Plans in development	Rec
Dexcom Rebates (£15k assumed in CIP plan)	to confirm any additional rebates above forecast	50	Plans in development	NR
CPAP consumables - increase in unfunded activity (£825k forecast pressure)	escalated at exec review as funded on block.activity impact of increased sleep studies. Options? cease activity & also pursue additional block funding?	400	Escalated at Exec Review & ICB contract discussions	Rec
Review of non-commissioned (unpaid) work/activity (CNS staff) - efficiency not cost out? Divert to community				
Ward Reviews - bed reduction				
Lung Cancer Screening - review of staffing resource & pathways across HHP			Scoping	Rec
Adjusted Forecast / Recovery Gap		(2,556)		

NHS
Humber Health
Partnership

Cash Committee TO Performance, Estates & Finance Committees-in-Common: ADVISE, ALERT and ASSURE	
Cash Committee:	
Meeting Date:	13th August 2026
Chair:	Philippa Russell, Deputy Group Chief Finance Officer

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Board to areas of non-compliance or matters that need addressing urgently)

Issue	Update	Assurance received	Action	Timescale
Impact on cash forecast due to limited progress in progressing CIP plans / Cash Releasing savings	At Month 4 the Group was £18.7m overspent with a risk adjusted CIP forecast that is £58.3m short of delivering the target. As a result of this slippage on delivery, for H1 (Apr- Sep) the Group has requested Revenue Support PDC of £57.8m, which is £26.92m higher than planned for H1 and will have to be recovered in H2.	Financial position and lack of progress on CIP delivery highlighted at SLT. Care Groups RAG rated as red following June Board session have started to develop recovery action plans. Grant Thornton providing direct support to 8 Care Groups in escalation.	The impact on cash requirements due to slippage on CIP to be highlighted to PEF and Board as a continuing significant risk. Care Groups will require intensive support to further develop recovery plans and close remaining forecast gaps.	Sep 26
Revenue Support PDC required for both HUTH and NLAG for Q2 which is significantly in excess of the planned value.	August approved cash support was £2.45m less than requested for HUTH, but it was above the planned level. Advised that plan plus any further adverse variance	Cash allocations confirmed for August - £2.85m for NLAG and £6.56m for HUTH. NHSE Regional team have	Awaiting confirmation from NHSE on September PDC applications. October requirements to be	Confirmation of outcome / Memorandum of Understanding due 11th September 26

August cash allocation was lower than requested and this is impacting on the Group's ability to pay suppliers promptly.	in Creditor value would be considered for funding. An application for cash support has been submitted to NHS England as follows: Sep: £15.61m for HUTH, £5.98m for NLAG Overall Q2 cash requirements remain within the £37.6m total envelope approved at July PEF meeting.	supported the September applications. Cash forecast reviewed daily to confirm future requirements. Prioritisation process in place to ensure critical suppliers are paid promptly. Capital cash remains higher than planned.	confirmed once confirmation of allocation for September has been received and applications completed in line with national deadlines. Cash support applications have been explicit about short term likely requirement to utilise capital cash to manage payroll and priority suppliers if there is a further shortfall in cash allocated.	Deadline for Oct submission is 16th September 26

ADVISE (Provide here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)

Issue	Update	Assurance received	Action	Timescale
Delays in approval and payment of intergroup recharges.	Still a significant value waiting for approval with some concerns raised by approving managers due to the age.	This has been raised with Heads of Finance and highlighted as a priority.	Update list of outstanding invoices and send out to all Finance Managers	Aug 26
Exceeded £3m minimum revenue cash values in July.	Cash in July was higher than expected due to a higher than forecast settlement from NHSE for prior year specialist commissioning contract.		Explore opportunity to add an additional payment run 2 days before the end of the month to allow additional payments in the event of higher than forecast cash balance.	Sep 26

Progress in reducing aged debt	Increase in debtors over 90 days at the end of July now at £8.0m Overall biggest debtors remain linked to recharges between HUTH and NLAG and with York & Scarborough with which there is a similar value of outstanding payables. Areas of concern are longer standing debts with City Health Care Partnership, North Lincolnshire Council, Alliance Medical, University of Hull & HNY ICB. Overseas debt continues to make a large proportion of debt over 360 days.	Working closely with York & Scarborough to reduce level of debt on both sides and have seen some progress during August that should be reflected in next month's report (£1.8m agreed for payment). Aged Debt updates received from all Care Groups detailing actions and escalations. Circle Health Group old debt cleared.	Confirm level of bad debt provision in place for Overseas debt. Escalate old invoices relating to CAP (York & Scarborough).	Sep 26 Aug 26
Increasing number of threats from Suppliers to put Trusts on stop.	Alexandra Uniforms on stop and won't resume until all invoices cleared. Increasing number of threats by suppliers are due to cashflow rather than delays in approval.			
ASSURE (Provide any areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Stock levels	Financial Improvement Director is pushing for 2 weeks maximum holding which would release significant cash value.	Edd is leading on this and will work with his team to support.	Will need to discuss how we manage this across areas that are not within Procurement team.	Sep 26
Non-Pay Panel	Non Pay panel to be set up and will need co-ordination between Finance and Procurement teams to ensure it works smoothly.	Terms of Reference drafted	Set up planning meetings to agree principles and process. Panel to be up and running by the beginning of	August 26

	Includes review and approval of all non-clinical non pay over £500.		Sept	

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)209

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 10th September 2026**
Director Lead	Julie Beilby, Non-Executive Director and Chair of Workforce, Education and Culture Committees-in-Common
Contact Officer / Author	Lauren Rowbottom, Personal Assistant
Title of Report	Minutes from the Workforce, Education and Culture Committees-in-Common held on Wednesday 27th May 2026
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	The minutes attached are for information.
Prior Approval Process	Minutes from the Workforce, Education and Culture Committees-in-Common held on Wednesday 22nd July 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, 27th May 2026 at 09:00 to 12:30
Via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

David Sulch	Non-Executive Director (HUTH) - Chair
Julie Beilby	Non-Executive Director (NLaG)
Paul Bunyan	Director of Planning, Recruitment, Wellbeing and Improvement (attending for Group Chief People Officer)
Professor Jack Kastelik	Consultant in General Medicine (attending for Interim Group Chief Medical Officer)

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Lauren Rowbottom	Personal Assistant (Minute Taker)
Myles Howell	Director of Communications & Engagement
Lucy Vere	Group Director of Learning and Organisational Development
Wendy Page	Care Group Nurse Director
Helen Marks	Senior HR Consultant

Observers:

Clare Woodard	Governor Observer

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committees-in-Common Chair welcomed those present to the meeting. Apologies for absence were noted for Dr Kate Wood, Group Chief Medical Officer, Simon Nearney, Group Chief People Officer, Peter Sedman, Deputy Group Chief Medical Officer (attending for Group Chief Medical Officer), David Sharif, Group Director of Assurance, Fran Moverley, Freedom to speak up champion, Jo Ledger, Deputy Group Chief Nurse.

1.2 Staff Charter and Values

David Sulch noted the Staff Charter and Group Values and reminded everyone to follow these within the meeting.

1.3 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.4 To approve the minutes of the meeting held on 25th March 2026

The minutes of the meeting held on 25th March 2026 were accepted as a true and accurate record.

1.5 Matters Arising

None to raise.

1.6 Committees-in-Common Action Tracker

Updates to the Action Tracker were provided within the agenda items.

1.7 Urgent and Emerging Issues

Paul Bunyan highlighted the upcoming closure of consultant and SES ballots in early July, noting the significant cost pressures and operational disruptions caused by previous industrial actions, and flagged this as an ongoing risk.

Julie Beilby raised concerns following the hot weather over the bank holiday week noting staff on social media pages faced confusion on the use of fans and uniform protocol. She added that guidance wasn't posted on the Group intranet until after the heatwave had passed. Wendy Page reassured the CiC that communications were being updated and proactive guidance would be issued in advance of hot weather.

Paul Bunyan committed to developing a standardised hot weather protocol to ensure timely and consistent guidance on uniforms, fan usage, and infection control.

Helen Marks inquired whether wellbeing checks were being conducted in relation to staff on the wards. Wendy Page reassured that a daily huddle is held every morning, and reminders are sent through that channel to ensure wellbeing checks and additional ward rounds are conducted.

2. MATTERS REFERRED

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

None to note.

3. RISK & ASSURANCE

3.1 Review of Relevant External & Internal Audit Report(s) & Recommendation(s), as appropriate

None to note.

3.2 Review of Relevant External Reports, Recommendations & Assurances as appropriate

None to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 People Strategy Progress Report – Q4

Paul Bunyan gave an update on the People Strategy informing the CiC that a lot of the quarter 4 position was related to the planning of quarter 1.

He gave some positive insight into the performance position, such as reducing 2.4% of overall gross pay bill following significant reductions in agency usage. He reported the Group was achieving the 30% reduction from quarter 1 of agency usage.

Paul Bunyan reported that the Group met the 95% target in job planning, expressing further work was required to link capacity and demand. He updated that Sam Peate (CDO) was running training across the Group to aid in this.

Paul Bunyan updated that Health and Wellbeing target had been achieved at NLaG and was 0.2% under position at HUTH, despite the report submitted to the CiC showing this wasn't achieved. He added that the figures would be updated and recirculated to the CiC. Most pressures in this area related to burn out.

Paul Bunyan reported that the Group reported to hit the flexible working and appraisal target. The area which did not hit target fell under the culture and engagement criteria. He announced that first year turnover and turnover both met their target areas. Nationally the Group had a low turnover, but noted a decline nationally due to uncertainties within the workforce position.

Paul Bunyan explained that a lot of work had been underway to ensure the Organisation was utilising all the digital products such as Health Roster to increase productivity and efficiency positions.

Paul Bunyan reported that Wendy Page and Jo Ledger had been creating ward action cards to ensure robust processes where in place to ensure deployment of staff was efficient.

Myles Howell gave an update on the culture and engagement piece of work, as well as the Pulse survey results. He expressed the key approach to improving the culture was to improve the senior leadership visibility across the Organisation. Part

of this work was identifying areas that the Senior Leaders Team (SLT) can visit each quarter. He informed the CiC that he and Lucy Vere began these visits by visiting Rehab.

Myles Howell hopes that following the SLT visiting these areas they can identify any quick wins, any feedback or support required, any long-term issues and work with the Learning Improvement Safety Academy (LISA) to triage any issues arising. He added that the SLT are cited on what is expected of them and feel comfortable with what is expected following two briefing sessions led by Sam Peate.

Myles Howell reported that the Pulse survey had gone backwards in comparison to the staff survey, noting that the Pulse survey usually deteriorates. Myles Howell described how the staff survey feedback showed that staff didn't want to recommend the organisation as place to work or receive care/treatment, noting that the overarching effort was to make staff feel assured that the Group was focusing on patient care, safety and experience.

Lucy Vere explained how she had been working with Sue Page and Scott Fitzgerald on the LISA programme mapping out each quarter and focusing on practical delivery and aiming to get an integrated service.

Lucy Vere expressed the communications team had been helpful with creating visibility, including creating clear branding and an easy access portal on Bridget by mid-June.

Lucy Vere communicated that the team had done a surgical safety day as part of the LISA agenda, which helped the team understand the never ever events in a restorative approach which created an action plan and new learning approach.

Lucy Vere explained how the Group had created an Operational Managers Essential Programme in collaboration with 'getting it right first time' that focuses on training and capacity and demand. The programme was currently working on reducing the wait to 1st outpatient appointment over the next 8 weeks.

Julie Beilby thanked everyone for the work and updates. She questioned what was being done about the mandatory training alert as this was a red flag at two CiC's. Lucy Vere explained how NLaG and HUTH both had different ways of learning, but both trusts had a lot of people trained to train the trainer. She added that a lot of work needed to be done with nursing teams to identify barriers, and a permanent simulation nurse lead was now in place and she was working with Paul Bunyan's team around further recruitment to promote carrying out training in their own areas.

Jack Kastelik gave thanks to Lucy Vere's team for the excellent work undertaken with Gastroenterology at NLaG, adding it was very beneficial and provided assurance to post-graduates.

Julie Beilby felt disappointed to see the pulse surveys being low following the programmes of work and effort and needed to see a shift to get out of tier 5. Myles Howell agreed, however pointed out that the pulse survey does not inform the NOF rating. He explained that they were speaking to a number of Organisations who were doing well with their staff surveys to learn from them.

David Sulch praised the reduction in never events, and pointed out that fixing staff experience and survey results was also about operational experience.

Helen Marks praised the programme and the work being undertaken but asked if it would be useful to bring the KPI's to the CiC that show how the work is making a positive impact on the next staff survey.

Julie Beilby acknowledged that the staff survey did not feed into the NOF rating and was more about the staff and organisational health, but voiced that the Group would not be able to move forward unless this was controlled.

Julie Beilby informed Paul Bunyan she felt it was difficult to track the metrics around reduction in temporary spend and queried how do they pull together some key metrics around the workforce issues. David Sulch seconded this, and stated in the workforce KPI's submitted he could not see the trend lines for the key metrics being tracked for people strategy. Paul Bunyan agreed that the information needed to be consolidated into a report including a breakdown of metrics and would be something he would bring in the future.

ACTION Paul Bunyon to review KPIs to feed into IPR

The Committees-in-Common agreed limited assurance. They noted the good work ongoing, but acknowledged there was some uncertainty on effectiveness as it was too early to see positive outcomes. .

The agenda was taken out of order at this point

Pulse Survey

Myles Howell updated on the pulse survey within item 4.1 but welcomed questions.

4.4

David Sulch queried how much validity was in the low numbers of people who responded to the pulse survey, and noted the data did not show much of a difference from the staff survey and national picture and was this a cause for concern. Myles Howell reassured that this was not a cause for concern, as the majority of responses reflect office staff rather than the Organisational view. However, he explained it did reflect how support services were feeling. Julie Beilby noted some learning could be taken from this for effective communication and how the Group was deciding on efficiency savings.

David Sulch felt uneasy around the reward and recognition, worried that some people delivering excellent patient care within the Group would fly under the radar. Myles Howell reassured the CIC that nobody within the Group was disqualified, or would be exempt from receiving a shining light nomination or golden star. Julie Beilby queried whether Non-Executive Directors (NED's) would still present shining lights.
Myles Howell informed the CiC that the Group receives around 150 shining lights every month and welcomed NED visits although it was acknowledged that the NEDs would not be able to attend them all due to the numbers

Action: Julie Beilby and David Sulch to pick up shining light visits in the NED workplans at another meeting.

Julie Beilby questioned if the recruitment of the Health and Wellbeing Practitioners were permanent or fixed term. Paul Bunyan stated these was fixed term, with funding coming from a national funding model but this ended on the 31st March 2026.

The agenda returned to order from here

4.2 **Mechanisms Processes**

Wendy Page explained that the paper submitted outlined the governance arrangement about variable pay costs within clinical areas receiving investment following the SAFER care Nursing tool. She updated that governance arrangements and control measures had been implemented throughout the Organisation by strengthening governance, oversight and strict operational controls.

Wendy Page outlined the introduction of monthly meetings with nurse directors and finance leads to review run rates, roster efficiencies, and approval processes for agency, bank, and overtime spend, ensuring alignment with funded establishments.

The CiC discussed the importance of weekly forecasting meetings with matrons and ward managers to enhance grip and control, with senior nursing teams being held accountable for maintaining financial discipline and patient safety.

Wendy Page informed the CiC that the Emergency Department (ED) on the North Bank had reduced agency staffing by 50% following a reduction in temporary escalation spaces.

David Sulch questioned if the Group was doing anything different following the investment as he expected to see the controls already in place following the previously financial targets. Wendy Page agreed, stating they needed refreshing and reinforcing.

David Sulch asked where reductions in financial spend was being tracked. Paul Bunyan explained this was tracked in the IPR, WEC CiC and Performance, Estates and Finance CiC. Julie Beilby and Helen Marks raised concerns about fragmented data reporting, advocating for the workforce committee to have comprehensive oversight of all workforce KPIs, and for clear escalation pathways to the Board.

Helen Marks stated it was great that the senior nurse leadershp were conducting monthly meetings, and explored the possibility of a weekly meeting which would be a challenge and confirm meeting in order to enhance grip and control.

David Sulch and Julie Beilby thanked Wendy Page for the paper. They agreed to take the current report for information, noting the need for outcome data and metrics before providing assurance on the effectiveness of the controls, and committed to revisiting the topic at a future meeting.

4.3 **Apprenticeship Levy Update following National Guidance**

Lucy Vere apologised for the delay in receiving the report to this CiC.

Lucy Vere explained the government's shift in focus to entry-level apprenticeships for 16–24year-olds, the reduction in levy spend timeframes, and the removal of public funding for level 7 apprenticeships, which had impacted leadership and management development. The leadership and management apprenticeship spending levy had changed from 24 months to 12 months which Lucy Vere noted meant the Group was unable to bank some of the levy.

Wendy Page clarified that, due to financial constraints the number of Registered Nurse Degree Apprenticeships and Nursing Associates had been significantly reduced, with a shift towards Support Worker Apprenticeships, and that the funding model was being finalised for Board escalation. Lucy Vere explained that the Group was not limited, but would work towards over 18s to aid with unsociable working hours.

Lucy Vere gave assurance that the overall Apprenticeship position was in a good place and the Group increased their levy spend from 2.9 million to 3.9 million. She reported that there was some underspend position and Anne Burdis was working with finance teams to create a financing model.

Lucy Vere updated that there was going to be 100 apprenticeship places across three chartered degree programmes: level 3, 5 and 6. She declared these needed to be started before September 2026.

Julie Beilby raised the need for a coordinated approach to Artificial Intelligence (AI) adoption and governance across the partnership, highlighting current gaps in guidance, skills development, and the potential risks. Paul Bunyan explained this was a conversation to be had with Alistair Pickering (Interim Group Chief Digital Officer) in the digital team to explore opportunities posed by AI for workforce roles, and to explore the capabilities and strengthen the General Data Protection Regulation (GDPR) with the current AI tools in the Group. Julie Beilby noted it would be important to see this as an alert item to escalate to the board.

Julie Beilby questioned whether the Registered Midwife Apprenticeships feature in SAFER Nursing tool and whether this had any impact. Wendy Page explained due to the small numbers it would not impact in the first instance, but could impact going forward as the Group grows their own Registered Midwives. Wendy Page emphasised the importance of working with the Maternity service to improve the culture.

Break commenced at 10.30 for 15 minutes

Elizabeth Houchin joined the meeting at 10.45

4.5 Freedom to Speak Up Quarterly Report - HUTH & NLaG

4.5.1 Freedom to Speak Up Report - Q3 and Q4 Report - HUTH

Elizabeth Houchin gave a brief update in the absence of Fran Moverley.

She reported that HUTH saw 307 concerns raised in the year, a 13% increase from the previous year and the highest ever reported, with the top reasons being poor behaviours, concerns about role, and general concerns.

Elizabeth Houchin noted a significant increase in cases from admin and clerical staff at HUTH, followed by nursing and midwifery. The staff survey indicated 11 individuals reported detriment after speaking up, prompting the development of a local detriment guidance, based on national guidance and reviewed by Lindsey Harding, which was now available for staff to access on Bridget.
A feedback survey reported that 100% of staff who had reported would speak up again.

The Committees-in-Common agreed significant assurance.

4.5.2 **Freedom to Speak Up Report - Q3 and Q4 Report - NLaG**

Elizabeth Houchin took the report as read. She updated that NLaG had 388 concerns, slightly lower than the previous year at 401 concerns. Worker safety, HR process, and inappropriate behaviours as main themes. 3 concerns were raised anonymously in quarter 4, concluding 10 raised anonymously throughout the year which was below the national average. Nursing and Midwifery was the highest reporting profession.

The latest Freedom to Speak up (FTSU) survey results showed a decline in staff being able to raise concerns in clinical practice, but did see an increase in confidence that the Organisation would address the concern. The report also showed an increase in confidence to use the FTSU guardian to raise a concern.

Elizabeth concluded that both trusts (HUTH & NLaG) where below the national and regional average.

Julie Beilby expressed disappointment seeing the detriment figures and endorsed integrating detriment management into existing HR policies rather than creating a new one and clarified that issues involving board members would be escalated to the Chair of WEC, with NED involvement as needed.

Julie Beilby cited that it was important to have a radar on how the group manages staff within clerical and administration following the pulse survey reporting a higher degree of less settled staff in this area. She went on to thank Elizabeth Houchin and Fran Moverley for all their hard work through the year.

Helen Marks praised the report and wondered how they were going to close the loop on lessons learned and how they’re going to incorporate these into training programmes. Elizabeth Houchin explained that high-level stories are published monthly on the Bridget page, and themes are discussed with care group leads and medical directors, with relevant learning shared with Lucy Vere as appropriate. Helen Marks asked if it would be helpful in future reports to talk about lessons learnt and any training that has been completed.

Paul Bunyan reassured the CiC that HUTH would see an improvement in Administration staff following recruiting into vacant positions in patient experience.

David Sulch queried the difference in trends between HUTH and NLaG, and Elizabeth Houchin attributed NLaG's plateau to dedicated communications support, while HUTH's increase may reflect growing awareness of the service. She also noted that her absence in late March may have affected reporting figures.

Julie Beilby asserted that inappropriate behaviours within the Organisation are never acceptable, but felt assured by Elizabeth Houchin and Fran Moverley that these incidents related to a culture broader issue around behaviours towards colleagues.

The Committees-in-Common agreed significant assurance. The CiC recognize the challenges the Organisation is facing and continue to support the work Elizabeth Houchin and Fran Moverley do.

Elizabeth Houchin left the meeting at 11.00

4.6 **Undergraduate Medical Education Six-month Progress Report – NLaG**

Jack Kastelik provided a brief update on undergraduate medical education. He confirmed that there were no major issues reported by the outgoing clinical dean, and that recruitment for the site clinical dean at HUTH and the group undergraduate clinical dean was underway.

Julie Beilby highlighted the need for transparency in undergraduate funding at NLAG, noting historical challenges, and requested an update on when care groups would receive clarity on funding allocations to support teaching.

Julie Beilby noted that student feedback remained very positive, with 99% recommending placements, and congratulated NLaG for receiving four of the eight Hymms Teaching Excellence Awards, suggesting these achievements be escalated to the board.

David Sulch asked about the risk of not recruiting all six teaching fellows for bedside teaching. Jack Kastelik responded that, nationally, there was a shortage of training posts, making these roles attractive, and historically there had been no recruitment issues.

The Committees-in-Common agreed reasonable assurance. Julie Beilby and David Sulch agreed that while the quality of teaching and student experience was high, assurance remained 'reasonable' until funding clarity was achieved and transparently reported.

4.7 **Operational Workforce Planning Processes: including Job Planning**

Paul Bunyan took the report as read. He explained the national approach to job planning, the limitations of the 12-month business cycle, and the need to align business planning with clinical strategy, highlighting the complexity of managing 16

care groups with separate plans and the importance of identifying critical investments and potential areas for de-investment. He added that Sam Peate the Group Chief Delivery Officer was working with all the Care Groups to understand their current position.

Paul detailed the operational plan's focus on substantive, agency, and bank workforce, cost improvement targets, and the interplay between headcount reduction, variable pay, and non-pay work streams, with monthly monitoring against planned and actual baselines.

Paul Bunyan reported that HUTH's sickness rate was 4.4% (below national average), NLAG's was 5.4%, and job planning compliance was at 95% for both organisations. He described ongoing efforts to improve reporting dashboards, track team-based job planning, and manage headcount reduction through various work streams.

Paul Bunyan shared a presentation to the CiC that outlined all HHP substantive WTE changes in finer detail.

Julie Beilby expressed that she found the presentation very helpful but challenged how the metrics could be captured in a simple way to aid in understanding and give assurance to the Board. She queried what metric was the top target for workforce reduction vs variable pay. Paul Bunyan informed that the Group was underway with an operational transformation piece, and Urgent and Emergency Care (UEC) transformation was the most urgent. He voiced plans to aid in patient flow, reduce corridor care and the overall transformation of the UEC floor. Julie Beilby added it would be helpful to see the key metrics within the Integrated Performance Report (IPR). Paul Bunyan agreed that the reporting cycle needed to be increased and how often this came to the CiC for assurance.

Action: Paul Bunyan to review and simplify the current IPR to embed key workforce and financial metrics, ensuring clear and coherent reporting for committee assurance.

Helen Marks felt that it would be beneficial to see the trajectories in relation to variable pay within an IPR.

Helen Marks discussed the need for clarity on PMO versus improvement capacity, with ongoing mapping of improvement capability and plans for further discussion at board level. Julie Beilby suggested a meeting with Paul Bunyan and Helen Marks to plan a step change in reporting before the July board.

David Sulch thanked Paul Bunyan for the comprehensive information given.

Helen Marks advised that it would be helpful to be clear on the ask around capacity. Lucy Vere replied that she was looking at all the roles and a paper would be created to understand what is needed.

The Committees-in-Common agreed limited assurance due to challenges in triangulating data and the pace of transformation and recommended escalating these concerns to the board.

4.8 Target Operating Model for People Services

Paul Bunyan shared his screen to present a presentation to the CiC. He outlined the national plan to scale up transactional people services such as payroll and recruitment at regional level. He stated this had been piloted in London Trusts already. He noted the lack of clarity on rollout timelines, regional leadership, and the impact on local outsourcing plans, with KPMG invited to present to regional people services leads for further insight.

Paul Bunyan explained that People Services was an NHS England scheme which would come with a significant financial benefit of around 65-77 million per region two years of implementation.

Paul Bunyan gave an insight into the Digital First HR Strategy which would replace the current system of ESR. He reported the new system would be more user friendly for staff and managers. With the new system there would come singular policies across the NHS in the country, which would allow AI bots to answer any policy-based questions. He expressed he was unsure what the new system would look like but would be attending a meeting to get learning of what's taken place in Southern Trusts.

Helen Marks wondered whether it would be beneficial to have a board development session to understand the initiative, noting that a maturity assessment would be required and that the organisation.

Lucy Vere highlighted the need to consider local operational differences such as equipment and training when implementing regional solutions, and questioned how feedback from provider-level teams would be incorporated into the national model.

The Committees-in-Common agreed limited assurance.

Peter O'Sullivan joined the meeting at 12.00

5. ITEMS FOR INFORMATION

5.1 Occupational Health Annual Report

Peter O'Sullivan took the report as read updating that Occupational Health (OH) services had a standardised policy across the Group under 1 single leadership. He noted differences with the digital formats across the North and South Bank which would continue due to high costs to integrate the systems.

Peter O'Sullivan informed the CiC that staff turnover had impacted how the OH service was running and the team was looking at ways how the Service can invest in staff. The North bank showed mostly retirements.

Peter O'Sullivan described the Employee Assistant Programme (EAP) was a valuable, externally provided counselling and support service, with contract costs set to increase but assured it was still competitive. He added that the EAP would be a single point of access for staff and Managers. Julie Beilby emphasised the importance of maintaining EAP support, including Freedom to Speak Up Guardians, as national support had now ended.

Julie Beilby queried whether the investment into the IT services was being considered to which Peter O'Sullivan explained that the systems was already in place but the backgrounds of the systems was different, noting it would be a cost of around £1000 to merge them.

Julie Beilby queried the higher referral numbers from South Bank. Peter O'Sullivan attributed this to policy alignment and increased referrals, with ongoing work to educate managers and standardise processes. He added that higher sickness and vacancy rates at NLaG explain increased activity.

Julie Beilby voiced she was a supporter of the EAP programmes.

The Committees-in-Common agreed limited assurance.

Peter O'Sullivan left the meeting at 12.10

5.2 **Workplan (Deep Dive additions)**

This CiC agreed that future deep dives would be identified following the reports brought to the meeting in July.

5.3 **Minutes of Workforce Transformation Group**

None to note

6. ANY OTHER URGENT BUSINESS

6.1 **Any Other Urgent Business**

Julie Beilby queried whether the Workforce Transformation Group had recently met. Lucy Vere explained the last meeting was cancelled in April due to the industrial action, and the next one was due to take place the following day.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

None to note

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

None to note

7.2 **Matters to be escalated to the Trust Boards including any proposed changes to the BAFs**

The CiC alerted to the Board issues in Staff Survey/Pulse Survey Q1, Resident doctor industrial action and financial impact, the Workforce consolidated report, AI

usage and governance arrangements, Operational Workforce Planning and Job planning.

They advised to the Board the ATHENs training, Apprenticeship Levy – national funding changes continue to constrain levy spend, and the Transforming People Services.

They gave assurance to Agency expenditure which met target, LISA, Freedom to speak up annual reports HUTH/NLAG, Undergraduate Medical Education Report, and the Occupational Health Annual Report

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Wednesday 22 July 2026 at 9am till 12:30pm, Via MS Teams

The Committee Chair closed the meeting at 12.20 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2026/2027

Name	Title	2025/26											
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
CORE MEMBERS													
Julie Beilby	Non-Executive Director (NLaG) / Chair	Y		Y									
David Sulch	Non-Executive Director (HUTH) / Chair	Y		Y									
Simon Nearney	Group Chief People Officer	D		D									
Amanda Stanford	Group Chief Nurse	D		D									
Jo Ledger	Interim Group Chief Nurse	D		D									
Kate Wood	Group Chief Medical Officer	D		D									
Vacant	Non-Executive Director (HUTH)	Y											
Vacant	Non-Executive Director (NLaG)												
Vacant	Non-Executive Director (HUTH)												
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y		D									

KEY: *Y = attended* *N = did not attend* *D = nominated deputy attended*

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)210

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	10 September 2026
Director Lead	Mr Peter Sedman, Deputy Group Chief Medical Officer
Contact Officer / Author	Dr Ananthakrishnan Ananthasayanam, Responsible Officer Rachael Smith, Group Senior Revalidation Officer
Title of Report	**HUTH Medical Appraisal & Revalidation Annual Report 2026**
Executive Summary	The purpose of this report is to provide assurance that Hull University Teaching Hospitals NHS Trust (HUTH) continues to meet its statutory obligations for medical appraisal, revalidation, employment checks, and clinical governance. During 2025/26, significant progress has been made in addressing historic appraisal capacity challenges through implementation of the appraiser business case, successful recruitment of appraisers, deployment of the SARD appraisal platform, and increased collaborative working across Humber Health Partnership (HHP). The most significant achievement has been the reduction in the number of doctors without an allocated appraiser from over 240 to 15, supported by a substantial recruitment campaign and cross-partnership support arrangements . However, several strategic risks remain, including the need to achieve full appraiser establishment, complete outstanding governance actions, ratify group policies, and embed a sustainable long-term appraiser model **Alert** **Sustainability of Appraiser Capacity Remains a Strategic Risk** Although substantial progress has been made through the implementation of the appraiser business case, the service has not yet reached a fully sustainable position. HUTH continues to rely upon cross-trust appraiser support, reserve appraisers and a limited number of senior appraisers. Risks remain relating to: • Loss of senior appraisers through promotion or retirement. • Continued reliance on goodwill and capacity from partner organisations. • Potential re-accumulation of appraisal backlog as the number of prescribed connections increases. • Requirement for additional funding if doctor numbers continue to grow. Continued senior oversight is required until the revised appraiser model is fully embedded and operating sustainably across HHP.

	High Number of Unapproved Missed Appraisals Despite the significant improvements made during the reporting period, HUTH reported: 753 completed appraisals. 46 approved missed appraisals. 153 unapproved missed appraisals. Whilst much of this reflects historic capacity challenges that are now being addressed, appraisal compliance remains an area requiring continued monitoring and oversight. **Incomplete Clinical Governance Self-Assessment** The GMC Effective Clinical Governance Self-Assessment remains incomplete. Outstanding contributions from senior leaders relating to recruitment and patient safety continue to delay completion. This limits the organisation's ability to demonstrate comprehensive assurance against GMC governance standards and identify opportunities for improvement. **Delayed Policy Harmonisation Across HHP** Several key policies remain in draft form, including: Group Medical Appraisal and Revalidation Policy. Group Maintaining High Professional Standards (MHPS) Policy. The absence of fully ratified group policies presents a governance risk while HHP continues its move towards greater integration. **Administrative Capacity Pressures** One element of the approved business case remains unresolved due to vacancy controls affecting Band 3 administrative support. Although a workforce review is underway to identify efficiencies, this represents a potential operational risk if workload demands increase. **Assure** **Statutory Compliance Maintained** The organisation remains compliant with the Medical Profession (Responsible Officers) Regulations, with an appropriately trained Responsible Officer in post who continues to participate in regional and national development networks, professional standards forums and continuing professional development activities. **Significant Improvement in Appraisal Capacity** The appraiser business case has delivered substantial improvements during the year: • Reduction of doctors without an allocated appraiser from over 240 to 15. • Recruitment and mobilisation of new appraisers. • Appointment of senior appraisers and revalidation leads. • Collaborative deployment of appraisers across HHP. • Progress towards centralised funding arrangements.

	These actions have significantly reduced historical appraisal backlogs and supported improved compliance performance. **Effective Appraisal and Revalidation Systems** The SARD appraisal platform is now fully embedded and supports a consistent and comprehensive appraisal process covering doctors' whole scope of practice. Governance information is provided in advance of appraisals, supported by robust escalation processes for non-engagement and quality assurance arrangements. Revalidation outcomes provide positive assurance: • 71 GMC recommendations submitted. • No late recommendations. • 56 positive recommendations. • No doctors failed to revalidate. All GMC recommendations issued within required timescales. **Robust Quality Assurance and Governance Arrangements** Multiple assurance mechanisms remain in place, including: • Monthly Revalidation Panels. • Responsible Officer Advisory Group meetings. • Quality assurance reviews. • Internal appraisal audits. • Annual appraisal training events. • Appraisee feedback mechanisms. • HR, GMC ELA and governance oversight processes. These arrangements provide assurance that concerns relating to performance, conduct and fitness to practise are appropriately identified, reviewed and managed. **Strong Recruitment and Employment Governance** All 606 doctors appointed during the reporting period completed pre-employment checks before commencing employment, providing strong assurance regarding recruitment governance and patient safety. **Positive Organisational Culture** The organisation continues to promote: • Equality, diversity and inclusion. • Freedom to Speak Up arrangements. • Sexual Safety initiatives. • Learning from incidents and concerns. • Fair and transparent management processes. No employment tribunal claims or appeals against professional standards processes were upheld during the reporting period. **Advise** **Priority Actions for 2026/27** The following priorities are recommended for the coming year:

	• Continue recruitment activity to achieve full establishment of appraisers and senior appraisers across HHP while maintaining a reserve pool to support resilience and business continuity. • Complete the GMC Effective Clinical Governance Self-Assessment with support from senior leaders and report outcomes through governance structures. • Achieve ratification of all remaining HHP-wide appraisal, revalidation and MHPS policies to support a fully harmonised approach across the partnership. • Complete the remaining business case actions, including centralisation of funding arrangements and resolution of administrative support requirements. • Undertake the scheduled peer review with Tees University Hospital and implement any recommendations arising from both the peer review and NHS England Higher Responsible Officer review. • Continue development of the proactive GMC recommendation model to enable earlier identification and management of doctors approaching revalidation. • Strengthen appraisal quality assurance through quarterly appraiser network meetings, internal audit reporting and continued appraiser development programmes. • Consider progression towards a single Humber Health Partnership designated body arrangement, subject to GMC approval and organisational agreement, to formalise existing collaborative arrangements. The Responsible Officer can provide substantial assurance that medical appraisal, revalidation and governance systems are operating effectively and that HUTH remains compliant with its statutory responsibilities. The implementation of the appraiser business case has delivered significant improvements in capacity, reduced historic appraisal backlogs and strengthened partnership-wide working arrangements. However, continued executive oversight is recommended until outstanding governance actions are completed, appraisal compliance is further strengthened, and a stable, fully sustainable appraiser model is embedded across Humber Health Partnership. **Recommendations** **Approval and endorsement from the BIC for submission to NHS England.**
Background Information and/or Supporting Document(s) (if applicable)	**The attached report is compliant with national reporting standard and format as set by NHS England.**

Prior Approval Process	**Workforce, Education and Culture Committees-in-Common – approved 22/07/2026**
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

Annex A – Main Report

1A – General

The board/executive management team of NHS Humber Health Partnership which incorporates the Designated Body, Hull University Teaching Hospitals NHS Trust, can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	To continue to attend Responsible Officer Network meetings and professional development activities to remain up to date with Responsible Officer role.
Comments:	The RO attends quarterly face to face and virtual RO network meetings. The RO also receives regular updates from the GMC. The RO also attends relevant training and CPD meetings to fulfil the requirement for the role and reviews these during annual appraisal process. The RO will also be attending the regional Professional Standards Network group for shared learning.
Action for next year:	To regularly attend the regional Professional standards Group meeting

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	To begin the implementation of the business case, investing into appraiser recruitment and retention.
Comments:	There are 4 actions from the business case which are near completion. 1 – Develop peer reviews (once every 2 years from 2026) – HHP and Tees University Hospital will collaboratively conduct the 1st peer review in November 2026. Dates agreed and booked in diaries. Tees Revalidation Team and RO will visit the Humber Health Partnership and conduct the peer review on HHP revalidation service. Any action plans and reports will be included in 2027 Revalidation Report. 2 -Redistribution of funds from Care Groups to CMO – this action is for HUTH site only as the Appraisal/revalidation funds are already centralised at NLG. At the time of writing the report (11/06/2026), the finance team are in process of moving funds from care group to the CMO. This is nearly complete, and update will be provided in 2027 report to confirm completion 3 -Increase number of senior appraisers – currently 8 x senior appraisers across the HHP. 2 vacancies to recruit to and prospective

	candidates have been identified. Update to be provided to confirm completion. 4. Recruit to 149 appraiser positions – across HHP there are 137 appraisers, which includes 5 x “super” appraisers who appraise up to 30 doctors. (the standard limit is 9). At NLG there is a reserve pool of trained appraisers which have been utilised to conduct appraisals across the HHP and to assist with HUTH appraiser shortage. The number of HUTH doctors without an allocated appraiser has reduced from over 240 to 15 following the recruitment and mobilisation of new appraisers. Many doctors who had exceeded 12 months without appraisal are now actively undertaking appraisals. Despite progress, the following risks remain • Sustainability of appraiser capacity, particularly if senior appraisers leave or are promoted into other roles. • Reliance on cross-trust goodwill and capacity, which is not a long-term substitute for substantive HUTH appraisers. • Risk of re-accumulation of backlog if current recruitment momentum is maintained for new doctors. If momentum is maintained additional funds will need to be allocated proportionally due the increase in prescribed connections. The actions implemented following approval of the appraiser business case have delivered a positive trajectory, evidenced by increased capacity, a reduction in backlog, and sustained compliance performance. However, continued senior oversight remains necessary until the appraiser model is fully embedded and operating sustainably across HHP
Action for next year:	To continue to recruit to full establishment of appraisers and senior appraisers. To continue to develop and maintain reserve pool of trained appraisers to ensure business continuity.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Undertake further reviews of connections to ensure there are no illegitimate connections, with a particular focus on those working through the Remarkable Bank.
Comments:	There is an established process for ensuring that there are appropriate connections for bank doctors and this is informed by the pre-employment checks for Bank Doctors. The revalidation team review workload undertaken by bank doctor and remove prescribed connections for bank doctors have not undertaken recent bank shifts. This is now business as usual process Accurate list of all licensed medical practitioners with prescribed connection is always maintained using GMC Connect and SARD appraisal system which is cross referenced with ESR Business Intelligence reports for Medical Starters and Leavers). At recent extensive review was conducted in April 2025 which confirmed that connections were up to date. The revalidation team submits updates to the Responsible Officer each month.
Action for next year:	Maintain business as usual practices

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Develop and implement a Group Policy.
Comments:	Joint policy in draft phase. Ratification to be completed by next annual report.
Action for next year:	Ratified joint policy.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	A peer review is intended to take place for HUTH in 2026.
Comments:	NHSE Higher RO visit conducted May 2026 – awaiting outcome report and action plan. Peer review scheduled with Tees University hospital November 2026
Action for next year:	Update committee and board on outcomes and action plans from NHS E higher level visit and the peer review.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	No action required.
Comments:	Short-term contract holders are fully supported in their continuing professional development (CPD), revalidation, and governance in alignment with the standards applied to substantive medical staff. They are not managed differently in terms of appraisal or revalidation processes. All short-term contract holders are expected to actively maintain their professional development through established Trust mechanisms. This includes accessing study leave, completing mandatory training, and participating in medical teaching sessions, among other opportunities. In accordance with their licence to practise and contractual obligations, short-term contract holders are required to engage with the medical appraisal and revalidation processes. Upon appointment, short-term contract holders are integrated into the Trust's appraisal system (SARD) and formally welcomed by the appraisal coordinator via email. The General Medical Council (GMC) is notified of the doctor's prescribed connection to Northern Lincolnshire and Goole NHS Foundation Trust. With respect to clinical governance, all new short-term contract holders are introduced to key governance processes, such as incident reporting, through the Trust's induction policy, consistent with the orientation and Trust inductions provided to all new starters.
Action for next year:	Continue as above.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Ensure continuity of processes that allow doctors to receive governance information on time for appraisal. Tender for a Group appraisal system launching June 2025, with an intention to implement in late 2025. Continue with current escalation processes. Continue to monitor well-being of doctors during appraisals and provide appropriate support and guidance.
Comments:	Doctors who have prescribed connection to Northern Lincolnshire and Goole NHS Foundation Trust use the SARD software system. The doctors are required to fill their appraisal form via the SARD system and there are three basic elements to the appraisal: **Appraisal Inputs** – doctor fills in each section of the SARD form and uploading supporting information/evidence which covers their scope of practice, which may include non-NHS work. The doctor must cover and reflect on each section which are displayed below. Once the inputs are complete, the doctor completes a checklist which acts a prompt to ensure that they have considered the various aspects for their appraisal. The form is then submitted to appraiser ahead of appraisal meeting. **Appraisal meeting** – meeting between doctor and assigned appraiser. This is where the confidential discussion will take place, verbal reflection, and discussions around wellbeing, professional development, and quality improvement. **Appraisal outputs** – Doctor and appraiser agree a Personal Development Plan for the year going forward and the appraiser writes up a summary on how the doctor meets the four domains of Good Medical Practice, an overview of reflective discussions and quality improvements identified, with the supporting evidence provided. The appraiser and doctor both sign off the appraisal. The appraiser then completes their own checklist to ensure completeness and submits to the Responsible Officer office for completion. All doctors at Northern Lincolnshire and Goole NHS Foundation Trust are reminded that annual appraisal must cover their full scope of practice. This includes all roles, clinical, managerial, educational, private, or voluntary, and doctors must provide evidence demonstrating

	fitness to practise across each area, as every role can impact patient care. The nature of supporting information will vary between individuals, but certain core elements are expected. These include: • **Clinical Governance Data**: The Revalidation Senior Officer has an established and efficient process for collecting governance information and sharing it with doctors ahead of appraisal. This includes: • **Incidents**: Doctors named in incidents or significant events within the past 12 months must summarise and reflect on these. • **Formal Complaints**: Any complaints in which the doctor has been named over the previous year must also be included. • **Patient and Colleague Feedback**: Required at least once every five years in line with GMC revalidation. Feedback is collected via the SARD system, and doctors must reflect on their results. • **Medical Indemnity**: Doctors must either provide evidence of indemnity or confirm in writing their understanding of their legal obligation to hold valid cover. Although mandatory training is not a formal requirement for appraisal or revalidation, persistent non-compliance may affect revalidation outcomes depending on the severity. Doctors are encouraged to reflect on such training for CPD purposes. All supporting information must include reflection mapped to the domains of *Good Medical Practice*, with reflective practice seen as key to personal, professional, and quality improvement. Doctors are contractually and professionally obligated to participate in annual appraisal. Automated reminders are sent via SARD and the Responsible Officer's office. Doctors who fall behind are supported by the Responsible Officer team. Persistent non-engagement, despite intervention, may lead to referral to the General Medical Council's Employment Liaison Advisor. In such cases, the GMC may issue a formal warning with a deadline for compliance. Failure to meet this deadline results in referral to the GMC for non-engagement. All actions from last year report have been completed and embedded for business as usual.
Action for next year:	Nil – business as usual until contract approaches expiration at which point new procurement exercise will be required.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	To continue with HUTH/NLaG escalation policies in circumstances of delayed/late/missed appraisals.
Comments:	There is group escalation policy for appraisals that are not received by deadline. All incidences of missed/late appraisals are investigated. For where there is mitigating circumstances, this recorded on SARD appraisal system and new appraisal deadline is agreed. For where there are no mitigating circumstances, doctors will be managed by the escalation process which can result in a GMC referral for non-engagement.
Action for next year:	To continue with HUTH/NLaG escalation policies in circumstances of delayed/late/missed appraisals.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Develop and implement a Group Policy.
Comments:	Revalidation and Appraisal Policy for Medical Staff (V5) last reviewed in July 2023, next review date July 2026. Current HUTH policy has been renewed for one year. Once group policy is ready, HUTH policy will be archived and placed by group version.
Action for next year:	Joint policy in development and ratification is expected to be completed before 2027 report.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Implement the Appraiser Business Case leading to: • Reduced workload to expected level for current appraisers. • Recruitment and training of new appraisers • Implement a potential pool for reserve appraisers
Comments:	The number of HUTH doctors without an allocated appraiser has reduced from over 240 to 15 following the recruitment and mobilisation of new appraisers. Many doctors who had exceeded 12 months without appraisal are now actively undertaking appraisals. Despite progress, the following risks remain

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	• Sustainability of appraiser capacity, particularly if senior appraisers leave or are promoted into other roles. • Reliance on cross-trust goodwill and capacity, which is not a long-term substitute for substantive HUTH appraisers. • Risk of re-accumulation of backlog if current recruitment momentum is maintained for new doctors. If momentum is maintained additional funds will need to be allocated proportionally due the increase in prescribed connections The actions implemented following approval of the appraiser business case have delivered a positive trajectory, evidenced by increased capacity, a reduction in backlog, and sustained compliance performance. However, continued senior oversight remains necessary until the appraiser model is fully embedded and operating sustainably across HHP
Action for next year:	To continue with recruitment of appraisers across HHP and keep training doctors who are interested in appraisal role to ensure a healthy pool for reserve appraisers.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	To organise quarterly joint appraiser network meetings to compliment the annual training day.
Comments:	Each Medical appraiser undergoes performance review. A report which collates appraisee's feedback via the post-appraisal questionnaire (PAQ) which is built into the SARD system. This report is sent to every appraiser to reflect upon and identify improvements where needed which increases the quality of appraisals and improves the process for doctors. Joint networks are now established.
Action for next year:	Maintain quality assurance processes for appraisers. Develop new training for existing and new appraisers.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	No action required.
Comments:	All medical appraisers receive a feedback report to include in their own appraisal. Each appraisee is asked to complete a post-appraisal questionnaire to reflect on their appraisal and the process. The Revalidation Leads and Revalidation Team ensures the training of the appraisers is up to date, deliver training to new appraisers and perform Quality Assurance (QA) of appraisals. HUTH has an annual Appraiser Network Meeting, led by the Responsible Officer and Revalidation Leads. This provides the opportunity for the Trust's appraisers to share best practice and receive updates on local and national processes surrounding revalidation and appraisal.
Action for next year:	To organise quarterly Group appraiser network meetings

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	To standardise internal audits for quality assuring medical appraisal outputs and process.
Comments:	Current quality assurance processes and measures are outlined below: • Appraisee feedback on the overall process and their appraiser. • Monthly group revalidation panel meetings involving RO, appraisal leads, management and coordinators. • RO attendance at the RO network meeting. • Annual Training events for medical appraisers and all medical staff who wish to learn more about local process. • Annual revalidation report. • Statement of compliance signed by the Chief Executive Officer, which is then submitted to NHS England. Internal audit is now standardised across the group assessing quality of medical appraisals.
Action for next year:	Maintain above processes across HHP. Audit reports will be available from 2027 as we are now in process of auditing appraisals that are being submitted between April 2026-March 2027.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	Nil
Comments:	There are joint monthly panel meetings which review doctors under notice. The GMC has advised that the designated bodies should adopt a more proactive approach to submitting revalidation recommendations. As doctors enter the 12-month notice period prior to their revalidation date, designated bodies are expected to review cases earlier and make timely recommendations, whether for revalidation, deferral, or non-engagement. In response, a paper has been developed and proposes a proactive, risk-based model that uses SARD data and a streamlined GMC-aligned checklist to identify doctors who already meet the requirements, enabling earlier submission of recommendations while focusing resources on those who require targeted support.
Action for next year:	To continue with meeting format and agenda whilst proposal is considered for implementation.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	nil
Comments:	Each doctor is notified individually of their GMC recommendation. Should a deferral be required, reasoning behind the deferral and the relevant actions required are explained to the doctor. The Revalidation team and Leads support the doctors throughout their deferral period.
Action for next year:	Continue as above.

1D – Medical Governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Conduct self-assessment.
Comments:	A self assessment will need to be undertaken to assess how far the organisation is meeting this statement which is derived from "Effective Clinical Governance for the medical profession". This self-assessment tool can be used to help the organisation evaluate where it is meeting the outcomes listed under each principle below, and identify ways we can improve. More time is required to complete this self-assessment from senior leadership with respect to recruitment and patient safety. There is no specific requirement to report against the self-assessment.
Action for next year:	To complete self-assessment. To support completion of the self - assessment, senior engagement is required as some responses and acknowledgments from some senior members are still outstanding. The areas that require completion in the self-assessment relate to recruitment and patient safety.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	No action required.
Comments:	Systems that are in place include. • All doctors are required to undergo annual appraisals whereby there are opportunities to assess performance against national standards, personal development goals and feedback from patient and peers. As part of the appraisal, doctors reflect on their CPD activities to ensure they are keeping up to date with clinical best practices. • Doctors are required to undergo quality improvement activities which assess their performance against local and national standards. This may include regular clinical audits to assess quality of care against defined standards. • Peer reviews or Multi source feedback are used to gather 360-degree input on a doctor's clinical and professional behaviour. • Doctors must undergo revalidation if they have a license to practice. • Incident reporting and learning systems. For example, Ulysses. Doctors are informed of any incidents they need to reflect on in their appraisal. • Complaints and patient feedback. Doctors are informed of any complaints which require reflection in their appraisal. • Maintaining High Professional Standards Policy (responding to concerns). • Support from Responsible Officers who oversees the performance and conduct of doctors. • Freedom to Speak Up Guardians.
Action for next year:	Continue as above

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	A procurement exercise is due to start for the Group to have a joint supplier of appraisal system. The future supplier must meet the standards outlined above to ensure information governance requirements are met.
Comments:	The SARD appraisal system allows unlimited upload of documentation as well as supporting all common formats of documentation type. Doctor's are required to confirm that no patient identifiable information has been uploaded with every document that is uploaded. Doctors are also provided clinical governance information for their appraisal, 3 months before appraisal is due. This is allowed for reflection and quality improvement purposes. Action above completed.
Action for next year:	Nil – embedded and business as usual

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	A joint group procedure/policy will be developed.
Comments:	HUTH has an active Maintaining High Professional Standards procedure managed by Human Resources department. Joint MHPS policy in draft form and ratification is expected by next reporting period There is a group policy on Sexual Safety Policy : GP021 Freedom to Speak Up Policy for the NHS : GP083 Patient Safety Incident Response Policy (PSIRF) : DCP433 & CP453) Raising Concerns at Work (Whistleblowing) policy: CP169)
Action for next year:	Ratification of joint policy for next report 2027

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	No action required.
Comments:	A report is submitted annually to "Workforce Education and Culture Committees-in-Common." The report detailed employee relation cases. Analysis includes number of cases, staff type, department, type of case and outcomes. The report also contains statistics on employees protected characteristics who are involved in employee relation cases. Monthly meetings, attended by HR, the Responsible Officer and Chief Medical Officer, to review current cases and new cases which meet criteria for investigation. Weekly Responsible Officer Advisory Group meeting to discuss all serious concerns about doctors. Regular discussions with GMC ELA for advice and appropriate actions.
Action for next year:	No action required.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Nil
Comments:	The Medical Practitioner Information Transfer Form is used by the Revalidation Team to be completed by the Responsible Officer from the prospective employee's previous organisation: this includes revalidation date, date of last appraisal and any concerns arising from appraisal, details of ongoing or previous GMC/NHS Resolution investigations (formerly NCAS), local conditions or undertakings, and any unresolved performance concerns. The prospective Responsible Officer is informed accordingly.
Action for next year:	Continue as above.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	Nil
Comments:	All Trust employees are required to undertake Equality and Diversity Training as part of their mandatory training. Equality impact assessments are conducted on all policies and procedures before they are implemented.
Action for next year:	No action required.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	Ensure new supplier for IT appraisal system has mechanism to ensure capturing of development requirements and learning opportunities.
Comments:	HUTH has a Learning Strategy policy which identifies learning opportunities from governance systems and wider systems. Doctors are also required to reflect on incidents/events that have been captured via clinical governance systems. Reflecting on serious incidents is a mandatory requirement from GMC. Doctors do this via the SARD appraisal system. Doctors must also produce a PDP to demonstrate where new learning must take place as a result of events that have been captured via the Clinical Governance systems. HUTH is signed to the National Sexual Safety Charter and are committed to implement all elements of the charter. There is now a Group Sexual Safety Policy. Action above completed
Action for next year:	Nil – continue to work with regulators and clinical governance systems to maintain business as usual approach.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Nil
Comments:	All healthcare professionals, including AfC, are required to undergo appraisal. The method of how this appraisal is conducted differs between AfC staff and Medical and Dental contract staff. Doctors in training professional standards are monitored via their health education board and via the ARCP process. There is policy relating to professional staff registration policy AT huth (CP121)
Action for next year:	No action required.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	Nil
Comments:	The Trust uses the Trac jobs recruitment system to ensure all pre-employment checks are completed before all doctors undertake their professional duties. All qualifications, skills and relevant knowledge is verified during this process. The Recruitment team and recruiting managers follow the Trust's Recruitment and Selection Training. Completion of this training is required to gain access to the Trac jobs system.
Action for next year:	No action required.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Nil
Comments:	Please refer to 1d regarding completion of self assessment
Action for next year:	Refer to 1D

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	No action required.
Comments:	Please refer to 1D
Action for next year:	No action required.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	No action required.
Comments:	There is a Freedom to Speak up Guardian in place at HUTH, who is available to all staff.
Action for next year:	No action required.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	With aims to develop a Group Medical Appraisal Policy/Procedure, the complaints process for appraisal will be reviewed.
Comments:	There is a Group Grievance Procedure which outlines the mechanism doctors have should they wish to raise a complaint. The Grievance Procedure is subject to review to identify training needs and gaps in knowledge based on the monitoring information. Currently at HUTH, there is not a specific procedure/process for complaints about the appraisal process. Group policy in draft which will contain complaint procedures about appraisal process.

Action for next year:	Group policy to be ratified for next revalidation report update 2027

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	No action required.
Comments:	"Workforce Education and Culture Committees-in-Common." The report detailed employee relation cases. The report contains statistics on employees protected characteristics who are involved in employee relation cases. Areas where there is disparity are reviewed to understand the why, and the group is further supported.
Action for next year:	No action required.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Conduct a Peer review in 2026.
Comments:	RO attends network meetings. Peer review organised for November 2026
Action for next year:	Updates on review outcomes for next revalidation report.

Section 2 - Metrics

Year covered by this report and statement: 1st April 2024 – 31st March 2025.

All data points are in reference to this period unless stated otherwise.

2A - General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	**952**

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below:

Total number of appraisals completed	**753**
Total number of appraisals approved missed	**46**
Total number of unapproved missed	**153**

2C – Recommendations

Number of recommendations and deferrals in the reporting period:

Total number of recommendations made	71
Total number of late recommendations	0
Total number of positive recommendations	56
Total number of deferrals made	13
Total number of non-engagement referrals	2
Total number of doctors who did not revalidate	0

2D – Governance

Please note that the below applies to HHP

Total number of trained case investigators	31
Total number of trained case managers	Number varies* please see below
Total number of new concerns registered	12
Total number of concerns processes completed	9
Longest duration of concerns process of those open on 31 March	131 days
Median duration of concerns processes closed	91 days
Total number of doctors excluded/suspended	1
Total number of doctors referred to GMC	1

***HUTH policy**

Appendix 1 –Appointment of Key Roles Doctor subject to the Policy	**Role of Case Manager**	**Role of Case Investigator**
Health Group Medical Director	Chief Medical Officer	Deputy Chief Medical Officer/Senior Manager
Clinical Director	Health Group Medical Director or equivalent	Health Group Medical Director/Senior Manager
Lead Consultant	Health Group Medical Director or equivalent	Clinical Director/ Manager
Consultant	Health Group Medical Director or equivalent	Clinical Director or Lead Consultant/Manager
Associate Specialist/ Speciality Doctor/ Specialist Grade	Clinical Director or Lead Consultant	Consultant/Manager
Junior Doctor in Training ST3+	Clinical Director or Lead Consultant	Consultant/Manager
Junior Doctor in Training	Clinical Director or Lead Consultant	Consultant/Manager

NLAG Policy

Can only be the CMO.

2E – Employment Checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	606

This figure includes doctor in training however HUTH are not responsible for trainee doctors and their revalidation. NHS England oversees trainee doctors' revalidation.	
Number of new employment checks completed before commencement of employment	606

2F - Organisational Culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	Data unavailable

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report:

Progression of Business Case:
Medical Appraiser recruitment has gone extremely well and there is now group wide collaborative working amongst the appraisers. Some appraisers are conducting appraisals for NLG and HUTH medical staff.

The business case is almost fully implemented – 4 of the actions are near completion as highlighted in 1a.

However, one action from the business case is unlikely to be deliverable currently due to vacancy controls affecting administrative staff, specifically in relation to Band 3 support.

To mitigate this, the e-medical workforce consultation has now concluded, with outcomes confirmed and individuals allocated to roles. In relation to the revalidation team specifically, a workload analysis will be undertaken to ensure that tasks are appropriately aligned to roles, in line with the consultation proposals.

It is anticipated that this analysis may identify efficiencies within the current structure, which could reduce or remove the requirement for additional Band 3 administrative support

Identified Gap: Incomplete Data on Trained Case Managers and Investigators (reported in 2025 report)

There is now a comprehensive and verified record of trained case managers and case investigators for HHP. This record is held within the RO office for reference.
Newly trained managers and investigators are updated onto the record held in RO office

Actions still outstanding:

A self-assessment will need to be undertaken to assess how far the organisation is meeting this statement which is derived from "Effective Clinical Governance for the medical profession". – The Revalidation team will ask for RO input to get the final responses in. If this is not successful, this will be further escalated.

Current issues:

- Full establishment of medical appraisers
- Maintain accurate lists of licensed medical practitioner.
- Ratify draft joint appraisal policy for HHP
- Conduct peer review in November 2026
- maintain quarterly joint appraiser networking meetings.
- The RO to continue to attend RO network meetings and professional development activities to remain up to date with RO role.
- Obtain final responses for the self-assessment tool "Effective Clinical Governance to support Revalidation."

Actions for next year:
(replicate list of 'Actions for next year' identified in Section 1):

- Implementation of business case.
- Maintain accurate lists of licensed medical practitioner.
- Create a joint appraisal policy for HUTH and NLaG.
- Organise peer review for HUTH in 2026.
- Implementation of joint appraisal software system for appraisal and revalidation.
- Train senior doctors in medical appraiser skills.
- Organise quarterly joint appraiser networking meetings.
- Standardise internal audits for quality assuring medical appraisal outs and the appraisal process.
- The Responsible Officer to continue to attend Responsible Officer Network meetings and professional development activities to remain up to date with the Responsible Officer role.
- Implement self-assessment tool "Effective Clinical Governance to support Revalidation."
- Case managers and case investigators (see current issue section)

Overall concluding comments:
(consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Overall, the organisation has made strong progress over the past year. A key achievement has been the successful implementation of the SARD system, which is now fully embedded as business as usual, supporting a more streamlined and robust approach to appraisal and revalidation processes. From implementation to embedded for business as usual, completion time was 3 months. The revalidation team are supporting medical staff who require support with using new system.

In addition, appraisers are now working collaboratively across the Humber Health Partnership (HHP), which is helping to address previous appraiser capacity challenges at HUTH. A successful appraiser recruitment campaign has also been completed, including the appointment of revalidation leads and senior appraisers, bringing the service close to full establishment.

Following the e-medical workforce consultation, the revalidation team now operates within the new post-consultation group model, delivering appraisal and revalidation support across the wider HHP region. This collaborative approach is further strengthened by the alignment of financial arrangements, with the final stages of centralised funding nearing completion.

Looking ahead, the Responsible Officer is also considering formalising the current joint working arrangements by bringing the designated bodies of HUTH and NLG together. The GMC have informed the RO that An application would need to be submitted to the GMC, and initial guidance indicates that this is expected to be a straightforward process.
As services are already operating as a joint designated body in practice, this would represent the final phase of integration and would formalise existing arrangements rather than introduce significant change. The only material change would be the production of a single annual revalidation report under the proposed designated body name of Humber Health Partnership.

While significant progress has been made, there remain challenges, particularly in relation to engagement with collaborative working in relation to the self-assessment which will require continued focus and senior support if required,

Looking ahead, priorities for the coming year will focus on strengthening engagement, embedding the new group model, and ensuring effective alignment of roles and responsibilities through workload analysis. This includes identifying potential efficiencies within the revalidation function to support a sustainable and resilient service model going forward.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the Designated Body
[(Chief Executive or Chairman (or Executive if no Board exists)]

Official name of the designated body:	Hull University Teaching Hospitals NHS Trust
Name:	Lyn Simpson
Role:	Group Chief Executive Officer

Signed:	
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)210

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	10 September 2026
Director Lead	Mr Peter Sedman, Deputy Group Chief Medical Officer
Contact Officer / Author	Dr Ananthakrishnan Ananthasayanam, Responsible Officer Rachael Smith, Group Senior Revalidation Officer
Title of Report	**NLaG Medical Appraisal & Revalidation Annual Report 2026**
Executive Summary	The purpose of this report is to provide assurance that Northern Lincolnshire and Goole NHS Foundation Trust continues to meet its statutory obligations for medical appraisal, revalidation and clinical governance. Significant progress has been achieved during 2025/26, particularly through implementation of the SARD appraisal system, successful recruitment of appraisers, strengthened collaborative working across Humber Health Partnership (HHP), and continued compliance with GMC revalidation requirements. Whilst overall performance remains positive, several areas require continued oversight, including completion of outstanding business case actions, ratification of group policies, completion of the GMC clinical governance self-assessment, and the embedding of a sustainable long-term appraiser model across HHP. **Alert** **Outstanding Clinical Governance Self-Assessment** The self-assessment against the GMC's Effective Clinical Governance for the Medical Profession remains incomplete. Progress is dependent upon contributions from senior leaders, particularly regarding recruitment and patient safety arrangements. Completion of this assessment is important to demonstrate organisational compliance and identify opportunities for governance improvement. Continued escalation may be required should responses remain outstanding. **Policy Harmonisation and Ratification** Several key group-wide policies remain in draft form, including: Group Medical Appraisal and Revalidation Policy. Group Maintaining High Professional Standards (MHPS) Policy. Whilst interim arrangements remain compliant, delayed ratification prolongs variation between legacy organisational processes. **Appraiser Workforce Not Yet at Full Establishment** Although recruitment has been highly successful, the appraiser

	workforce has not yet reached full establishment. Across HHP there are 137 appraisers against a target of 149, with continued reliance on reserve appraisers and a small number of "super-appraisers" managing larger portfolios. Sustained recruitment remains necessary to ensure resilience and future capacity. **Administrative Capacity Risk** One element of the approved business case remains at risk due to vacancy controls affecting Band 3 administrative support posts. While a workforce review is underway and may identify efficiencies, this represents a potential risk to future operational resilience if not addressed. **Appraisal Compliance Impact from System Transition** Thirty-four appraisals were recorded as unapproved missed appraisals during the reporting period due to the implementation of the new appraisal IT system. Although most cases have subsequently been resolved or are progressing, one doctor required referral to the GMC for non-engagement. This demonstrates the importance of continued monitoring during periods of organisational change. **Assure** **Statutory Compliance Maintained** The organisation remains compliant with the Medical Profession (Responsible Officers) Regulations and has a suitably trained Responsible Officer in post who participates in national and regional networks and ongoing professional development activities. **Effective Appraisal and Revalidation Arrangements** Robust appraisal systems remain embedded through the SARD platform, ensuring annual appraisal processes are completed in accordance with GMC requirements and cover doctors' full scope of practice. Structured governance information is provided to doctors in advance of appraisal, supported by established escalation arrangements for non-engagement. **Performance indicators demonstrate effective delivery:** 417 appraisals completed during the reporting period. 37 GMC recommendations submitted. No late recommendations. 32 positive recommendations. No doctors failed to revalidate. **Business Case Benefits Being Realised** Implementation of the approved appraiser business case has delivered measurable improvements, including: • Increased appraiser recruitment. • Appointment of senior appraisers and revalidation leads.

- Collaborative deployment of appraisers across HHP.
- Progress towards centralised funding arrangements.
- Development of external peer review arrangements.

These actions have improved resilience and reduced previous appraiser capacity pressures across the partnership.

Strong Governance and Quality Assurance Frameworks

A comprehensive governance framework is in place including:

- Monthly revalidation panels.
- Responsible Officer Advisory Group meetings.
- Internal appraisal audits.
- Quality assurance reviews.
- Appraisee feedback mechanisms.
- Links with HR, GMC Employment Liaison Advisors and Clinical Governance systems.

There is clear evidence that concerns, incidents, complaints and professional standards issues are appropriately identified, monitored and escalated.

Effective Employment Checks and Medical Workforce Controls

All doctors joining the organisation during the reporting period underwent appropriate pre-employment checks prior to commencing employment, providing assurance regarding recruitment governance and patient safety.

Positive Organisational Culture

The organisation has established systems supporting:

- Equality, diversity and inclusion.
- Freedom to Speak Up.
- Sexual safety initiatives.
- Whistleblowing arrangements.
- Learning from incidents and governance activity.

No employment tribunals or appeals relating to professional standards processes were upheld during the reporting period

Advise

Priority Actions for 2026/27

The following activities should be prioritised during the coming year:

	• Complete the GMC Effective Clinical Governance Self-Assessment with support from senior leaders and report outcomes through established governance structures. • Achieve full ratification of all outstanding HHP-wide appraisal, revalidation and MHPS policies to support a consistent partnership-wide approach. • Continue recruitment activity to achieve and maintain full appraiser establishment and sustain the reserve appraiser pool. • Complete the remaining actions from the approved business case, including final centralisation of funding arrangements and resolution of administrative capacity requirements. • Undertake the planned peer review with Tees University Hospital and implement any resulting recommendations and action plans. • Continue development of the proposed proactive GMC recommendation model to support earlier identification and management of revalidation outcomes. • Consider progression towards a single Humber Health Partnership designated body arrangement, subject to GMC approval and organisational agreement, to formalise existing collaborative arrangements. The Responsible Officer can provide substantial assurance that appraisal, revalidation and medical governance processes are operating effectively and that the organisation remains compliant with statutory requirements. The implementation of actions arising from the appraiser business case has maintained a positive trajectory, evidenced by increased capacity, reduced workforce pressures and strengthened partnership working. However, continued senior oversight remains necessary until outstanding governance actions are completed and a stable, sustainable appraiser model is fully embedded across Humber Health Partnership **Recommendations** **Approval and endorsement from the BIC for submission to NHS England.**
Background Information and/or Supporting Document(s) (if applicable)	**The attached report is compliant with national reporting standard and format as set by NHS England.**
Prior Approval Process	**Workforce, Education and Culture Committees-in-Common – approved 22/07/2026**

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

Annex A

1A – General

The board/executive management team of Humber Health Partnership Trust which incorporates the Designated Body, Northern Lincolnshire and Goole NHS Foundation Trust, can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	To continue to attend RO network meetings and professional development activities to remain up to date with RO role.
Comments:	The RO attends quarterly face to face and virtual RO network meetings. The RO also receives regular updates from the GMC. The RO also attends relevant training and CPD meetings to fulfil the requirement for the role and reviews these during annual appraisal process. The RO will also be attending the regional Professional Standards Network group for shared learning.
Action for next year:	To regularly attend the regional Professional standards Group meeting

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	Implementation of business case and update the board in next annual report (2026)
Comments:	There are 4 actions from the business case which are near completion. 1 – Develop peer reviews (once every 2 years from 2026) – HHP and Tees University Hospital will collaboratively conduct the 1st peer review in November 2026. Dates agreed and booked in diaries. Tees Revalidation Team and RO will visit the Humber Health Partnership and conduct the peer review on HHP revalidation service. Any action plans and reports will be included in 2027 Revalidation Report. 2 -Redistribution of funds from Care Groups to CMO – this action is for HUTH site only as the Appraisal/revalidation funds are already centralised at NLG. At the time of writing the report (11/06/2026), the finance team are in process of moving funds from care group to the CMO. This is nearly complete and update will be provided in 2027 report to confirm completion 3 -Increase number of senior appraisers – currently 8 x senior appraisers across the HHP. 2 vacancies to recruit to and prospective candidates have been identified. Update to be provided to confirm completion.

	4. Recruit to 149 appraiser positions – across HHP there are 137 appraisers, which includes 5 x “super” appraisers who appraise up to 30 doctors. (the standard limit is 9). At NLG there is a reserve pool of trained appraisers which have been utilised to conduct appraisals across the HHP and to assist with HUTH appraiser shortage.
Action for next year:	To continue to recruit to full establishment of appraisers and maintain reserve pool of trained appraisers to ensure business continuity.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Maintain accurate list of licensed of medical practitioners
Comments:	Accurate list of all licensed medical practitioners with prescribed connection is always maintained using GMC Connect and SARD appraisal system which is cross referenced with ESR Business Intelligence reports for Medical Starters and Leavers). At recent extensive review was conducted in April 2025 which confirmed that connections were up to date. The revalidation team submits updates to the Responsible Officer each month.
Action for next year:	Maintain this action.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Create a joint policy for HUTH and NLaG. Actions are being undertaken to harmonise the current separate policies.
Comments:	Joint policy in draft phase. Ratification to be completed by next annual report.
Action for next year:	Ratified joint policy.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Organise a peer review for NLaG in 2026
Comments:	NHSE Higher RO visit conducted May 2026 – awaiting outcome report and action plan. Peer review scheduled with Tees University hospital November 2026
Action for next year:	Update committee and board on outcomes and action plans from NHS E higher level visit and the peer review.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Nil
Comments:	Short-term contract holders are fully supported in their continuing professional development (CPD), revalidation, and governance in alignment with the standards applied to substantive medical staff. They are not managed differently in terms of appraisal or revalidation processes. All short-term contract holders are expected to actively maintain their professional development through established Trust mechanisms. This includes accessing study leave, completing mandatory training, and participating in medical teaching sessions, among other opportunities. In accordance with their licence to practise and contractual obligations, short-term contract holders are required to engage with the medical appraisal and revalidation processes. Upon appointment, short-term contract holders are integrated into the Trust's appraisal system (SARD) and formally welcomed by the appraisal coordinator via email. The General Medical Council (GMC) is notified of the doctor's prescribed connection to Northern Lincolnshire and Goole NHS Foundation Trust. With respect to clinical governance, all new short-term contract holders are introduced to key governance processes, such as incident reporting, through the Trust's induction policy, consistent with the orientation and Trust inductions provided to all new starters.
Action for next year	To continue as outlined above

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Ensure continuity of processes that allow doctors to receive governance information on time for appraisal. Workshop events on revalidation and reflection. Tender for joint IT system with expected implementation December 2025. Continue with current escalation processes. Continue to monitor well-being of doctors during appraisals and provide appropriate support and guidance.
Comments:	Doctors who have prescribed connection to Northern Lincolnshire and Goole NHS Foundation Trust use the SARD software system. The doctors are required to fill their appraisal form via the SARD system and there are three basic elements to the appraisal: **Appraisal Inputs** – doctor fills in each section of the SARD form and uploading supporting information/evidence which covers their scope of practice, which may include non-NHS work. The doctor must cover and reflect on each section which are displayed below. Once the inputs are complete, the doctor completes a checklist which acts a prompt to ensure that they have considered the various aspects for their appraisal. The form is then submitted to appraiser ahead of appraisal meeting. **Appraisal meeting** – meeting between doctor and assigned appraiser. This is where the confidential discussion will take place, verbal reflection, and discussions around wellbeing, professional development, and quality improvement. **Appraisal outputs** – Doctor and appraiser agree a Personal Development Plan for the year going forward and the appraiser writes up a summary on how the doctor meets the four domains of Good Medical Practice, an overview of reflective discussions and quality improvements identified, with the supporting evidence provided. The appraiser and doctor both sign off the appraisal. The appraiser then completes their own checklist to ensure completeness and submits to the Responsible Officer office for completion. All doctors at Northern Lincolnshire and Goole NHS Foundation Trust are reminded that annual appraisal must cover their full scope of

	practice. This includes all roles, clinical, managerial, educational, private, or voluntary, and doctors must provide evidence demonstrating fitness to practise across each area, as every role can impact patient care.
	
	The nature of supporting information will vary between individuals, but certain core elements are expected. These include:
	• **Clinical Governance Data**: The Revalidation Senior Officer has an established and efficient process for collecting governance information and sharing it with doctors ahead of appraisal. This includes:
	  ○ **Incidents**: Doctors named in incidents or significant events within the past 12 months must summarise and reflect on these.
	  ○ **Formal Complaints**: Any complaints in which the doctor has been named over the previous year must also be included.
	• **Patient and Colleague Feedback**: Required at least once every five years in line with GMC revalidation. Feedback is collected via the SARD system, and doctors must reflect on their results.
	• **Medical Indemnity**: Doctors must either provide evidence of indemnity or confirm in writing their understanding of their legal obligation to hold valid cover.
	
	Although mandatory training is not a formal requirement for appraisal or revalidation, persistent non-compliance may affect revalidation outcomes depending on the severity. Doctors are encouraged to reflect on such training for CPD purposes.
	
	All supporting information must include reflection mapped to the domains of *Good Medical Practice*, with reflective practice seen as key to personal, professional, and quality improvement.
	
	Doctors are contractually and professionally obligated to participate in annual appraisal. Automated reminders are sent via SARD and the Responsible Officer's office. Doctors who fall behind are supported by the Responsible Officer team.
	
	Persistent non-engagement, despite intervention, may lead to referral to the General Medical Council's Employment Liaison Advisor. In such cases, the GMC may issue a formal warning with a deadline for compliance. Failure to meet this deadline results in referral to the GMC for non-engagement.
	
	All actions from last year report have been completed and embedded for business as usual.

Action for next year:	Nil – business as usual until contract approaches expiration at which point new procurement exercise will be required.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	To continue with HUTH/NLaG escalation policies in circumstances of delayed/late/missed appraisals.
Comments:	There is group escalation policy for appraisals that are not received by deadline. All incidences of missed/late appraisals are investigated. For where there is mitigating circumstances, this recorded on SARD appraisal system and new appraisal deadline is agreed. For where there are no mitigating circumstances, doctors will be managed by the escalation process which can result in a GMC referral for non-engagement.
Action for next year:	To continue with HUTH/NLaG escalation policies in circumstances of delayed/late/missed appraisals.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Develop unified medical appraisal policy for NLaG and HUTH
Comments:	Policy ratified in 2023 and due for review July 2026. Draft group policy soon ready for ratification. Current NLaG policy has been renewed for one year to ensure compliance in the interim whilst draft policy is in progress.
Action for next year:	Joint policy in development and ratification is expected to be completed before 2027 report.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Nil
Comments:	Between April 2024 and March 2025, NLaG had a full cohort of trained appraiser (no vacancies). NLaG have a reserved pool of trained appraisers for when a vacancy arises. The budget for medical appraisers is within the Chief Medical Officer's group. The Senior Officer oversees recruitment.
Action for next year:	To keep training doctors who are interested in appraisal role to ensure a healthy pool for reserve appraisers.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	To organise quarterly joint appraiser network meetings to compliment the annual training day.
Comments:	Each Medical appraiser undergoes performance review. A report which collates appraisee's feedback via the post-appraisal questionnaire (PAQ) which is built into the SARD system. This report is sent to every appraiser to reflect upon and identify improvements where needed which increases the quality of appraisals and improves the process for doctors. Joint networks are now established.
Action for next year:	Maintain quality assurance processes for appraisers Develop new training for existing and new appraisers.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	To standardise internal audits across the Group for quality assuring medical appraisal outputs and the process.
Comments:	Current quality assurance processes and measures are outlined below: • Appraisee feedback on the overall process and their appraiser. • Monthly group revalidation panel meetings involving RO, appraisal leads, management and coordinators. • RO attendance at the RO network meeting. • Annual Training events for medical appraisers and all medical staff who wish to learn more about local process. • Annual revalidation report. • Statement of compliance signed by the Chief Executive Officer, which is then submitted to NHS England. Internal audit is now standardised across the group assessing quality of medical appraisals.
Action for next year:	Maintain above processes across HHP. Audit reports will be available from 2027 as we are now in process of auditing appraisals that are being submitted between April 2026- March 2027.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	Nil.
Comments:	There are joint monthly panel meetings which review doctors under notice. The GMC has advised that the designated bodies should adopt a more proactive approach to submitting revalidation recommendations. As doctors enter the 12-month notice period prior to their revalidation date, designated bodies are expected to review cases earlier and make timely recommendations, whether for revalidation, deferral, or non-engagement. In response, a paper has been developed and proposes a proactive, risk-based model that uses SARD data and a streamlined GMC-aligned checklist to identify doctors who already meet the requirements, enabling earlier submission of recommendations while focusing resources on those who require targeted support.
Action for next year:	To continue with meeting format and agenda whilst proposal is considered for implementation.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	Nil
Comments:	Each doctor is notified individually of their GMC recommendation. Should a deferral be required, reasoning behind the deferral and the relevant actions required are explained to the doctor. The Revalidation team and Leads support the doctors throughout their deferral period
Action for next year:	Continue as described above.

1D – Medical Governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Conduct self-assessment and report to board in next year's report on any actions identified as result of self-assessment
Comments:	A self assessment will need to be undertaken to assess how far the organisation is meeting this statement which is derived from "Effective Clinical Governance for the medical profession". This self-assessment tool can be used to help the organisation evaluate where it is meeting the outcomes listed under each principle below, and identify ways we can improve. More time is required to complete this self-assessment from senior leadership with respect to recruitment and patient safety. There is no specific requirement to report against the self-assessment.
Action for next year:	To complete self-assessment. To support completion of the self - assessment, senior engagement is required as some responses and acknowledgments from some senior members are still outstanding. The areas that require completion in the self-assessment relate to recruitment and patient safety.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Nil
Comments:	Systems that are in place include: • All doctors are required to undergo annual appraisals whereby there are opportunities to assess performance against national standards, personal development goals and feedback from patient and peers. As part of the appraisal, doctors reflect on their CPD activities to ensure they are keeping up to date with clinical best practices. • Doctors are required to undergo quality improvement activities which assess their performance against local and national standards. This may include regular clinical audits to assess quality of care against defined standards. • Peer reviews or Multi source feedback are used to gather 360-degree input on a doctor's clinical and professional behaviour. • Doctors must undergo revalidation if they have a license to practice. • Incident reporting and learning systems. For example, Ulysses. Doctors are informed of any incidents they need to reflect on in their appraisal.

	• Complaints and patient feedback. Doctors are informed of any complaints which require reflection in their appraisal. • Maintaining High Professional Standards Policy (responding to concerns) • Support from Responsible Officers who oversees the performance and conduct of doctors. • Freedom to Speak Up Guardians.
Action for next year:	Nil

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	There is an ongoing procurement exercise for joint appraisal software. Future supplier must be able to meet these standards of documentation upload as described above and ensure information governance requirements are met.
Comments:	The SARD appraisal system allows unlimited upload of documentation as well as supporting all common formats of documentation type. Doctor's are required to confirm that no patient identifiable information has been uploaded with every document that is uploaded. Doctors are also provided clinical governance information for their appraisal, 3 months before appraisal is due. This is allowed for reflection and quality improvement purposes. Action above completed.
Action for next year:	Nil – embedded and business as usual

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	A joint group procedure/policy will be developed with HUTH.
Comments:	NLaG has an active Maintaining High Professional Standards procedure managed by Human Resources department. Joint MHPS policy in draft form and ratification is expected by next reporting period There is a group policy on Sexual Safety Policy : GP021 Freedom to Speak Up Policy for the NHS : GP083 Patient Safety Incident Response Policy (PSIRF) : DCP433 & CP453) Raising Concerns at Work (Whistleblowing) policy: CP169)
Action for next year:	Ratification of joint policy for next report 2027

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Nil
Comments:	A report is submitted annually to "Workforce Education and Culture Committees-in-Common." The report detailed employee relation cases. Analysis includes number of cases, staff type, department, type of case and outcomes. The report also contains statistics on employees protected characteristics who are involved in employee relation cases. Monthly meetings, attended by HR, the RO and Chief Medical Officer, to review current cases and new cases which meet criteria for investigation. Weekly RO Advisory Group meeting to discuss all serious concerns about doctors. Regular discussions with GMC ELA for advice and appropriate actions.
Action for next year:	Nil

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Nil
Comments:	The Medical Practitioner Information Transfer Form is used by the Revalidation Team to be completed by the Responsible Officer from the prospective employee's previous organisation: this includes revalidation date, date of last appraisal and any concerns arising from appraisal, details of ongoing or previous GMC/NHS Resolution investigations (formerly NCAS), local conditions or undertakings, and any unresolved performance concerns. The prospective Responsible Officer is informed accordingly.
Action for next year:	Nil. Continue with process.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	Nil
Comments:	All staff are required to undertake Equality and Diversity training as part of mandatory training induction. Equality impact assessments are conducted on all policies and procedures before they are operational.
Action for next year:	Nil

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	Ensure new supplier for IT appraisal system has mechanism to ensure capturing of development requirements and learning opportunities.
Comments:	NLaG has a Learning Strategy policy which identifies learning opportunities from governance systems and wider systems. Doctors are also required to reflect on incidents/events that have been captured via clinical governance systems. Reflecting on serious incidents is a mandatory requirement from GMC. Doctors do this via the SARD appraisal system. Doctors must also produce a PDP to demonstrate where new learning must take place as a result of events that have been captured via the Clinical Governance systems. NLaG is signed to the National Sexual Safety Charter and are committed to implement all elements of the charter. There is now a Group Sexual Safety Policy. Action above completed.
Action for next year:	Nil – continue to work with regulators and clinical governance systems to maintain business as usual approach.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Nil
Comments:	All healthcare professionals, including AfC, are required to undergo appraisal. The method of how this appraisal is conducted differs between AfC staff and Medical and Dental contract staff. Doctors in training professional standards are monitored via their health education board and via the ARCP process. NLaG have three policies relating to healthcare professional standard arrangements: 1. Maintenance of General Medical Council and General Dental Council Registrations and the Electronic Staff Record (DCP110) 2. Maintenance of Nursing, Midwifery and Nursing Associates Professional Registration and the Electronic Staff Record (DCP117) 3. Procedure for Maintaining Effective Registration for Pharmacists, Pharmacy Technicians, Dental Care Professionals, Allied Health Professionals, Biomedical Scientists and Clinical Scientists Working in the Trust (DCR025)
Action for next year:	Nil

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	Nil
Comments:	• Recruitment team follow “recruitment and selection – A best practice guide”. Background checks are undertaken to ensure all new doctors are suitably qualified and skilled for the role they have been offered. • NLaG uses TRAC job recruitment system which ensures all pre-employment checks are completed before doctors undertake their post. All qualifications, skills, knowledge and experience are verified at this stage. • All doctors undergo qualification checks
Action for next year:	No action required.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Nil
Comments:	Please refer to 1D
Action for next year:	Please refer to 1D

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	Nil
Comments:	Please refer to 1D
Action for next year:	Refer to 1D

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	Nil
Comments:	Freedom To Speak up Guardian in place at NLaG and Freedom to Speak Up Policy.
Action for next year:	Nil

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	With aims to develop a Group Medical Appraisal Policy/Procedure, the complaints process for appraisal will be reviewed.
Comments:	There is a procedure whereby doctors can submit complaints about the appraisal process (section 8.2.7 Management of Complaints about the Appraisal Process – Medical Appraisal and Revalidation Procedure DCR100). There is a Group Grievance Procedure which outlines the mechanism doctors have should they wish to raise a complaint. The Grievance

	Procedure is subject to review to identify training needs and gaps in knowledge based on the monitoring information. Group policy in draft.
Action for next year:	Group policy to be ratified for next revalidation report update 2027

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	Nil
Comments:	"Workforce Education and Culture Committees-in-Common." The report detailed employee relation cases. The report contains statistics on employees protected characteristics who are involved in employee relation cases. Areas where there is disparity are reviewed to understand the why, and the group is further supported.
Action for next year:	Nil

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Conduct Peer review for 2026
Comments:	RO attends network meetings. Peer review organised for November 2026
Action for next year:	Updates on review outcomes for next revalidation report.

Section 2 – Metrics

Year covered by this report and statement: 1st April 2025 to 31st March 2026.

All data points are in reference to this period unless stated otherwise.

2A – General NLG only

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	515

2B – Appraisal – NLG only

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below:

Total number of appraisals completed	417
Total number of appraisals approved missed	64
Total number of unapproved missed	34*

All 34 cases experienced postponed appraisals due to the transition to a new appraisal IT system, with appraisals rescheduled to February 2026. As a result, these appraisals were not completed before 31 March 2026, marking the end of the audit year, and were therefore recorded as unapproved missed.

Following this, doctors' appraisal months have been reverted to their original allocated schedule. This reflects NLG's established practice of avoiding routine allocation of appraisal months in January, February, and March, to minimise the risk of unapproved missed appraisals at year-end.

Of the 34 –
16 have completed appraisal.
12 appraisals are awaiting appraiser sign off
6 doctors are being monitored for non-engagement with appraisal process. Of those 6, 5 have reassured the RO that they are now engaging with process.
The remaining 1 doctor has been referred to GMC for non-engagement.

2C – Recommendations – NLG only

Number of recommendations and deferrals in the reporting period:

Total number of recommendations made	37
Total number of late recommendations	0
Total number of positive recommendations	32
Total number of deferrals made	5
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Please note that the below applies to HHP

Total number of trained case investigators **HHP**	31
Total number of trained case managers **HHP**	*number varies. Please see below
Total number of new concerns registered	12
Total number of concerns processes completed	9
Longest duration of concerns process of those open on 31 March	131 days
Median duration of concerns processes closed	91 days
Total number of doctors excluded/suspended	1
Total number of doctors referred to GMC	1

***HUTH policy**

Appendix 1 –Appointment of Key Roles Doctor subject to the Policy	**Role of Case Manager**	**Role of Case Investigator**
Health Group Medical Director	Chief Medical Officer	Deputy Chief Medical Officer/Senior Manager
Clinical Director	Health Group Medical Director or equivalent	Health Group Medical Director/Senior Manager
Lead Consultant	Health Group Medical Director or equivalent	Clinical Director/ Manager
Consultant	Health Group Medical Director or equivalent	Clinical Director or Lead Consultant/Manager
Associate Specialist/ Speciality Doctor/ Specialist Grade	Clinical Director or Lead Consultant	Consultant/Manager
Junior Doctor in Training ST3+	Clinical Director or Lead Consultant	Consultant/Manager
Junior Doctor in Training	Clinical Director or Lead Consultant	Consultant/Manager

NLAG Policy

Can only be the CMO.

2E – Employment Checks- NLG only

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment:

Total number of new doctors joining the organisation between 1st April 2025-31st March 2026 This figure includes doctor in training however NLaG are not responsible for trainee doctors and their revalidation. The local education health board oversees trainee doctors revalidation.	300
Number of new employment checks completed before commencement of employment	300

2F - Organisational Culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	Data unavailable

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report:
Progression of Business Case: Medical Appraiser recruitment has gone extremely well and there is now group wide collaborative working amongst the appraisers. Some appraisers are conducting appraisals for NLG and HUTH medical staff. The business case is almost fully implemented – 4 of the actions are near completion as highlighted in 1a. However, one action from the business case is unlikely to be deliverable currently due to vacancy controls affecting administrative staff, specifically in relation to Band 3 support. To mitigate this, the e-medical workforce consultation has now concluded, with outcomes confirmed and individuals allocated to roles. In relation to the revalidation team specifically, a workload analysis will be undertaken to ensure that tasks are appropriately aligned to roles, in line with the consultation proposals.

It is anticipated that this analysis may identify efficiencies within the current structure, which could reduce or remove the requirement for additional Band 3 administrative support

Identified Gap: Incomplete Data on Trained Case Managers and Investigators (reported in 2025 report)

There is now a comprehensive and verified record of trained case managers and case investigators for HHP. This record is held within the RO office for reference.
Newly trained managers and investigators are updated onto the record held in RO office

Actions still outstanding:

A self-assessment will need to be undertaken to assess how far the organisation is meeting this statement which is derived from
"Effective Clinical Governance for the medical profession". – The Revalidation team will ask for RO input to get the final responses in. If this is not successful, this will be further escalated.

Current issues:

Actions for next year:
(replicate list of 'Actions for next year' identified in Section 1):

- Full establishment of medical appraisers
- Maintain accurate lists of licensed medical practitioner.
- Ratify draft joint appraisal policy for HHP
- Conduct peer review in November 2026
- maintain quarterly joint appraiser networking meetings.
- The RO to continue to attend RO network meetings and professional development activities to remain up to date with RO role.
- Obtain final responses for the self-assessment tool "Effective Clinical Governance to support Revalidation."

Overall concluding comments:
(consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Overall, the organisation has made strong progress over the past year. A key achievement has been the successful implementation of the SARD system, which is now fully embedded as business as usual, supporting a more streamlined and robust approach to appraisal and revalidation processes. From implementation to embedded for business as usual, completion time was 3 months. The revalidation team are supporting medical staff who require support with using new system.

In addition, appraisers are now working collaboratively across the Humber Health Partnership (HHP), which is helping to address previous appraiser capacity challenges at HUTH. A successful appraiser recruitment campaign has also been completed, including the appointment of revalidation leads and senior appraisers, bringing the service close to full establishment.

Following the e-medical workforce consultation, the revalidation team now operates within the new post-consultation group model, delivering appraisal and revalidation support across the wider HHP region. This collaborative approach is further strengthened by the alignment of financial arrangements, with the final stages of centralised funding nearing completion.

Looking ahead, the Responsible Officer is also considering formalising the current joint working arrangements by bringing the designated bodies of HUTH and NLG together. The GMC have informed the RO that An application would need to be submitted to the GMC, and initial guidance indicates that this is expected to be a straightforward process.
As services are already operating as a joint designated body in practice, this would represent the final phase of integration and would formalise existing arrangements rather than introduce significant change. The only material change would be the production of a single annual revalidation report under the proposed designated body name of Humber Health Partnership.

While significant progress has been made, there remain challenges, particularly in relation to engagement with collaborative working in relation to the self-assessment which will require continued focus and senior support if required,

Looking ahead, priorities for the coming year will focus on strengthening engagement, embedding the new group model, and ensuring effective alignment of roles and responsibilities through workload analysis. This includes identifying potential efficiencies within the revalidation function to support a sustainable and resilient service model going forward.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief Executive or Chairman (or Executive if no Board exists)]

Official name of the designated body:	Northern Lincolnshire and Goole NHS Foundation Trust
Name:	Lyn Simpson
Role:	Group Chief Executive Officer
Signed:	
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)211

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	10 September 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 – June 2026 - Public**
Executive Summary	Public minutes of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting held on 18 June 2026, approved at the ARG CiC meeting on 30 July 2026.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – June 2026
Prior Approval Process	ARG CiC meeting – 30 July 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:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 18 June 2026 at 1.30pm to 4.30pm via Microsoft Teams

For the purpose of transacting the business set out below:

Present:
Core Members:

Jane Hawkard	Chair of ARG CiC (HUTH) - Non-Executive Director
Julie Beilby	Non-Executive Director (NLaG)

In Attendance:

Alan Downey	Group Chair
Lyn Simpson	Group Chief Executive Officer (left after Item 6)
Murray MacDonald	Non-Executive Director (HUTH & NLaG) / Vice Chair (HUTH)
Emma Sayner	Group Chief Financial Officer
Rebecca Crashley	Group Deputy Director of Assurance
Sally Stevenson	Assistant Director of Finance - Compliance & Counter Fraud
Harriet Fisher	Director, KPMG – Group Internal Audit
Louise Kay	Manager, KPMG – Group Internal Audit
Nicola Hallas	Engagement Lead, Forvis Mazars – External Audit HUTH
Makhosi Mazibia	Audit Manager, Forvis Mazars – External Audit HUTH
Brian Clerkin	Partner, Sumer NI – External Audit NLaG
Chipo-Grace Tete	Audit Manager, Sumer NI – External Audit NLaG
Nicola Parker	Assistant Director of Finance – Financial Services (left after item 6)
Dr Alastair Pickering	Group Chief Digital Officer (left after item 9.2)
Hilda Gwilliams	Group Chief Patient Safety Officer (left after item 9.3)
Vicky Sharman	Nurse Director (HUTH) (left after item 11.1)
Mike Bateson	NLaG Governor Observer
Jo Palmer	PA to Committees-in-Common (Minutes)

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

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

1. Welcome and Apologies for Absence

Jane Hawkard, Audit, Risk and Governance Committees-in-Common (ARG CiC) Chair, welcomed colleagues to the meeting. There were no apologies for absence.

2. Declarations of Interest

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

3. To approve the minutes of the meetings held on 23 April 2026

3.1 Public Minutes – 23 April 2026

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

The running order of the agenda was amended to enable discussion of sections 6 and 7 whilst the Group CEO was in attendance.

6. Public Disclosure Documents – NLaG

6.1 NLaG Audited Annual Accounts 2025/26

Emma Sayner introduced the report and thanked the teams, both within the Trust and the auditors for their work, for the good output and the limited number of minor changes between the draft accounts and the audited accounts. There remained one outstanding piece of work around the way that the arrangements for the former CEO were represented through the HUTH accounts and she and Nicola Parker were working with NHS England (NHSE) colleagues, together with Jane Hawkard and this was likely to be completed close to the deadline but was hoped to be resolved as soon as possible as there were likely to be only minor presentational disclosure changes to be made.

Nicola Parker advised that there had been three changes since the draft accounts had been issued in April 2026. One was concerning the statutory audit fee being amended to £181k in line with the agreed audit fee for this financial year. The second change related to directors remuneration, which are disclosed due to NLaG being a Foundation Trust, and there had been some changes due to confirmation of leaving dates, start dates, resulting in a reduced figure of £1,301, which was a reduction of £26k. The final change concerned a final reduction in Related Parties note 41 which incorrectly included some NHSE income of £545k which was related to previous years. Jane Hawkard asked if there had been any impact due to the reduction of the £545k and Nicola Parker responded that there had been none, and referred to the Related Parties section concerning the agreement of balances and confirmed it agreed with the income for 2025/26 for NHSE.

The ARG CiC Chair asked that the HUTH audited accounts item (7.1) be taken next.

7. Public Disclosure Documents – HUTH

7.1 HUTH Audited Annual Accounts 2025/26

Nicola Parker drew attention to some presentational issues, including one on Intangible Assets, a column was originally hidden on the Excel spreadsheet which had now been unhidden to enable sight of assets under construction, although the information in the hidden column did not affect the bottom line. Another change involved the movement of an MRI machine costing £1.9m and this had been classed under actual plant and equipment rather than assets under construction as it had not been delivered to the Trust and was on a vesting certificate.

There were no questions from the ARG CiC and the agenda returned to item 6.2.

6. Public Disclosure Documents – NLaG

6.2 NLAG Audit Completion Report/Management Letter of Representation 2025/26

Brian Clerkin advised that this was an internal document which updated management as to how the audit went and any findings from it. Brian Clerkin outlined the various sections of the document and advised that once the accounts had been signed, an unqualified audit opinion on the NLaG accounts would be provided. Since the original document was issued on 10 June 2026, all outstanding points had been resolved as well as the external quality control review of the audit file. Appendix 2 dealt with control weaknesses of which four had been identified in terms of strengthening controls in advance of next years audit. Brian Clerkin was of the view that the audit had gone very well and was pleased to share that there had been good engagement from the team and thanked all involved.

6.3 NLAG Draft Audit Opinion & Certificate 2025/26

Brian Clerkin advised that this item was for assurance and summarised that the draft audit opinion would be signed once the accounts had been signed and was a cross reference of information in relation to the quality completion certificate. Brian Clerkin stated that once again, as with last year, the certificate could not be signed off until the Group Audit is signed off nationally by the National Audit Office (NAO), which was expected to be in Autumn 2026. This applied to HUTH also.

6.4 NLAG Draft Consistency Opinion 2025/26

Brian Clerkin outlined the document, which again was for assurance purposes, and confirmed no issues with the consistency of figures in the Trust Consolidation Schedules spreadsheets against the Word version of audited financial statements.

6.5 NLAG Draft Annual Auditors Report 2025/26

Brian Clerkin advised that this document remained in draft until the audit opinion was signed. He explained that it is a public facing document which summarises the outcome of the audit of the financial statements, and which also met the requirements of the Audit Code and legislation in terms of auditors providing a commentary on the Value for Money (VFM) arrangements in place within the Trust. The External Auditor was required to provide commentary on financial sustainability, governance and improving economy, efficiency and effectiveness, and to identify any significant weaknesses in terms of the VFM work. Brian Clerkin stated that they had highlighted issues around financial sustainability in terms of the reported deficit for the last two years and the forward-looking requirements in terms of future savings plans and also referenced the National Oversight Framework (NOF) 5 rating.

Jane Hawkard referred to the completion of the VFM work and whether a management response had now been received in terms of the recommendations. Brian Clerkin explained that because of the timing in issuing the various documents, the response was still to be provided, but anticipated receipt within the following few days, and it would be included within the final version of item 6.2. Emma Sayner added that this timeframe would be achievable to finalise everything.

Jane Hawkard asked for any questions and there were none. The ARG CiC were

therefore assured on the completion of the audit and the VFM work, acknowledging that work was completed but the management responses remained outstanding.

6.6 NLAG & HUTH Draft Annual Governance Statements 2025/26

Rebecca Crashley introduced the combined Annual Governance Statement (AGS) and clarified that there were subtle differences between the two Trusts which were identified in the document through colour coding any differences for the final individual versions which required to be submitted. The Head of Internal Audit Conclusion section would be inserted into the final document (received at agenda items 6.7 and 7.5). Rebecca Crashley also outlined that the significant internal controls had been worked up and that further information had been added in relation to NOF5 since the draft document was received in April 2026. Rebecca Crashley advised that the AGS had also been added to the Trust's Annual Reports, and had been reviewed by internal and external audit, and was asking the Committees to approve the final versions of the Trust's AGS documents.

Julie Beilby noted that the document stated the Section 31 enforcement notice for maternity services in HUTH remained in place, although it acknowledged the application for removal had been submitted and therefore suggested a bracketed comment that the removal had subsequently been confirmed. Julie Beilby was of the view that this would provide good evidence of the organisation's improvement journey. Lyn Simpson concurred. This was agreed by the ARG CiC and Rebecca Crashley agreed to add this to the final version.

ACTION: Rebecca Crashley

Jane Hawkard noted that the HUTH Charitable Funds Committee did not appear alongside other named Committees on page 18 and Rebecca Crashley confirmed it would be added.

ACTION: Rebecca Crashley

Jane Hawkard commented that a lot of hard work had gone into producing the AGS's and thanked Rebecca Crashley for her efforts in producing the documents.

The ARG CiC approved the AGS's subject to the addition of the agreed amendments.

Jane Hawkard asked that item 6.8 be taken next on the agenda.

6.8 NLAG Draft Trust Annual Report 2025/26

Rebecca Crashley confirmed that this document had been scrutinised by the NLaG External Auditors as well as Lyn Simpson, noting that page numbers, pictures and formatting would all be finalised once approved. It was due for submission to NHSE by 26 June 2026 and would then be submitted to the Department of Health and Social Care and subsequently laid before Parliament by 30 September 2026. Rebecca Crashley thanked all contributors who had provided lots of information to the document, and asked the Committee to approve the final draft.

Jane Hawkard asked for questions. Murray MacDonald noted some presentational issues, in that the data sources only appeared to go up to February 2026 and by the time of publication in September 2026, it would appear a little outdated if the full year data was not shown. Murray MacDonald asked whether the year-end data

was available and Rebecca Crashley confirmed that year-end data should have been provided given when it was sent to her, so would investigate this further and update the data as necessary.

ACTION: Rebecca Crashley

Jane Hawkard noted that some of the tables were a little blurred and Rebecca Crashley confirmed this would be resolved with the final formatting. Jane Hawkard also referred to page 109 and the statement that many Chief Delivery Officers had resigned and questioned whether this was accurate or whether they had been interims simply coming to the end of the fixed term contract. Rebecca Crashley confirmed she would check this and amend accordingly.

ACTION: Rebecca Crashley

The ARG CiC approved the NLAG Annual Report providing these relevant checks were made and updated as necessary.

The agenda returned to item 6.7.

6.7 NLAG Annual Internal Audit Report & Head of Internal Audit Conclusion 2025/26

Harriet Fisher clarified that this final version now contained a summary of the work completed during the year and confirmed that the overall Conclusion remained unchanged from the draft presented at the April 2026 ARG CiC meeting. Harriet Fisher explained that they now concluded on four different domains and these conclusions were amber/red rating for governance and risk management and amber/green for financial reporting and data quality.

There were no questions from the Committee and the ARG CiC accepted the NLAG Head of Internal Audit Conclusion 2025/26.

Jane Hawkard summarised the meeting to that point, namely that the ARG CiC received and approved both the NLAG and HUTH audited accounts, the NLAG Annual Report and both Trust's AGS. It also received the NLAG External Auditor reports and the NLAG Head of Internal Audit Conclusion.

7. Public Disclosure Documents – HUTH

7.2 HUTH Audit Completion Report inc. Letter of Representation & Consistency Opinion 2025/26

Nicola Hallas advised the meeting that the HUTH audit was largely complete with only a couple of areas being finalised, and anticipated sign-off the following week and an unqualified audit report to be issued. Nicola Hallas also thanked everyone in the Finance team for their contributions during an intense period, noting excellent engagement and prompt responses.

In terms of findings within the VFM section, two significant risk weaknesses had previously been identified (financial sustainability and CQC inspection report) and Nicola Hallas confirmed that these would remain so for 2025/26, although progress was acknowledged, particularly with the CQC item. A risk of significant weakness had also been noted in terms of the Trust being placed in NOF 5 and Nicola Hallas confirmed that work had been completed around this and issues

were identified within governance, particularly around risk management, the operating model and governance structure as well as general oversight. Evidence of this had been received through The Value Circle external report, the internal audit report and high-level discussions with Trust officers.

Nicola Hallas spoke of another potential recommendation which did not appear within the report as it was still being finalised, as Emma Sayner had mentioned earlier in the meeting, and was in relation to making special, or what could be considered contentious payments. The findings would appear in the auditor's annual report as a recommendation to improve arrangements around these. Makhosi Mazibia ran through the various areas of the report.

Jane Hawkard questioned why some of the balances were hard to reconcile and Nicola Hallas explained that it was simply a procedural issue and there was absolutely no issue with anything, adding that the Trust had a good understanding of all their income streams. Jane Hawkard also referred to triangulation across performance, quality and finance on page 27 in terms of the recommendation for improvement and whether the ARG CiC considered that the management response was sufficient. Murray MacDonald considered it was a fair response but there was clearly still work to be done.

The ARG CiC asked that the External Auditor recommendations were brought back to the next meeting in July 2026 for an update on implementation.

ACTION: Emma Sayner / Nicola Parker

Jane Hawkard requested that the issue around special and possible contentious payments should be a standing agenda item on the Remuneration CiC. Emma Sayner suggested this discussion would then enable a checklist of actions to be completed for the External Auditor to consider within their recommendation. Alan Downey, as Chair of the Remuneration CiC, agreed with this suggestion and confirmed he would take this action.

ACTION: Alan Downey

Brian Clerkin left the meeting at 2.10pm

Jane Hawkard thanked Nicola Hallas and her team for the report and the ARG CiC were pleased to receive the unqualified audit report for HUTH.

7.3 HUTH Draft Annual Auditors Report 2025/26 – *VFM commentary included in item 7.2*

7.4 HUTH Draft Annual Governance Statement 2025/26 – *see joint item 6.6 above*

7.5 HUTH Annual Internal Audit Report & Head of Internal Audit Conclusion 2025/26

Harriet Fisher clarified that it was substantially the same report as received for NLAG, except that there were two additional findings raised in the HUTH Data Security and Protection Toolkit (DSPT) report, which would be detailed later in the meeting and two additional high priority actions outstanding in the HUTH report, otherwise it was unchanged from the submission at the April 2026 meeting. The ARG CiC were assured by the report.

7.6 HUTH Draft Trust Annual Report 2025/26

Rebecca Crashley confirmed that this had been seen by the HUTH External Auditors and Lyn Simpson and was due to be published in line with the NLaG Annual Report timescales, adding that the final formatting would be done before publication. Jane Hawkard advised that she had raised a few additional comments on it the previous day with Rebecca Crashley, but nothing substantial.

Julie Beilby noted a fair amount of inconsistency in the phraseology around where further details could be found and suggested this be standardised in future. Julie Beilby also pointed out the relationship with equality impact assessment and social demographics in relation to digital exclusion and considered that whilst it was good that it was being included in the annual report, it was important to be actively working to improve inequality and the Trust Boards-in-Common should remain sighted on this. Jane Hawkard agreed that some detail around actions to be taken to address this needed to be included.

Jane Hawkard summarised the preceding section namely that the ARG CiC had received the External Audit completion report including details of management actions, and approved the HUTH Annual Report.

Lyn Simpson thanked everyone involved in the production of the reports and apologised for having to leave the meeting early due to other commitments.

Lyn Simpson left the meeting at 2.17pm. The agenda returned to normal running order at item 4.

4. Matters Arising and Review of ARG CiC Action Tracker

4.1 Public Action Tracker

The following items were discussed from the public action tracker:

- November 2025 - item 9.3(a) – action closed.
- January 2026 – item 11.1(b) – the issue was around how to establish effective delivery of actions through good governance. Jane Hawkard shared that she had asked that for each of the CiC's Review of Effectiveness, an additional question was added in terms of whether the CiC was satisfied that through actions at their CiC's, improved delivery was visible. Rebecca Crashley agreed to include this in the CiC's Review of Effectiveness. Action closed.
- April 2026 – item 12.2 – Rebecca Crashley advised that a paper had been presented at the recent Non-Executive Director (NED) meeting and following this, she and Alan Downey would do a further work-through before presenting at the Trust Boards-in-Common for approval. The decision was for the management of Digital risks to reside with the Performance, Estates and Finance (PEF) CiC for the time being. Action closed.
- April 2026 – item 12.5 – Emma Sayner confirmed she had emailed Myles Howles to include this in the overall financial challenges campaign. To remain open.
- April 2026 – item 12.5 – a checklist of actions agreed at the Remuneration Committee to be completed – action closed.

All other actions were either confirmed as on the agenda, closed or due at a later ARG CiC meeting.

4.2 Private Action Tracker

No private action tracker items due at this meeting.

5. Group Internal Audit Progress Report 2025/26 – Final Reports

Harriet Fisher introduced the final version of the Risk Management report and the NLaG and HUTH DSPT reviews. Harriet Fisher also drew attention to the summary of progress against the 2026/27 plan which was now underway with the first scheduled review from the plan, and was also pleased to advise that there were no overdue management actions, with 25 actions being implemented since the April 2026 meeting and acknowledged the strong engagement with the team in getting to this point and hoped that this would continue for the next quarter when a number of actions were due at the end of June 2026.

Jane Hawkard asked Emma Sayner to relay the ARG CiC's thanks to the Group Executive Risk & Assurance Committee (GERAC) for its hard work in enabling such a positive improvement in the position with overdue management actions. Emma Sayner agreed to do this and also acknowledged the significant involvement of Hilda Gwilliams, Group Chief Patient Safety Officer.

DSPT Internal Audit reports – see private minutes.

Louise Kay moved to the Risk Management & Governance report which she advised had been rated as 'partial assurance with improvements required'. This was due to issue within the Group Risk Register (e.g. duplicate risks, missing mitigations and missing oversight committees) which were having an adverse effect on ownership and oversight of risks, unclear processes on identifying risks, along with limited challenge noted within meeting minutes over unchanged or high scoring risks.

Jane Hawkard commented on the extra recommendations over and above those that originated from The Value Circle review and suggested that these were possibly duplications. Emma Sayner responded that Hilda Gwilliams was working to ensure all the findings were streamlined and to understand how they interrelated to each other.

Jane Hawkard also queried the comment around the approval of risks going onto the risk register and referred to the policy stating that Care Groups managed this. Jane Hawkard also noted the comment around updating the Terms of Reference for GERAC and the ARG CiC to clearly state what each Committee's responsibilities were, but she felt this was unnecessary and possibly due to the fact that the same report was received at both meetings to save capacity. Jane Hawkard commented that it was clear that GERAC was focused on delivery and that the ARG CiC was focused on assurance. Harriet Fisher responded that the discussions within both Committees were very similar in terms of risk, which was surprising considering the remit of the Committees individually and Jane Hawkard agreed, explaining that an original report was shared at more than one Committee.

The ARG CiC accepted the progress report, noting that the draft mortuary audit report had been passed to Dr Peter Sedman, Deputy Group Chief Medical Officer, for his oversight and comment on the final version. It was agreed that this paper would be submitted to the July 2026 meeting as part of the 2026/27 reporting period.

The ARG CiC noted the progress on the completion of audit actions and thanked the Executive team for their involvement. It also noted the 'partial assurance with improvements required' rating for the DSPT reports, which was a deterioration from the previous year for NLaG. Issues within Digital governance required resolution and would be added to the action tracker for oversight along with referral to either Trust Board or a specific Committee for focused action.

ACTION: Sally Stevenson

Alastair Pickering and Vicky Sharman joined the meeting at 2.44pm, however the meeting paused for a ten-minute break at 2.44pm.

8. Documents for Review/Approval

8.1 ARG CiC Annual Report to the Trust Boards-in-Common 2025/26

Sally Stevenson introduced the report, which was due to be submitted to Trust Boards-in-Common and the NLaG Council of Governors for information, and detailed the work of the ARG CiC over the last year.

Jane Hawkard reflected that, since originally reviewing the draft report, she now considered the report to be too positive given the position the Group was currently in and suggested an edit to acknowledge that there was still a lot of work to do despite the improvements made so far. The management of the Risk Register and the BAF, along with oversight of the audit management actions, would be the planned focus for the upcoming year.

Julie Beilby concurred and suggested that within section 6 'Management Reports', there be an added reference to The Value Circle work as the report had been received prior to 31 March 2026 and a statement that the ARG CiC were undertaking a thorough review of its reporting arrangements.

The ARG CiC approved the draft report subject to the amendments discussed.

ACTION: Sally Stevenson

Post Meeting Note: Amendments made to the draft report and agreed with the ARG CiC Chair prior to submission to the Trust Boards-in-Common and the NLaG Council of Governors.

9. Governance Items

9.1 Digital Internal Audit Actions Update inc. Digital Resilience Actions

Refer to private minutes for item 9.1 discussion.

Hilda Gwilliams joined the meeting at 2.57pm

Alastair Pickering left the meeting at 3.15pm

9.2 Group Risk Register – Digital Risks

This item was discussed as part of item 9.1 – see private minutes.

9.3 The Value Circle Actions Implementation Plan Update

Jane Hawkard recapped the earlier conversation about the recommendations being no different to other external reports that have been received. Hilda Gwilliams commented that the Group was up to six external reports and the cross-pollination of all that information into the Integrated Improvement Plan (IIP) had been very complex, and that approximately 80 to 90% of them were similar. Hilda Gwilliams considered that the organisation now had a robust implementation plan and the recommendations were moving into the programme delivery phase, with key dates aligned to all the recommendations. It had been incorporated into the IIP which was due to be shared at the July 2026 Board Development day. It was noted that each recommendation now had a Senior Responsible Officer (SRO) with a senior operational lead also aligned. Hilda Gwilliams accepted that whilst some progress had been made, it lacked pace. This was partly due to one person originally having total oversight but also due to lack of capacity and it had recently been confirmed that the organisation had been offered some short-term support in this regard that would focus primarily on corporate governance.

Hilda Gwilliams shared that a new meeting providing oversight and assurance on the IIP would commence in August 2026, chaired by the Group CEO.

Murray MacDonald referred to Appendix A not being included in the papers but in anticipation of this, looked forward to delivery of the plan. *Hilda Gwilliams emailed Appendix A to Sally Stevenson during the meeting, and this was then circulated to the ARG CiC members at this point.*

Julie Beilby reflected that the theme of lacking pace appeared to be common in many areas and questioned what would make a difference to this. Julie Beilby also referred to section 3.2 and the seven Executive-led domains with interims and vacancies currently, but noted that recruitment was underway for certain positions, so did not expect a significant change in pace until a new postholder was settled into their role. However, Hilda Gwilliams responded that the postholders were accountable for the recommendations and had agreed on their responsibilities therefore she did expect that pace would pick up as a result and through Group CEO oversight.

Jane Hawkard asked whether the NPIP assessment had been received and Hilda Gwilliams responded that it had recently been finalised and would be ready for the next ARG CiC meeting in July 2026. Jane Hawkard also asked which of the governance issues required specific focus and whether there was a RAG rating within Appendix A to indicate which were the most important. Hilda Gwilliams replied that she had met with The Value Circle team following the Group Chair's request for them to prioritise the issues at the May 2026 Trust Board meeting and agreement had been reached on the level of support.

10. Private Agenda Items

There were no Private Agenda items to discuss.

11. Any Other Urgent Business

11.1 EQIA – ED Flooring

Jane Hawkard explained that this item had been added to the agenda because the

Equality & Quality Impact Assessment (EQIA) Policy states that any EQIA with a residual risk higher than 16 needs to be escalated to the ARG CiC. Jane Hawkard was concerned that the EQIA had been signed off despite having a residual risk of 20 and being one of the largest areas with performance issues.

Hilda Gwilliams left the meeting at 3.26pm

Vicky Sharman introduced the report, in the absence of Dr Peter Sedman, explaining that it was in relation to the essential flooring replacement work within the Emergency Department (ED) at HRI. Estates colleagues had advised that the flooring was deteriorating quickly due to subsidence, and without repair was a risk to patient and staff safety and Infection Prevention and Control (IPC) issues. The work required the temporary relocation of ED majors and a reduction in capacity for around six weeks, which had been extended to eight weeks by the Estates team. The proposal had been presented at various forums, including Care Group governance of ED processes, reviewed by the Executive EQIA review panel, approved through SLT and Executive team processes as well as at IQIG with ICB representation. The proposal had been approved, and it was recognised would cause more of an impact on patients if it was agreed at short notice later in the year approaching the winter period. The report was being presented to provide assurance on the management of risk, with work continuing to strengthen this with the involvement of Care Groups around their use of ED and their discharge processes. In addition, by moving it into a formal incident management structure, this would provide Executive-led operational oversight. The ICB were looking to receive support from the community in terms of social care, mental health services and so on in terms of patient flow.

Murray MacDonald questioned whether the paper had been presented at the Quality & Safety (QSC) CiC and Vicky Sharman replied that it had not so far, due to the speed of aligning various elements e.g. the timing of the work, the need for a specific piece of machinery (to dig up the concrete) with a certain window of opportunity and the involvement of the ICB. Murray MacDonald suggested that this be referred to either the QSC CiC or PEF CiC with a request for them to assure themselves that the operational response be implemented correctly.

Julie Beilby considered that this was a very high risk to the organisation currently which would move during the work to a different area but then reduce once the work was completed. Julie Beilby asked about the demand on services during the summer months, particularly on the South bank, and asked whether this was the case on the North bank and whether there was a timing issue around demand. Vicky Sharman responded that the demand was largely continuous, whether it be the summer or winter period.

The ARG CiC received the paper but requested that it be presented to the next QSC CiC meeting on 25 June 2026 and remained concerned that the process of identifying mitigations had not reduced the risk score and therefore accepted Vickys continued work with the service to identify and action further mitigations to further reduce the risk score.

ACTION: Vicky Sharman

*Vicky Sharman left the meeting at 3.*39pm.

12. 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:

- Receipt and approval of various year end reports from External and Internal Audit including unqualified audit opinions on the Trust financial statements
- Receipt of both Trusts Annual Reports and AGS's
- Digital governance agenda items
- EQIA – ED Flooring

13. Matters to Highlight to other Trust Board CiC

- Item 11.1 to be referred to the Quality & Safety CiC
- Special and possibly contentious payments to be referred to the Remuneration CiC as a standing agenda item for consideration

14. DATE AND TIME OF THE NEXT MEETING

The next full meeting of the Audit, Risk and Governance Committees-in-Common will be held on Thursday 30 July 2026 at 9.00am to 12.30pm via MS Teams.

On behalf of the ARG CiC, Jane Hawkard thanked everyone involved for their huge efforts in the preparation of the year end papers.

The ARG CiC Chair closed the meeting at 3.42pm.

Schedule of Attendance at ARG CiC Meetings 2026/27

Member / Attendee	Apr-26	Jun26 Audited Accounts	Jul-26	Nov26	Jan-27	Total
Members - HUTH:						
Jane Hawkard – NED - ARG Chair	Y	Y				1/5
Members - HUTH:						
Julie Beilby – NED	Y	Y				1/5
Regular Attendees:						
Emma Sayner – Group CFO	Y	Y				1/5
David Sharif – Group Director of Assurance	Y	N[3]				1/5
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	Y	Y				1/5
Daryl Cheetham – Local Counter Fraud Specialist	Y[1]					1/1
External Audit - NLAG (Sumer NI)	Y	Y				1/5
External Audit – HUTH (Forvis Mazars)	Y	Y				1/5
Internal Audit – Group (KPMG)	Y	Y				1/5
Sue Meakin - Group DPO / IG Lead	N	N				0/5
Mike Bateson - NLAG Governor Observer	N[2]	Y				1/5
Ad-hoc Attendees:						
HUTH Vice Chair (Murray MacDonald)	Y	Y				1
Asst. DoF – Planning & Control (Nicola Parker)	Y	Y				1
Group Chair (Alan Downey)		Y				
Group CEO (Lyn Simpson)		Y[1]				
Interim Group Chief Digital Officer (Alastair Pickering)		Y[1]				
Group Chief Patient Safety Officer (Hilda Gwilliams)		Y[1]				
Nurse Director, HUTH (Vicky Sharman)		Y[1]				

Notes:
[1] Part meeting
[2] Ian Reekie attended instead
[3] Rebecca Crashley in attendance

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)212

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	10 September 2026
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Chris Fry, Group Director of Performance
Title of Report	**Group Performance Report – NLAG/HUTH**
Executive Summary	Group Performance Report for information
Background Information and/or Supporting Document(s) (if applicable)	Presented to the September Performance, Estates and Finance CiC on 1 September 2026, Workforce, Education & Culture CiC July 2026 and Quality& Safety CiC July 2026
Prior Approval Process	As per above
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓Information ☐ Assurance ☐ Other – please detail below:

V2

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committees-in-Common Front Sheet

Agenda Item No: 4.6

Name of Meeting	Performance Estates and Finance Committees-in-Common
Date of the Meeting	1st September 2026
Director Lead	Sam Peate – Group Chief Delivery Officer
Contact Officer / Author	Chris Fry, Associate Director, Performance & Insights
Title of Report	Group Performance Report
Executive Summary	The purpose of this report is to provide visibility of delivery against key performance trajectories and associated enabler metrics **Alert** against Elective Care standards and UEC performance **Assure** actions are being monitored and assessed against delivery trajectories **Advise** where mitigations need Executive support **Recommendation/s** Please note that Quality and Workforce Sections are under development with respective leads and are provided in this version purely to demonstrate progress.
Background Information and/or Supporting Document(s) (if applicable)	Provided in the appendices
Prior Approval Process	N/A
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	☐ Approval by CiC ☐ Information

action(s) required	☐ Endorse for approval by Trust Board(s) ✓ Assurance ☐ Other – please detail below:

BAF to which the paper relates:	**Tick all those appropriate**
Our Patients - Access	✓
Our Patients - Safety	✓
Our People	✓
Our Partnerships	✓
Our Pioneers	✓
Our Public Purse	✓

NHS
Humber Health
Partnership

Integrated Performance Report

Reporting Month:
July 2026

United by Compassion:
Driving for Excellence

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

disability confident EMPLOYER

VETERAN AWARE

CiC Oversight Dashboard

Operational Performance

Metric	Period	Actual	Plan	V	A	Status
A&E - 4 Hour Standard (All - Footprint)	Jul-26	71.4%	≥ 74.2%			Alert
A&E - 4 Hour Standard (All)	Jul-26	66.0%	≥ 68.8%			Alert
A&E - Patients Waiting > 12 hours in Department	Jul-26	11.6%	≤ 13.0%			Assure
Cancer - 28 Day Faster Diagnosis Standard	Jun-26	66.1%	≥ 69.0%			Alert
Cancer - 62 Day All Referral Sources	Jun-26	57.4%	≥ 55.0%			Assure
Diagnostics - 6 Week Standard	Jul-26	35.2%	≤ 30.5%			Alert
RTT - Incomplete 18 Week Standard	Jul-26	57.3%	≥ 56.8%			Assure
RTT - Percentage of 52+ Week Waits	Jul-26	3.7%	≤ 3.4%			Alert

Quality of Care

Metric	Period	Actual	Plan	V	A	Status
CQC Inpatient Survey Satisfaction Mean Score	Jul-26	8.2				
CQC Safe Inspection Score	Jul-26	1.5				
Falls - Serious harm or death	Jul-26	5				
Infections - C.Difficile (Cumulative)	Jun-26	46				
Infections - E.Coli (Cumulative)	Jun-26	120				
Infections - Klebsiella (Cumulative)	Jun-26	37				Assure
Mortality - SHMI	Mar-26	1.0				Advise
Patient Safety Incidents - Moderate harm	Jul-26	97				
Patient Safety Incidents - Severe harm	Jul-26	9				
Pressure Ulcers - Category 3	Jul-26	19				
Pressure Ulcers - Category 4	Jul-26	1				

People (Group)

Metric	Period	Latest	Previous	Change
Staff Appraisal Rate (AfC)	Jun-26	81.8%	80.7%	0
Staff e-Job Planning	Jul-26	94.3%		1
Staff Mandatory Training - Core	Jun-26	87.1%	86.6%	0
Staff Mandatory Training - Role Specific	Jun-26	82.9%	81.7%	0
Staff Sickness Absence Rate	Jun-26	4.8%	4.8%	0
Staff Turnover Annual FTE Rate	Jun-26	12.0%	6.8%	0

Finance and Productivity (Group)

Metric	Period	Latest	Previous	Change
Finance - CIP YTD against Plan	Jun-26	65.3%	62.5%	0
Finance - Planned Surplus/Deficit	Jun-26	(63,065)	(63,065)	0
Finance - Variance YTD to Financial Plan	Jun-26	(10,207)	(5,972)	-4235

Monthly Trend Key

- Improvement on previous reported month
- Deterioration on previous reported month
- No change on previous reported month

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1. Overview

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

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

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

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

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

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

2. Regulation and Compliance

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

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

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

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

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

3. HHP Key Metric Oversight Scorecard

Oversight Group	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Access to Services	Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	55.5%	56.2%	62.2%	70.8%	65.8%	64.1%	55.9%	72.9%	73.0%	68.4%	66.2%	66.1%	
		Cancer - 62 Day All Referral Sources	≥ 80.0%	56.1%	55.9%	52.9%	59.7%	61.0%	57.4%	55.4%	55.3%	61.3%	56.9%	53.6%	57.4%	
	Elective Care	RTT - Incomplete 18 Week Standard	≥ 92.0%	58.5%	57.5%	57.6%	57.6%	57.1%	56.8%	56.0%	56.2%	58.0%	58.0%	58.8%	58.4%	
		RTT - Percentage of 52+ Week Waits	≤ 1.0%	3.2%	3.6%	3.5%	3.5%	3.6%	3.3%	3.4%	3.3%	3.0%	3.1%	3.3%	3.5%	
	Urgent & Emergency Care	A&E - 4 Hour Standard (All - Footprint)		72.5%	73.8%	70.9%	69.9%	68.7%	69.3%	69.6%	72.4%	73.8%	73.7%	70.8%	69.6%	71.4%
		A&E - 4 Hour Standard (All)	≥ 82.0%	67.1%	68.5%	65.0%	63.4%	62.5%	62.9%	62.0%	66.3%	68.1%	67.8%	65.0%	64.2%	66.0%
		A&E - Patients Waiting > 12 hours in Department	≤ 0.0%	13.0%	12.1%	15.3%	17.1%	15.9%	16.0%	20.2%	14.7%	11.7%	11.4%	12.8%	12.9%	11.6%
Effectiveness & Experience	Effectiveness	Inpatient - Days between DRD and Discharge Date		4.4	4.6	4.5	4.1	4.5	4.6	4.3	5.5	5.1	5.2	4.8	5.2	5.4
		Mortality - SHMI	≤ 1.0	1.029	1.025	1.023	1.015	1.015	1.015	1.005	1.012	1.024				
	Experience	CQC Inpatient Survey Satisfaction Mean Score		8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2
Finance & Productivity	Financial Balance	Finance - CIP YTD against Plan		83.0%	85.1%	85.3%	81.5%	77.6%	75.8%	74.9%	71.3%	72.9%	60.8%	62.5%	65.3%	
		Finance - Variance YTD to Financial Plan		(3,030)	(3,035)	(3,276)	(4,779)	(7,922)	(18,306)	(29,300)	(36,357)	(36,521)	(2,244)	(5,972)	(10,207)	
Patient Safety	Patient Safety	CQC Safe Inspection Score		1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
		Infections - C.Difficile (per 1,000 bed days)		0.23	0.20	0.21	0.20	0.18	0.28	0.36	0.25	0.29	0.39	0.25	0.25	
		Infections - E.Coli (per 1,000 bed days)		0.85	0.80	0.91	0.83	0.62	0.58	0.49	0.87	0.50	0.86	0.82	0.66	
		Infections - MRSA (per 1,000 bed days)		0.00	0.02	0.00	0.02	0.00	0.04	0.02	0.02	0.05	0.02	0.06	0.02	
		Staff Survey - Raising Concerns sub-score		6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1
People & Workforce	People & Workforce	Staff Sickness Absence Rate	≤ 4.0%	4.7%	4.7%	4.7%	4.8%	4.8%	4.8%	4.7%	4.8%	4.8%	4.8%	4.8%	4.8%	
		Staff Turnover Annual FTE Rate	≤ 8.0%	7.7%	7.9%	7.2%	7.4%	7.2%	7.0%	6.7%	6.9%	6.9%	6.4%	6.8%	12.0%	
Reducing Inequalities	Primary Prevention	Diagnostics - 6 Week Standard	≤ 1.0%	31.4%	36.2%	33.4%	35.3%	38.5%	43.7%	44.9%	36.6%	31.8%	35.9%	36.8%	35.2%	35.2%

4. HHP Group Executive Summary – Performance

Executive Lead: Sam Peate, Group Chief Delivery Officer

Accountable to: Performance, Estate and Finance Committee

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
A&E - 4 Hour Standard (All - Footprint)	Jul-26	≥ 72.6%	70.6%		
A&E - 4 Hour Standard (All)	Jul-26	≥ 62.6%	62.2%		
A&E - 4 Hour Standard (Type 1)	Jul-26	≥ 48.0%	49.8%		
A&E - 4 Hour Standard (Type 3)	Jul-26	≥ 95.0%	93.0%		
A&E - Ambulance Handovers within 45 minutes	Jul-26	≥ 96.3%	98.3%		
A&E - DTA to Admission > 12 hours	Jul-26	≤ 0.0%	5.5%		
A&E - Patients Waiting > 12 hours in Department	Jul-26	≤ 12.3%	5.6%		
Cancer - 28 Day Faster Diagnosis Standard	Jun-26	≥ 69.0%	67.3%		
Cancer - 31 Day All Stages	Jun-26	≥ 75.0%	77.2%		
Cancer - 62 Day All Referral Sources	Jun-26	≥ 53.0%	54.4%		
Diagnostics - 6 Week Standard	Jul-26	≤ 31.3%	36.6%		
Diagnostics - Total Activity Levels	Jul-26	≥ 21,850	21,652		
Inpatient - Cancelled Operations 28 Day perfomance	25/26 Q4	≤ 5.0%	39.1%		
Inpatient - Days between DRD and Discharge Date	Jul-26	≤ 3.8	5.3		
Outpatient - Total Overdue Backlog (3 months+)	Jul-26		47,753		
RTT - 52+ Week Waits	Jul-26	≤ 3,308	3,331		
RTT - 65+ Week Waits	Jul-26	≤ 0	277		
RTT - Incomplete 18 Week Standard	Jul-26	≥ 56.0%	56.0%		
RTT - Total Incomplete Pathways	Jul-26	≤ 83,196	85,756		
Theatres - Capped Theatre Utilisation	Jul-26	≥ 85.0%	82.0%		

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
A&E - 4 Hour Standard (All - Footprint)	Jul-26	≥ 75.9%	72.2%		
A&E - 4 Hour Standard (All)	Jul-26	≥ 74.0%	69.0%		
A&E - 4 Hour Standard (Type 1)	Jul-26	≥ 53.0%	50.3%		
A&E - 4 Hour Standard (Type 3)	Jul-26	≥ 99.0%	98.6%		
A&E - Ambulance Handovers within 45 minutes	Jul-26	≥ 88.5%	73.6%		
A&E - DTA to Admission > 12 hours	Jul-26	≤ 0.0%	50.3%		
A&E - Patients Waiting > 12 hours in Department	Jul-26	≤ 13.7%	17.3%		
Cancer - 28 Day Faster Diagnosis Standard	Jun-26	≥ 69.0%	64.0%		
Cancer - 31 Day All Stages	Jun-26	≥ 94.9%	94.1%		
Cancer - 62 Day All Referral Sources	Jun-26	≥ 60.3%	64.1%		
Diagnostics - 6 Week Standard	Jul-26	≤ 29.7%	33.5%		
Diagnostics - Total Activity Levels	Jul-26	≥ 28,830	18,971		
Inpatient - Cancelled Operations 28 Day perfomance	25/26 Q4	≤ 5.0%	16.7%		
Inpatient - Days between DRD and Discharge Date	Jul-26	≤ 4.4	5.6		
Outpatient - Total Overdue Backlog (3 months+)	Jul-26		35,902		
RTT - 52+ Week Waits	Jul-26	≤ 887	1,412		
RTT - 65+ Week Waits	Jul-26	≤ 0	98		
RTT - Incomplete 18 Week Standard	Jul-26	≥ 58.6%	59.8%		
RTT - Total Incomplete Pathways	Jul-26	≤ 40,093	42,605		
Theatres - Capped Theatre Utilisation	Jul-26	≥ 85.0%	81.5%		

Chief Delivery Officer Update – Performance Overview (July 2026)

Planned Care performance in July presents a deteriorating risk position despite some areas moving in the intended direction. RTT incomplete performance fell at both Trusts, long waits increased materially, cancer standards deteriorated across the principal measures and diagnostics remain significantly off the national standard and continue to be constrained by Outpatient capacity.

Cancer performance was mixed in June. HUTH improved against the 62-day and 31-day standards, while Faster Diagnosis deteriorated to 67.3%; but improved to 64% at NLAG, with the latest available position remaining below standard. Continued reliance remains on tumour pathway grip, protected diagnostics, pathology, MDT and treatment capacity.

Diagnostics remain a major constraint to elective and cancer recovery. Six-week performance improved at both Trusts, but total waits increased and performance remains materially above the 1% standard, requiring modality- and site-level recovery trajectories for MRI, CT, NOUS and endoscopy, alongside system agreement on capacity, workforce, reporting turnaround and seven-day CDC utilisation.

RTT recovery is fragile. Incomplete performance fell to 56% at HUTH and 59.8% at NLAG, while 65-week waits increased to 277 and 98 respectively and 52-week waits increased to 3,331 and 1,412. Weekly specialty trajectories dated patient-level plans and escalation of outpatient, diagnostic, theatre, workforce and mutual-aid gaps are required to prevent further replenishment of the long-wait cohorts.

Outpatient access and productivity remain key enablers. Time to First Appointment deteriorated at both Trusts, theatre utilisation remains below the 85% benchmark, NLAG follow-up backlog increased and cancelled operations not rebooked within 28 days worsened. Executive focus should remain on specialty-level ownership, booking and SPOA controls, use of PIFU and discharge, theatre session fill and daily cancellation PTL management.

Unplanned Care performance in July remained below plan across both Trusts, with all-type four-hour performance at 62.2% for HUTH against a 62.6% plan and 69.0% for NLAG against a 74.0% plan. The overall position reflects sustained Type 1 demand, adverse pathway mix and continuing downstream flow constraints, with NLAG presenting the greater immediate risk.

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

HUTH maintained Type 1 performance on plan and ambulance handovers remained assured; however, Type 3 performance and whole-pathway flow remain the key gaps. Although mean time to treatment and non-admitted time improved from June, both remain above target and require sustained focus on UTC access, streaming, rapid assessment and alternatives to ED.

NLAG saw Type 1 performance below plan, handovers deteriorate and decision-to-admit waits remain a material risk. Although mean time to treatment improved and non-admitted time remained relatively stable, the combination of handover, admission and front-door delay requires immediate recovery oversight.

Demand mix remains adverse: Type 1 attendances stayed above trajectory while Type 3 attendances remained below plan at both Trusts, increasing pressure on emergency departments and reducing the expected benefit of UTC and redirection pathways.

a. Hull University Teaching Hospitals Performance AAA Summary

Count: 13

Alert

A&E - 4 Hour Standard (All - Footprint)
A&E - 4 Hour Standard (All)
A&E - 4 Hour Standard (Type 3 - Footprint)
A&E - 4 Hour Standard (Type 3)
A&E - DTA to Admission > 12 hours
Cancer - 28 Day Faster Diagnosis Standard
Diagnostics - 6 Week Standard
Diagnostics - Total Activity Levels
Inpatient - Cancelled Operations 28 Day perfomance
Inpatient - Days between DRD and Discharge Date
Outpatient - Total Overdue Backlog (3 months+)
RTT - 65+ Week Waits
RTT - Total Incomplete Pathways

Count: 1

Advise

Theatres - Capped Theatre Utilisation

Count: 7

Assure

A&E - 4 Hour Standard (Type 1)
A&E - Ambulance Handovers within 45 minutes
A&E - Patients Waiting > 12 hours in Department
Cancer - 31 Day All Stages
Cancer - 62 Day All Referral Sources
RTT - 52+ Week Waits
RTT - Incomplete 18 Week Standard

b. Northern Lincolnshire and Goole Hospitals Performance AAA Summary

Count: 16

Alert

A&E - 4 Hour Standard (All - Footprint)
A&E - 4 Hour Standard (All)
A&E - 4 Hour Standard (Type 1)
A&E - 4 Hour Standard (Type 3)
A&E - Ambulance Handovers within 45 minutes
A&E - DTA to Admission > 12 hours
A&E - Patients Waiting > 12 hours in Department
Cancer - 28 Day Faster Diagnosis Standard
Cancer - 31 Day All Stages
Diagnostics - 6 Week Standard
Diagnostics - Total Activity Levels
Inpatient - Cancelled Operations (%)
Inpatient - Days between DRD and Discharge Date
RTT - 52+ Week Waits
RTT - 65+ Week Waits
RTT - Total Incomplete Pathways

Count: 1

Advise

Theatres - Capped Theatre Utilisation

Count: 3

Assure

A&E - 4 Hour Standard (Type 3 - Footprint)
Cancer - 62 Day All Referral Sources
RTT - Incomplete 18 Week Standard

c. Unplanned Care

Four-hour performance was below June plan at HUTH (58.6% against 62.1%) and NLAG (68.7% against 73.8%).

Demand mix remains adverse. HUTH Type 1 was on plan (46.9% against 47.0%); NLAG was below plan (50.3% against 52.0%). Type 3 was below plan at HUTH (87.9% against 95.0%) and NLAG (97.8% against 99.0%).

Admission delay is the principal risk: decision-to-admit waits over 12 hours were 15.7% at HUTH and 41.0% at NLAG. Ambulance handovers were strong at HUTH (98.3%) but below plan at NLAG (80.3%).

Progress

- HUTH Type 1 was on plan; handovers were strong and over-12-hour stays remained within threshold (10.2%).
- NLAG Type 1 improved, but overall performance, handovers and DTA waits remained off plan; over-12-hour stays were within threshold (15.6%).
- Mean time to treatment increased at both Trusts and non-admitted time remained above target.
- HRI frailty, streaming, SDEC and UTC work progressed alongside SHOP and stronger board and ward rounds.
- Golden Patient, EDD, criteria-led discharge and Home First remain the key actions for earlier flow.
- MADE, South Bank escalation and system reviews continued to support flow.

Action

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

Monitor delivery daily against Trust recovery milestones and escalate variance.

- The South bank are taking a flow out model to SLT in 3 weeks for agreement by all CoS and Exec – this was implemented in the North some time ago and is working well, this would improve Ambulance handovers, 4 and 12 hour performance within ED and give better patient experience, there may be a deterioration of TES spaces initially until the discharge AM profile improves accordingly.
- Continue work on Criteria to admit and ensure embedding once working well.
- Commencement of LoS rounds with GIRFT SGH 7th September, DPOW 14th September and HUTH 27th September, 3 wards each site and commencing with >21 days and working down to 7 days.
- Embed seven-day senior decision-making and criteria-led admission and discharge.
- Reduce long stays through weekly review of patients exceeding 21 days and escalate NCTR barriers.
- Actions to inform Winter Planning which is due for Board approval in September

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Effective	Urgent & Emergency Care	A&E - 4 Hour Standard (All - Footprint)		68.8%	71.6%	68.5%	67.3%	67.4%	69.5%	69.8%	70.4%	73.2%	74.6%	70.0%	67.5%	70.6%
		A&E - 4 Hour Standard (Type 1 - Admitted)		24.5%	25.8%	21.5%	21.4%	24.9%	26.3%	23.4%	24.2%	26.5%	31.0%	26.0%	26.2%	31.2%
		A&E - 4 Hour Standard (Type 1 - NonAdmitted)		52.5%	55.5%	51.0%	49.5%	50.5%	56.7%	50.9%	56.4%	61.5%	64.4%	56.7%	55.2%	57.5%
		A&E - 4 Hour Standard (Type 1)		44.1%	46.3%	42.1%	40.9%	42.6%	47.1%	42.6%	46.3%	50.7%	54.1%	47.7%	46.9%	49.8%
		A&E - Ambulance Average Handover Time		22.8	20.8	23.1	23.8	23.9	23.8	26.6	20.4	19.2	18.6	19.5	20.1	19.1
		A&E - Ambulance Handovers within 45 minutes		95.4%	96.8%	95.3%	94.6%	92.8%	93.2%	91.1%	90.4%	98.2%	96.3%	97.8%	98.3%	98.3%
		A&E - Assessed within 60 minutes		90.2%	91.4%	84.6%	80.4%	84.3%	88.0%	87.0%	92.5%	94.1%	93.3%	91.6%	92.1%	92.1%
		A&E - Corridor Care in Dept		37	34	48	41	30	33	44	26	22	17	23	29	12
		A&E - DTA to Admission > 12 hours	≤ 0.0%	12.6%	10.5%	19.8%	21.5%	16.3%	19.7%	28.0%	14.7%	11.7%	9.2%	15.0%	14.7%	5.5%
		A&E - DTA to Admission > 24 hours	≤ 0.0%	1.6%	1.4%	3.1%	5.2%	3.4%	4.8%	10.4%	1.0%	0.6%	0.8%	0.3%	0.8%	0.0%
		A&E - Patients Waiting > 12 hours in Department	≤ 0.0%	12.3%	10.1%	15.0%	17.4%	14.2%	14.0%	18.3%	11.8%	9.0%	6.9%	10.5%	10.2%	5.6%
		A&E - Specialty Referral to Departure within 30 minutes		11.7%	11.8%	10.8%	11.0%	11.0%	11.6%	11.1%	13.3%	13.1%	12.0%	10.6%	12.3%	12.4%
		A&E - Time to Initial Assessment	≤ 15	22	20	30	34	29	24	25	19	17	18	20	21	20
		A&E - Total Time in A&E (Admitted)	≤ 180	576	532	668	733	622	638	801	579	509	465	545	543	415
	Effectiveness	Inpatient - Corridor Care on Wards		56.2	51.8	65.2	60.7	57.4	64.9	70.9	68.8	49.3	40.0	46.7	45.9	41.1
		Inpatient - Discharge Lounge Utilisation		13.9%	13.5%	14.3%	12.2%	11.6%	7.3%	11.2%	14.9%	15.5%	14.7%	14.5%	15.0%	16.3%
		Inpatient - Discharge to Assess (D2A) over 14 days		1.5%	2.7%	2.6%	1.7%	1.7%	2.3%	2.4%	3.2%	2.9%	3.0%	2.9%	2.4%	3.1%
		Inpatient - Discharges by 5pm		64.2%	61.7%	63.8%	62.2%	63.9%	65.2%	61.0%	64.7%	64.7%	62.2%	61.6%	63.4%	64.0%
		Inpatient - Long Stay Occupancy (21+ days)		186.5	196.8	211.8	190.7	183.3	183.3	210.5	208.3	199.2	203.8	192.3	194.6	178.3

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

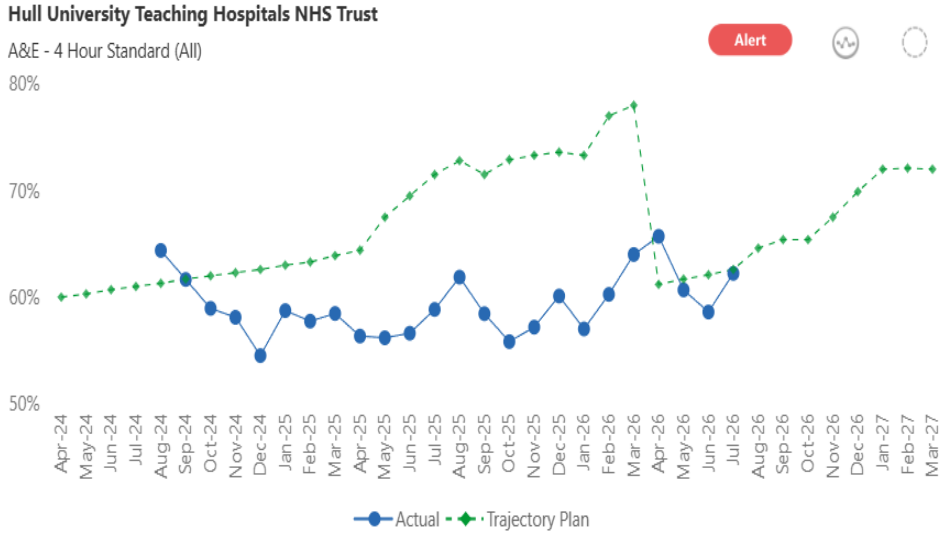
Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Effective	Urgent & Emergency Care	A&E - 4 Hour Standard (All - Footprint)		76.6%	76.1%	73.4%	72.7%	70.1%	68.9%	69.4%	74.6%	74.4%	72.8%	71.7%	71.7%	72.2%
		A&E - 4 Hour Standard (Type 1 - Admitted)		14.4%	17.9%	10.1%	11.1%	9.6%	11.2%	7.7%	8.8%	10.8%	8.3%	10.3%	8.7%	8.3%
		A&E - 4 Hour Standard (Type 1 - NonAdmitted)		64.3%	64.5%	57.9%	57.1%	51.9%	50.8%	50.5%	64.0%	64.7%	60.2%	58.3%	58.9%	58.3%
		A&E - 4 Hour Standard (Type 1)		54.5%	55.4%	48.9%	48.0%	43.7%	42.3%	41.8%	54.5%	54.9%	51.2%	49.9%	50.6%	50.3%
		A&E - Ambulance Average Handover Time		30.0	31.0	29.0	26.0	37.0	51.0	61.0	45.0	32.0	36.0	31.0	32.0	38.0
		A&E - Ambulance Handovers within 45 minutes		83.6%	82.4%	83.3%	86.5%	75.6%	65.6%	57.0%	71.5%	81.7%	77.2%	82.5%	80.3%	73.6%
		A&E - Assessed within 60 minutes		72.9%	77.8%	76.2%	73.7%	69.3%	66.8%	68.4%	79.0%	79.1%	80.9%	80.4%	78.2%	76.7%
		A&E - Corridor Care in Dept		7	7	9	9	10	11	10	11	9	11	10	11	8
		A&E - DTA to Admission > 12 hours	≤ 0.0%	27.0%	27.4%	33.0%	33.3%	38.0%	37.8%	52.5%	48.9%	32.9%	39.2%	38.5%	41.0%	50.3%
		A&E - DTA to Admission > 24 hours	≤ 0.0%	5.1%	7.5%	7.6%	7.9%	11.0%	11.6%	16.9%	14.7%	6.5%	9.7%	8.1%	10.3%	10.5%
		A&E - Patients Waiting > 12 hours in Department	≤ 0.0%	13.7%	14.2%	15.7%	16.8%	17.6%	18.1%	22.2%	17.5%	14.1%	15.8%	15.0%	15.6%	17.3%
		A&E - Specialty Referral to Departure within 30 minutes		5.6%	6.0%	5.2%	5.0%	4.1%	4.2%	4.5%	4.2%	5.0%	4.0%	3.7%	4.1%	5.0%
		A&E - Time to Initial Assessment	≤ 15	47	43	46	48	53	56	52	43	42	41	41	43	45
		A&E - Total Time in A&E (Admitted)	≤ 180	603	581	670	667	687	667	776	730	667	701	697	710	767
	Effectiveness	Inpatient - Corridor Care on Wards		2.0	2.1	2.9	2.5	1.8	3.8	3.8	3.8	4.0	7.0	3.4	3.7	1.9
		Inpatient - Discharge Lounge Utilisation		19.6%	19.8%	17.1%	20.9%	16.4%	17.7%	19.5%	19.4%	20.0%	21.2%	19.2%	18.0%	16.0%
		Inpatient - Discharge to Assess (D2A) over 14 days		1.3%	2.3%	1.9%	2.4%	2.4%	3.2%	3.2%	5.0%	4.0%	1.6%	4.5%	3.2%	0.6%
		Inpatient - Discharges by 5pm		74.8%	74.1%	74.7%	72.5%	75.5%	73.6%	71.3%	72.0%	73.1%	71.4%	71.8%	73.7%	71.2%
		Inpatient - Long Stay Occupancy (21+ days)		71.5	76.7	77.0	78.6	83.1	84.9	85.5	97.3	87.0	81.8	84.8	88.1	87.8

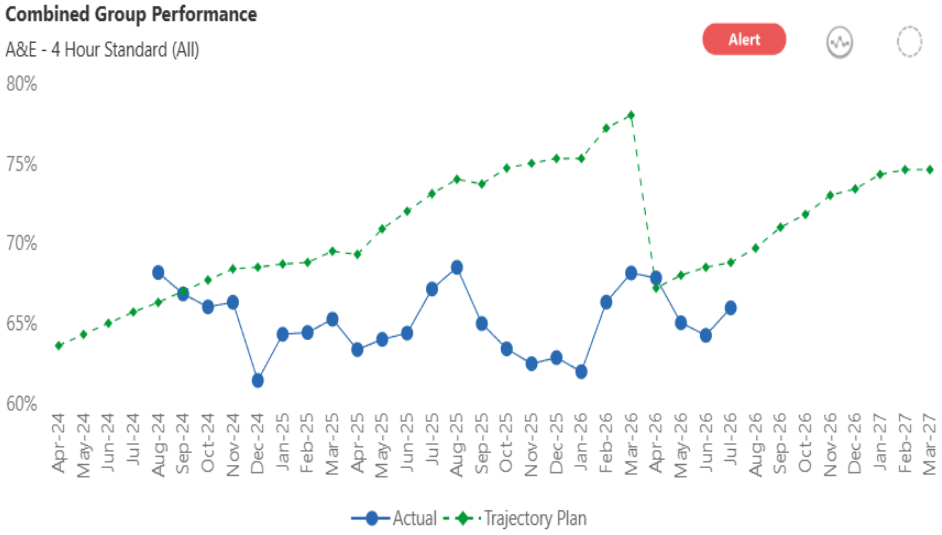
i. Emergency Care Standards – 4-hour Performance

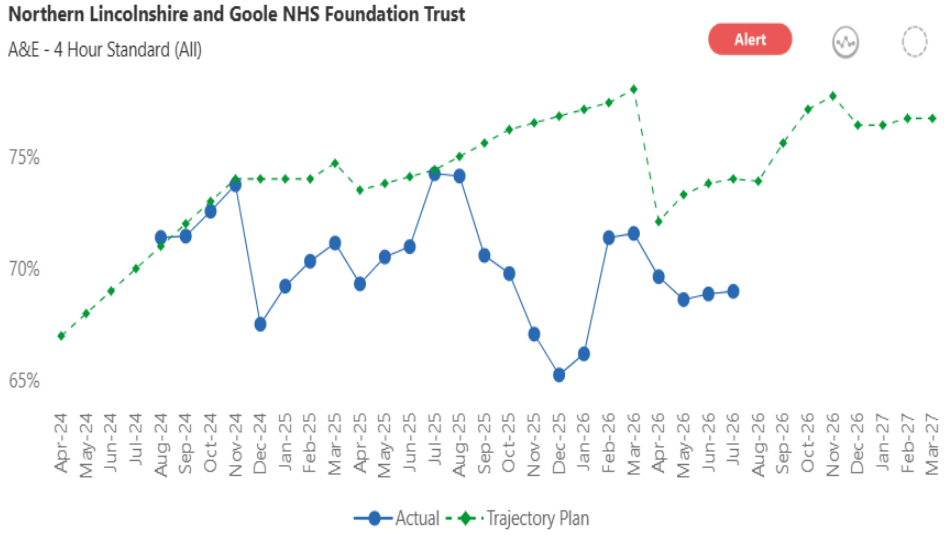
A&E - 4 Hour Standard (All)

Progress:
- All-type performance was below July plan at HUTH (62.2% vs 62.6%) and NLAG (69.0% vs 74.0%).
- HUTH Type 1 was on plan and handovers were assured; despite improvement, Type 3 and whole-pathway flow remain the gaps.
- NLAG Type 1 slipped by 0.3%, with handovers and decision-to-admit waits deteriorated.
- Frailty, UTC, streaming, MADE and NCTR work progressed during July.

Action:
- Recover HUTH UTC and Type 3 performance with CHCP; strengthen frailty, streaming and SDEC.
- Maintain flow through the HRI ED Majors decant and flooring works.
- Deliver South Bank actions to recover NLAG handovers and DTA performance.
- Escalate demand, NCTR and discharge constraints with partners; track named milestones daily. : FSDEC continues on the ward but working through plans for implementation at the front door.







ii. Enabler Metric 1: Mean Time to Treatment

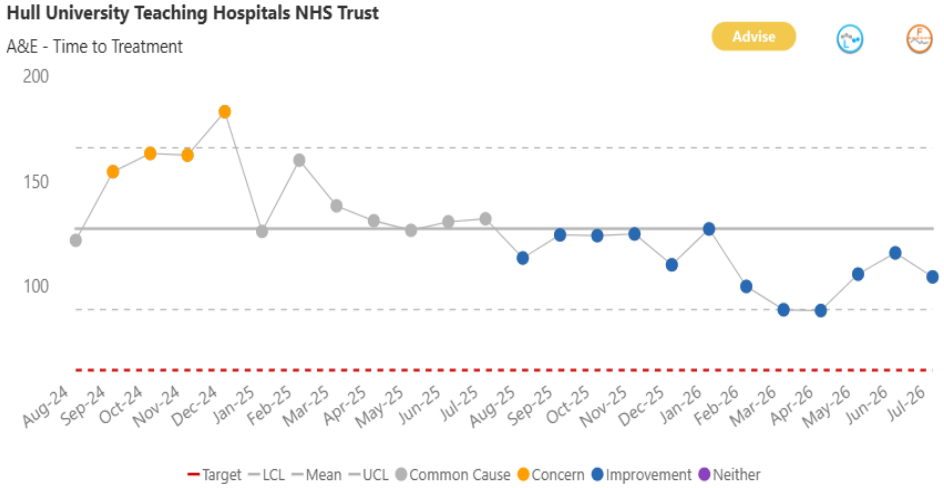
A&E - Time to Treatment

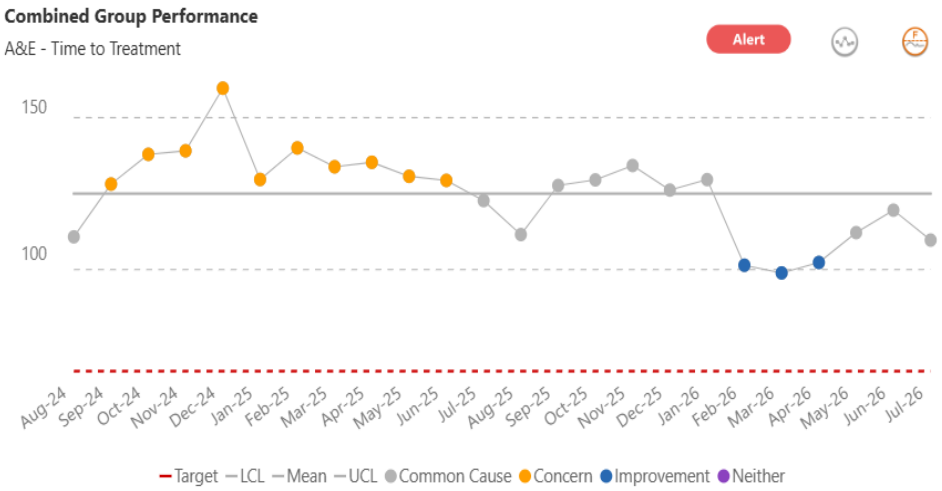
HUTH:

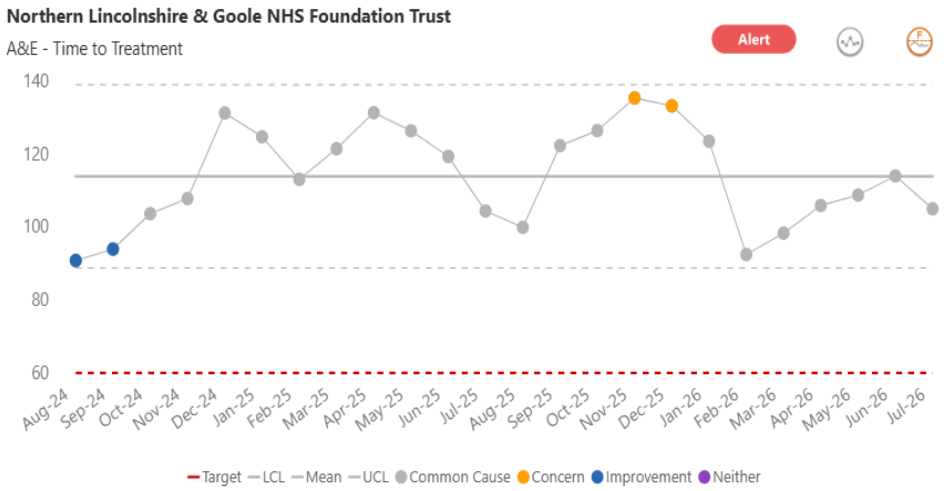
Mean time to treatment decreased in July following deterioration in May and June but remains above 100minutes. It remains below the historical mean but above the operational target, so early clinical assessment, streaming and rapid decision-making must be sustained during peak demand.

NLAG:

Mean time to treatment also improved in July but remains materially above target. This continues to reflect Type 1 demand and flow constraints; recovery requires rapid assessment, effective streaming, escalation of delays and senior clinical decision-making at the front door.







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

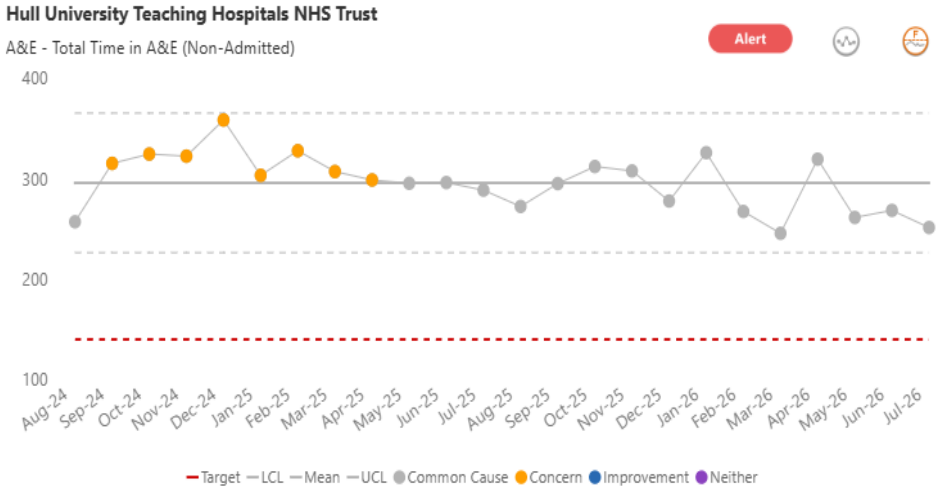
A&E - Total Time in A&E (Non-Admitted)

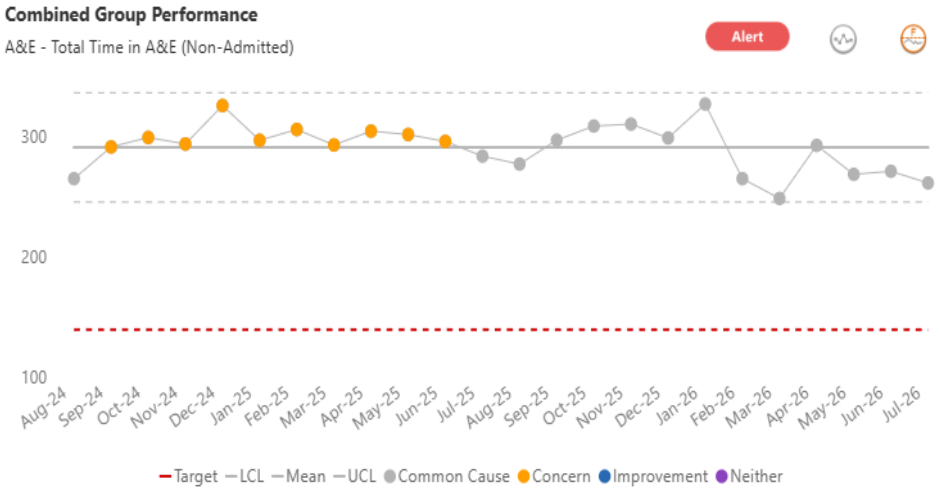
HUTH:

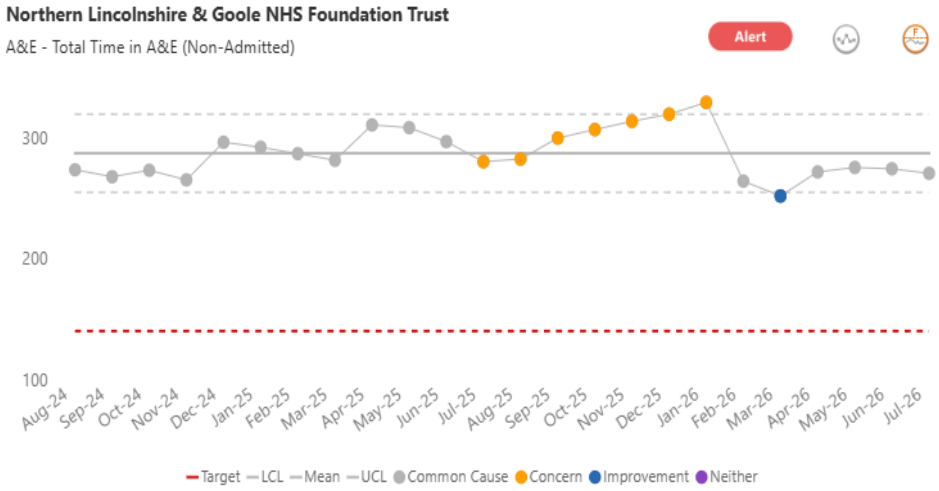
Non-admitted time reduced slightly in July following deterioration in June but remains substantially above target. The response is to strengthen early streaming, rapid assessment and discharge from ED pathways, with daily review of avoidable waits for patients who do not require admission.

NLAG:

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







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

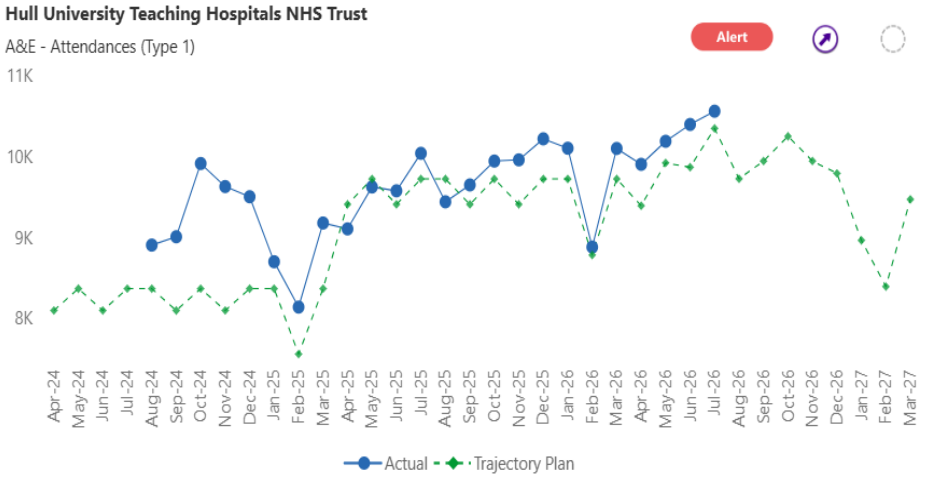
A&E - Attendances (Type 1)

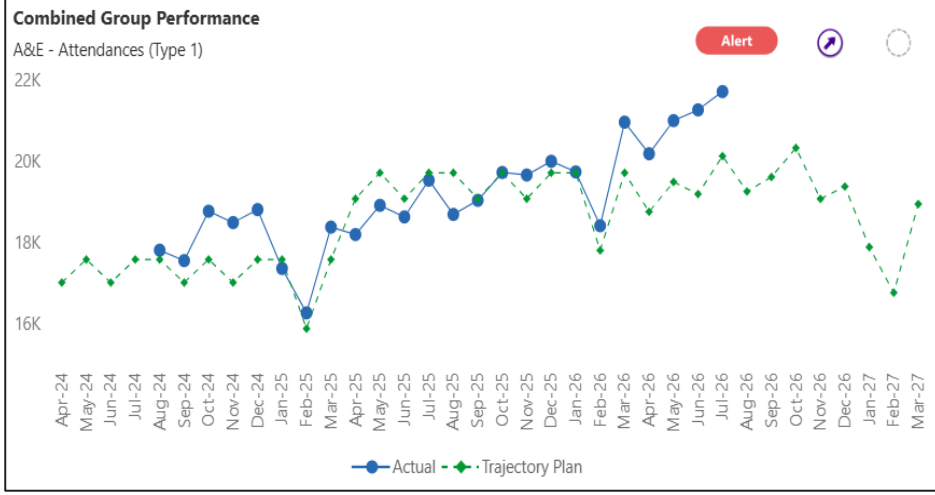
HUTH:

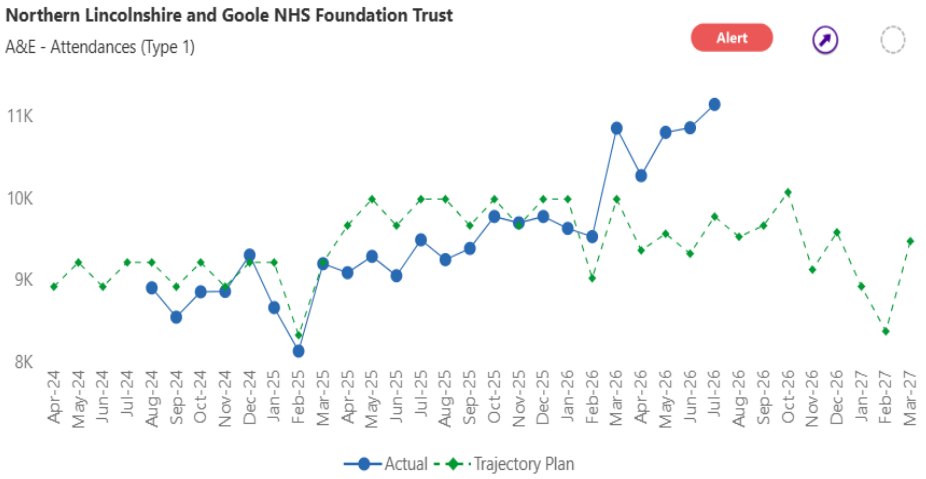
Type 1 attendances remained above trajectory in July (+213) and continue to show sustained upward pressure. This was not planned and is contributing to the four-hour performance gap; action is focused on streaming, alternatives to ED, SDEC and demand management with system partners.

NLAG:

Type 1 attendances remained materially above trajectory in July (+1,273), with recent months indicating a sustained shift in demand. Recovery requires stronger UTC streaming, alternatives to ED, site-level demand management and system action to reduce avoidable Type 1 conveyance and attendance.







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

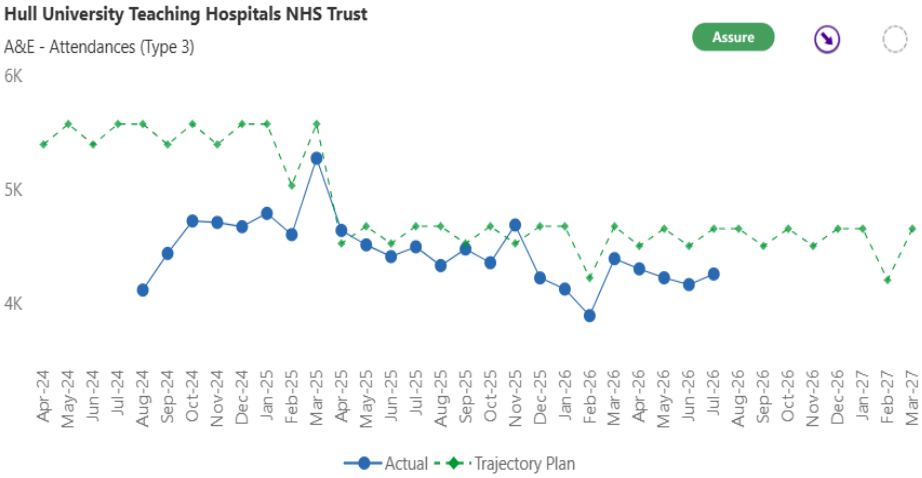
A&E - Attendances (Type 3)

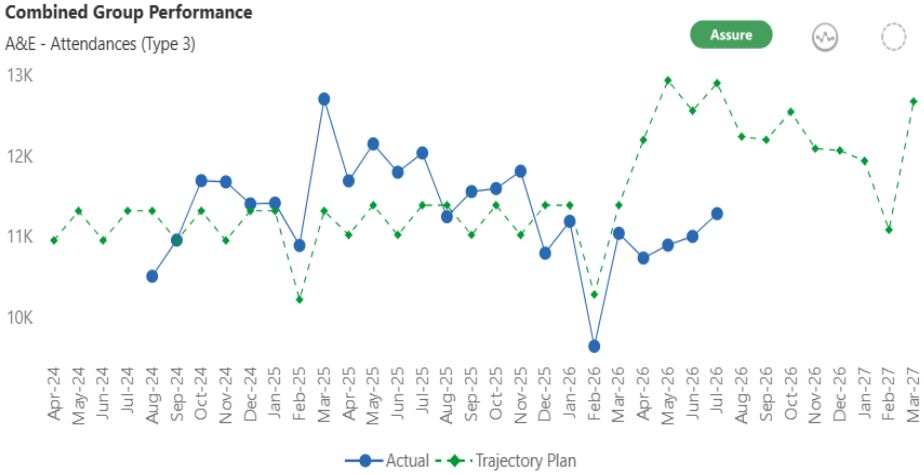
HUTH:

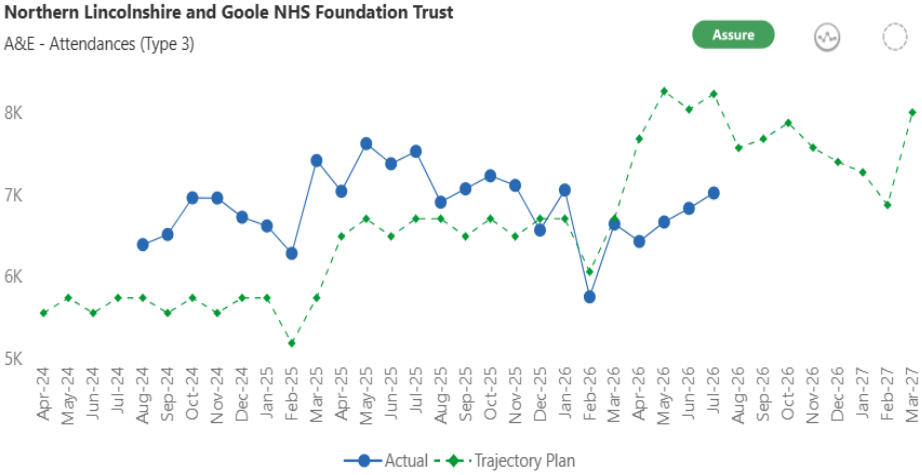
Type 3 attendances remained below trajectory in July (-398) while Type 1 demand was above plan. Although the statistical classification is Assure, the demand shift is operationally adverse and increases pressure on ED flow; UTC access, streaming and redirection pathways require review with system partners.

NLAG:

Type 3 attendances remained below trajectory (-1,213), while Type 1 activity was materially above plan. The Assure classification reflects the statistical direction, but the pathway mix is adverse; actions are to strengthen UTC utilisation, streaming, redirection and public access to alternatives to ED.







d. Planned Care

The national extended submission timetable for July RTT saw validation improve the HUTH 18wk position to 56%, which alongside NLAG at 59.8% maintains us on trajectory, however both PTL's are c2.5k higher than plan indicating that performance is inflated by growth.

Long waits remain the principal risk. 65-week waits were 277 at HUTH and 98 at NLAG, increases of 53 and 20 from June. The 52-week position increased by 143 at HUTH to 3,331 (+23 to plan) and by 94 at NLAG to 1,412 (+525 to plan).

Progress

Validation improved to 95.0% at HUTH but fell to 87.5% at NLAG. Time to First Appointment deteriorated to 62.6% and 69.6%, showing continuing pressure on first outpatient access and non-admitted clock stops.

Diagnostic six-week waits improved by 0.6 points at HUTH to 36.6% but worsened by 0.9 points at NLAG to 33.5%. Activity increased and total waits reduced slightly at both Trusts, but performance remains materially outside the 1% standard.

Cancer was mixed at HUTH: 62-day and 31-day performance improved to 54.4% and 81.4%, while Faster Diagnosis fell to 67.3%. July cancer data was not populated for NLAG; the latest available position remains below standard.

Theatre utilisation fell to 82.0% at HUTH and 81.5% at NLAG. Follow-up backlogs increased to 47,753 and 35,902 respectively, so current productivity and pathway actions are not yet producing the required reduction.

Action

Use weekly specialty trajectories for 52-, 65- and 78-week cohorts, with dated patients, named owners and immediate escalation where capacity is not secured.

- Recover first outpatient access through booking controls, validation, referral management and SPOA/GIRFT pathway redesign.
- Deliver MRI, CT, NOUS and endoscopy recovery by modality and site. Support required: agreement on additional capacity, workforce, reporting and funding.
- Reset tumour-site milestones against Best Practice Timed Pathways. Support required: protected diagnostics, pathology, MDT and treatment capacity.
- Improve theatre session fill, starts, finishes and cancellation recovery, with Care Group ownership and rapid resolution of workforce gaps.
- Reduce follow-up backlogs through clinical validation, PIFU and discharge, with funded capacity where demand exceeds supply.
- Report weekly through Planned Care governance, distinguishing published metrics from management information and showing trajectory, action impact, owner and delivery date.

HUTH

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Effective	Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	50.8%	52.1%	59.8%	70.7%	60.2%	58.7%	52.9%	74.6%	76.6%	71.2%	70.6%	67.3%	
		Cancer - 31 Day All Stages	≥ 94.0%	76.7%	74.0%	69.1%	75.5%	74.0%	76.7%	67.5%	76.2%	78.4%	73.5%	75.2%	77.2%	
		Cancer - 31 Day First Treatment	≥ 94.0%	80.1%	76.1%	73.7%	81.1%	80.3%	78.3%	72.3%	77.4%	80.0%	81.2%	79.7%	81.4%	
		Cancer - 62 Day All Referral Sources	≥ 80.0%	54.9%	48.8%	50.2%	55.5%	57.4%	53.7%	52.0%	51.6%	56.0%	52.9%	49.4%	54.4%	
		Cancer - 62 Day GP Referral	≥ 80.0%	52.2%	33.2%	44.3%	49.9%	49.7%	43.6%	39.7%	44.5%	55.8%	49.4%	41.2%	44.1%	
		Cancer - PTL Waits 104+ days		311	304	298	336	241	236	222	232	237	232	226	235	
	Elective Care	Outpatient - Clinic Slot Utilisation		95.8%	96.6%	95.4%	94.5%	94.4%	93.3%	95.1%	96.4%	95.6%	95.9%	95.5%	94.6%	95.0%
		Outpatient - DNA Rate	≤ 8.5%	7.2%	6.8%	5.8%	5.8%	5.9%	6.0%	5.9%	5.4%	5.6%	5.7%	5.8%	5.8%	5.9%
		Outpatient - Hospital cancellations < 6 weeks	≤ 5.0%	7.3%	7.2%	7.0%	7.1%	7.4%	7.0%	6.9%	6.9%	7.0%	6.4%	6.9%	7.1%	7.0%
		Outpatient - Total Overdue Backlog (3 months+)		44,856	46,268	46,343	46,284	47,461	48,561	47,880	46,880	47,001	46,354	46,905	46,821	47,753
		RTT - 52+ Week Waits		2,954	3,261	3,216	3,221	3,291	3,072	3,157	3,110	2,796	2,888	3,069	3,188	3,331
		RTT - 65+ Week Waits	≤ 0	63	62	85	96	134	112	131	109	65	89	141	224	277
		RTT - 78+ Week Waits	≤ 0	0	0	2	0	0	0	0	2	0	1	3	5	7
		RTT - Incomplete 18 Week Standard	≥ 92.0%	57.9%	56.7%	56.7%	56.5%	56.0%	55.6%	54.9%	54.6%	56.3%	56.3%	57.3%	56.8%	56.0%
		RTT - Pathways Validated within 12 weeks	≥ 90.0%	95.7%	90.2%	94.9%	93.5%	95.5%	95.6%	96.9%	95.5%	93.9%	92.0%	92.0%	92.5%	95.0%
		RTT - Patients waiting <= 18 weeks for 1st appointment		66.3%	65.1%	64.5%	64.3%	64.4%	62.6%	62.9%	62.9%	64.6%	65.1%	65.4%	64.3%	62.6%
		RTT - Total Incomplete Pathways		79,776	80,655	80,583	81,279	80,790	81,643	81,337	81,319	80,999	83,615	84,208	84,186	85,756
	Productivity	Theatres - Capped Theatre Utilisation	≥ 85.0%	79.8%	81.1%	79.6%	80.0%	81.3%	81.0%	80.0%	80.6%	82.1%	81.9%	82.2%	82.6%	82.0%
		Theatres - Early Finishes		64.5%	68.4%	65.6%	66.9%	64.2%	66.0%	69.7%	67.6%	67.2%	63.3%	64.8%	62.4%	65.9%
		Theatres - Late Starts		67.3%	65.4%	68.6%	69.9%	68.7%	66.0%	69.0%	65.4%	61.7%	64.7%	65.5%	66.4%	68.7%
Responsive	Primary Prevention	Diagnostics - 6 Week Standard	≤ 1.0%	26.2%	32.4%	30.0%	31.3%	34.5%	40.2%	42.8%	35.9%	33.8%	38.1%	38.6%	37.2%	36.6%
		Diagnostics - Total Activity Levels		20,598	18,463	20,488	20,788	19,009	18,875	20,662	20,542	21,934	18,996	19,337	20,386	21,652
		Diagnostics - Total Waits		16,742	15,668	17,424	18,458	19,247	20,037	21,431	21,518	23,025	22,796	22,456	23,901	23,885

NLAG

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Effective	Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	65.0%	64.3%	66.7%	70.8%	75.6%	73.8%	62.2%	69.9%	66.4%	63.0%	58.5%	64.0%	
		Cancer - 31 Day All Stages	≥ 94.0%	93.7%	95.1%	94.9%	95.5%	97.3%	98.7%	90.8%	96.0%	98.1%	97.1%	92.2%	94.1%	
		Cancer - 31 Day First Treatment	≥ 94.0%	93.2%	95.1%	96.5%	94.8%	97.3%	98.0%	92.1%	95.8%	98.1%	98.0%	93.8%	93.6%	
		Cancer - 62 Day All Referral Sources	≥ 80.0%	58.8%	71.7%	59.1%	67.2%	70.4%	66.1%	62.1%	63.3%	74.2%	65.0%	64.0%	64.1%	
		Cancer - 62 Day GP Referral	≥ 80.0%	46.6%	66.4%	45.1%	54.8%	58.5%	61.1%	57.1%	58.5%	66.8%	60.1%	61.0%	54.9%	
		Cancer - PTL Waits 104+ days		46	45	42	41	39	34	42	32	40	40	46	35	
	Elective Care	Outpatient - Clinic Slot Utilisation		94.5%	94.9%	95.7%	92.9%	91.9%	92.0%	92.8%	92.3%	92.9%	92.1%	92.3%	93.1%	79.0%
		Outpatient - DNA Rate	≤ 8.5%	7.4%	7.5%	7.6%	7.4%	7.3%	7.6%	7.2%	6.8%	7.0%	7.1%	6.7%	6.8%	6.8%
		Outpatient - Hospital cancellations < 6 weeks	≤ 5.0%	7.9%	8.3%	8.2%	8.0%	9.1%	8.0%	7.6%	7.5%	8.4%	8.3%	8.8%	7.8%	8.0%
		Outpatient - Total Overdue Backlog (3 months+)		33,445	34,506	33,862	33,993	33,696	34,055	33,275	33,183	33,951	34,735	35,405	35,729	35,902
		RTT - 52+ Week Waits		895	1,025	1,045	994	988	915	930	873	820	915	1,038	1,218	1,412
		RTT - 65+ Week Waits	≤ 0	40	54	64	27	29	42	26	38	32	41	50	78	98
		RTT - 78+ Week Waits	≤ 0	1	2	3	1	0	0	1	2	2	0	1	2	2
		RTT - Incomplete 18 Week Standard	≥ 92.0%	59.9%	59.1%	59.3%	59.7%	59.5%	59.2%	58.3%	59.5%	61.4%	61.4%	62.0%	61.6%	59.8%
		RTT - Pathways Validated within 12 weeks	≥ 90.0%	89.4%	90.6%	90.2%	89.1%	87.8%	90.0%	85.0%	91.2%	93.0%	86.1%	89.5%	90.4%	87.5%
		RTT - Patients waiting <= 18 weeks for 1st appointment		68.8%	68.4%	67.6%	67.3%	68.0%	67.2%	66.5%	69.7%	71.3%	72.2%	72.4%	71.6%	69.6%
		RTT - Total Incomplete Pathways		39,114	39,698	40,146	40,156	39,296	39,294	39,644	39,443	39,652	40,793	41,548	42,012	42,605
	Productivity	Theatres - Capped Theatre Utilisation	≥ 85.0%	79.7%	80.8%	81.9%	79.9%	81.1%	82.9%	81.3%	81.5%	81.8%	83.7%	83.9%	84.0%	81.5%
		Theatres - Early Finishes		58.2%	49.7%	50.3%	61.4%	57.1%	52.4%	53.9%	57.4%	53.2%	58.4%	52.7%	47.4%	58.5%
		Theatres - Late Starts		100.0%	98.0%	100.0%	98.4%	99.0%	99.4%	98.5%	98.2%	98.3%	100.0%	98.7%	98.8%	98.8%
Responsive	Primary Prevention	Diagnostics - 6 Week Standard	≤ 1.0%	35.1%	38.8%	35.9%	38.4%	41.6%	46.5%	46.5%	37.2%	29.9%	33.0%	34.4%	32.6%	33.5%
		Diagnostics - Total Activity Levels		27,347	26,367	25,259	25,578	24,155	23,942	25,902	25,258	30,874	17,662	16,752	17,219	18,971
		Diagnostics - Total Waits		24,103	22,803	23,942	24,162	25,675	26,004	26,804	27,270	24,997	17,062	16,998	18,789	18,447

a. Cancer 62 Day First Definitive Treatment

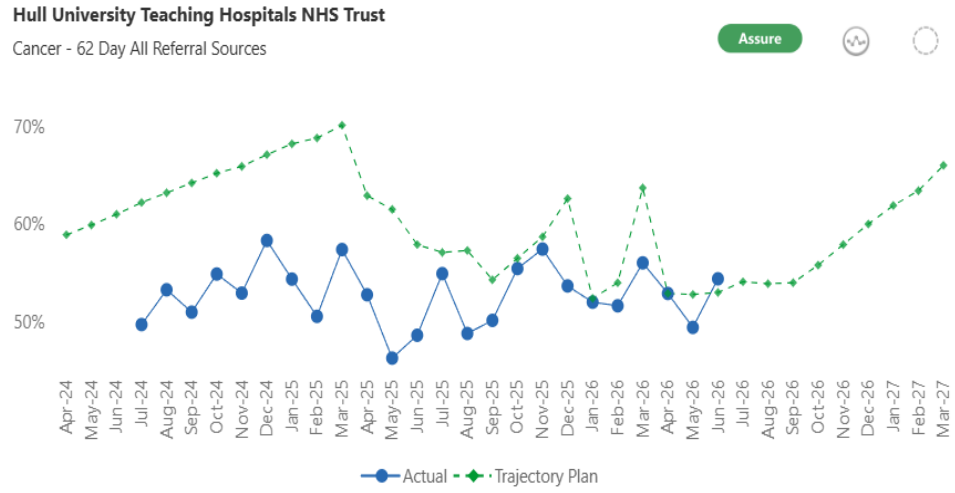
Cancer - 62 Day All Referral Sources

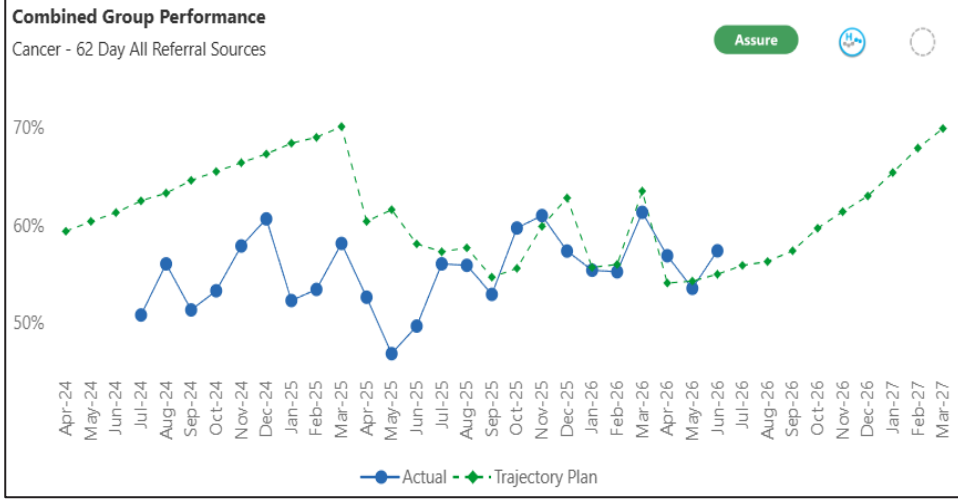
Summary:

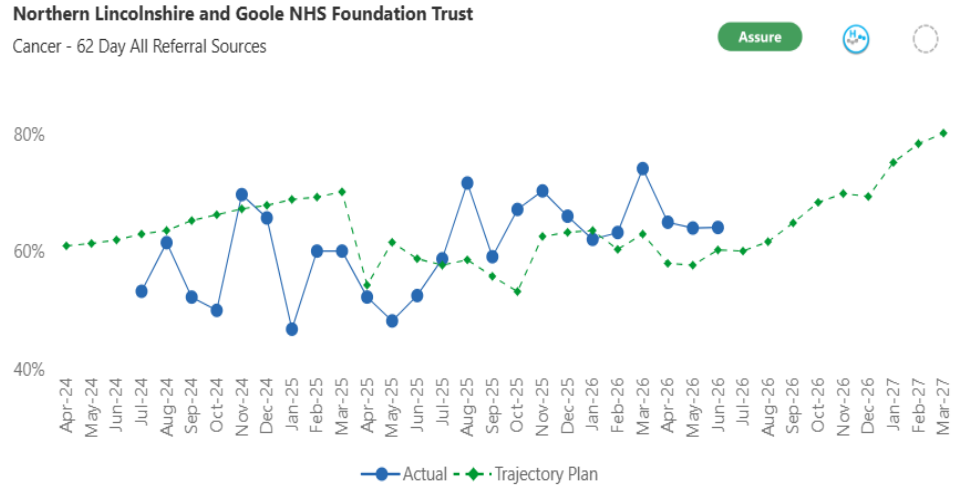
Performance improved by 5 points at HUTH to 54.4% and by 0.1 at NLAG at 64.1%. Both Trusts are above local trajectory, but below the 80% standard.

Progress: Radiotherapy, scheduling, histology cross-cover and urology recruitment were intended to improve delivery; the June change shows benefits have not yet translated into performance.

Action: Complete tumour-level breach analysis and BPTP review. Support required: protected diagnostics, pathology, MDT, theatre/robotic capacity and rapid Care Group escalation of gaps.







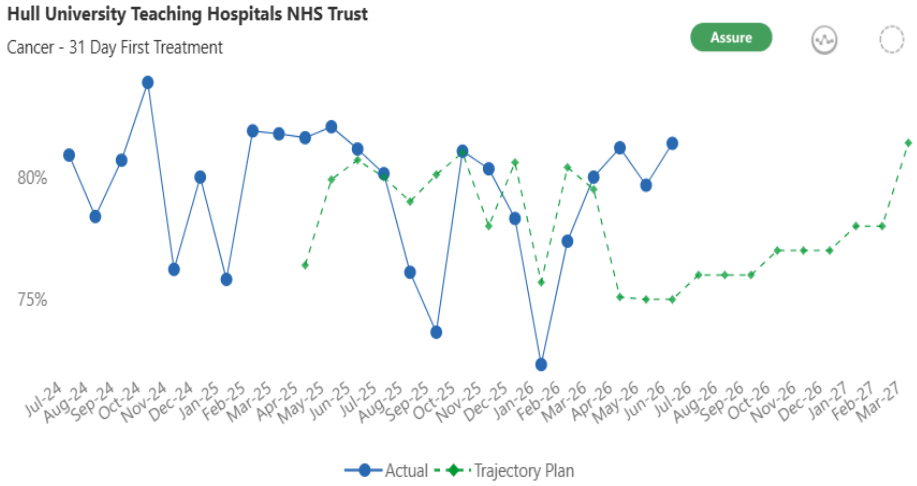
ii. Cancer 31-day First Treatment

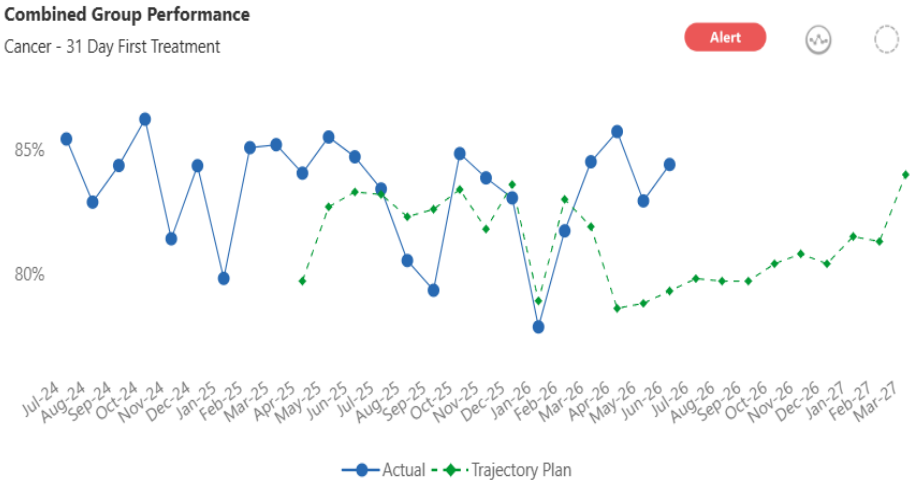
Cancer - 31 Day First Treatment

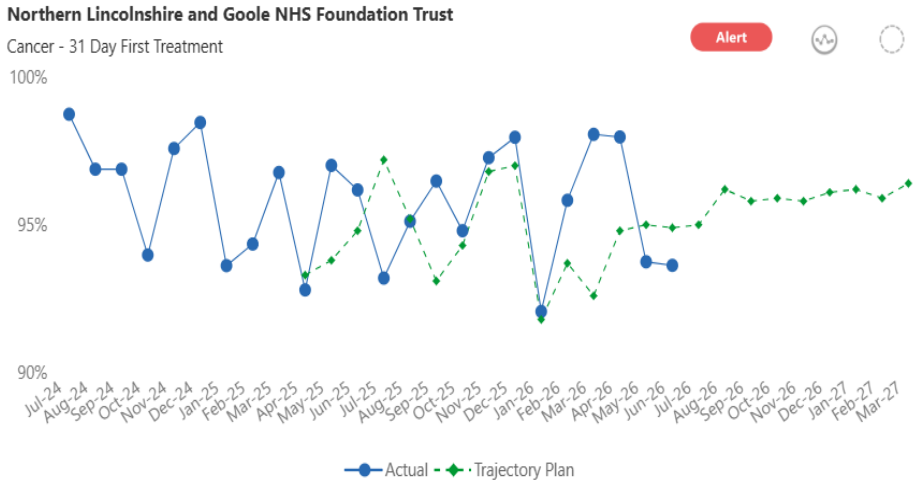
Summary:
Performance improved by 1.7 points at HUTH to 81.4% but deteriorated further at NLAG to 93.6%. The deterioration was not expected and both Trusts are below the 94% standard.

Progress:
Tumour pathway, radiotherapy, scheduling, histology and urology actions were planned to improve flow; the June result indicates inconsistent benefit.

Action:
Review every 31-day breach and reset tumour-level trajectories. Support required: timely diagnostics/MDT decisions, protected treatment slots and executive resolution of capacity gaps.







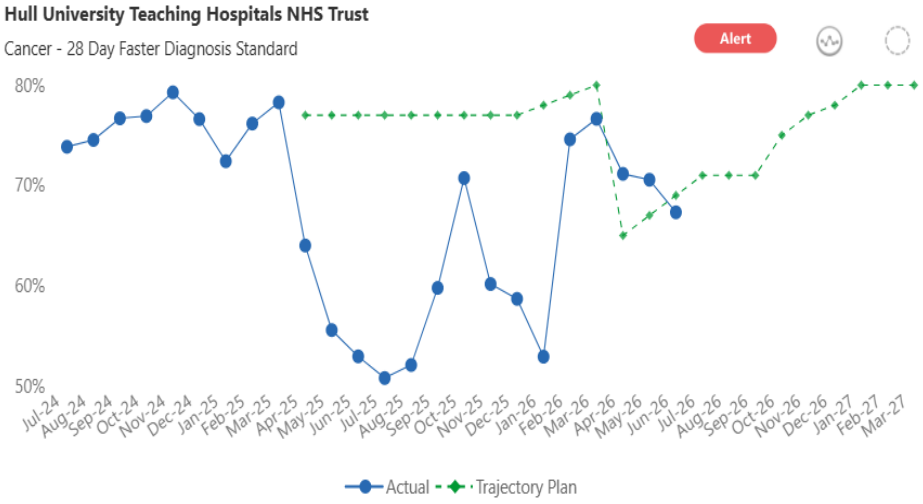
iii. Cancer 28-day Faster Diagnosis Performance

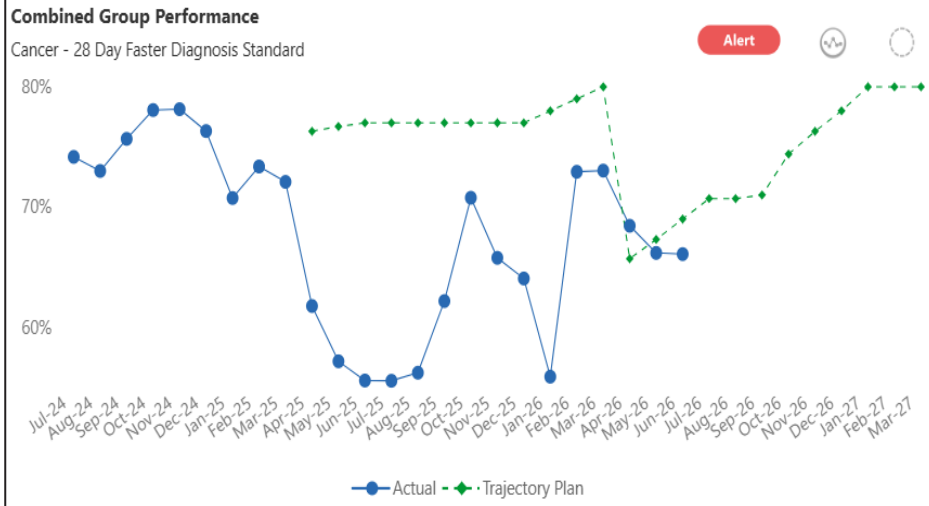
Cancer - 28 Day Faster Diagnosis Standard

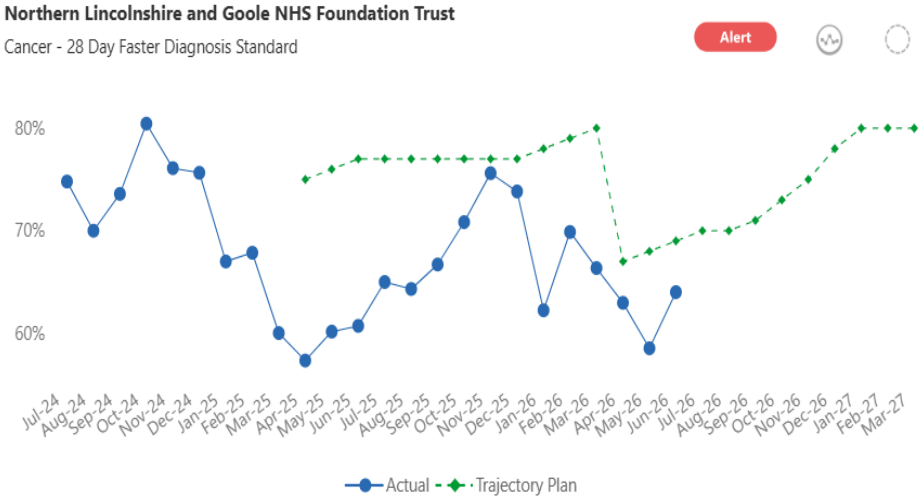
Summary:
Performance fell below trajectory to 67.3% at HUTH reflecting the deterioration in Outpatient capacity and NLAG improved to 64% but remains below trajectory.

Progress:
Urology, Lower GI and nurse-endoscopy work was intended to stabilise performance, but the improvement has not been sustained across pathways.

Action:
Complete BPTP reviews and weekly tumour-site diagnostics tracking. Support required: Breast Radiologist and fellow recruitment, increased nurse endoscopy and reporting capacity.







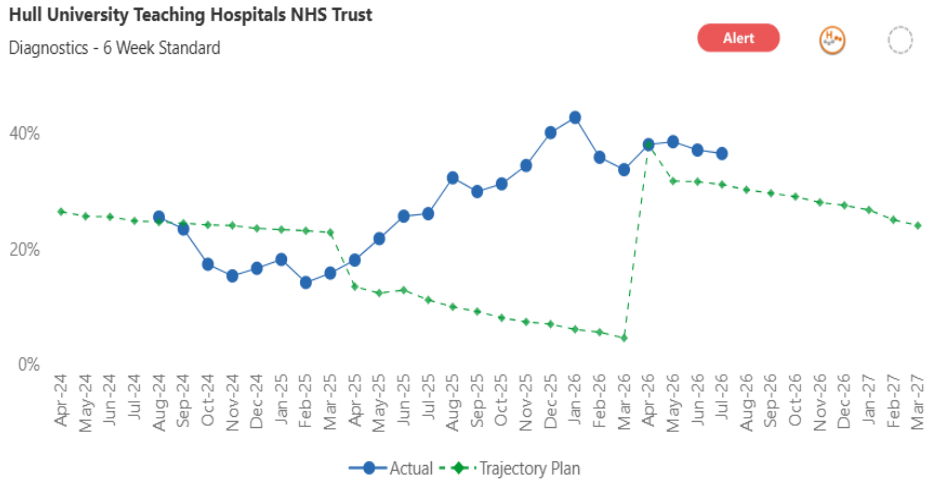
iv. Diagnostic 6-Week Standard

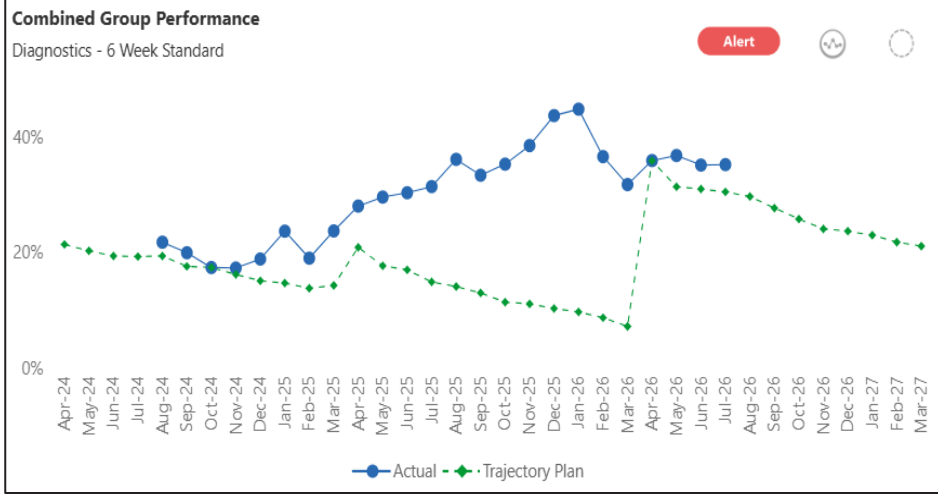
Diagnostics - 6 Week Standard

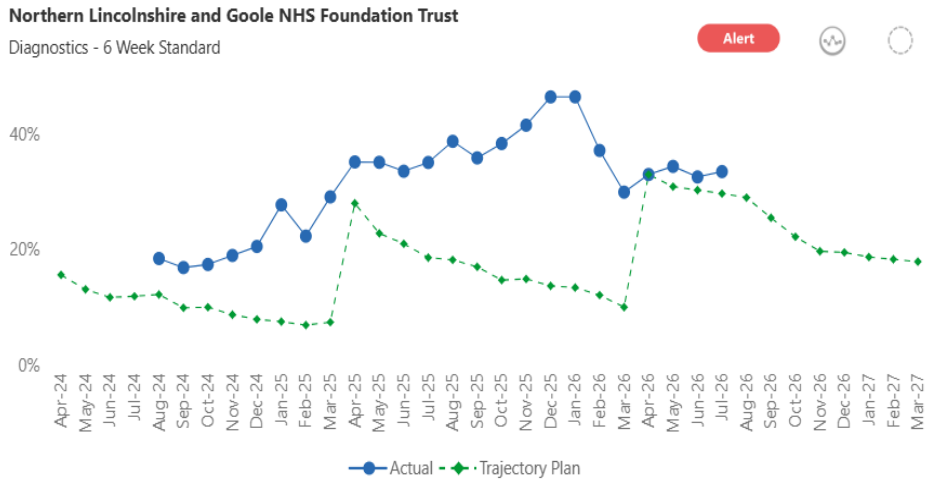
Summary:
Six-week waits improved by 0.6 points at HUTH to 36.6% and deteriorated by 0.9 points at NLAG to 33.5%. The direction is expected as recovery actions take traction however waiting list growth at HUTH is a factor.

Progress:
CDC, NOUS, non-recurrent investment and Scunthorpe MRI actions are generating some improvement, but demand continues to exceed delivered capacity.

Action:
Set modality/site recovery trajectories. Support required: system agreement on MRI/CT capacity, workforce, reporting turnaround, funding and seven-day CDC utilisation.







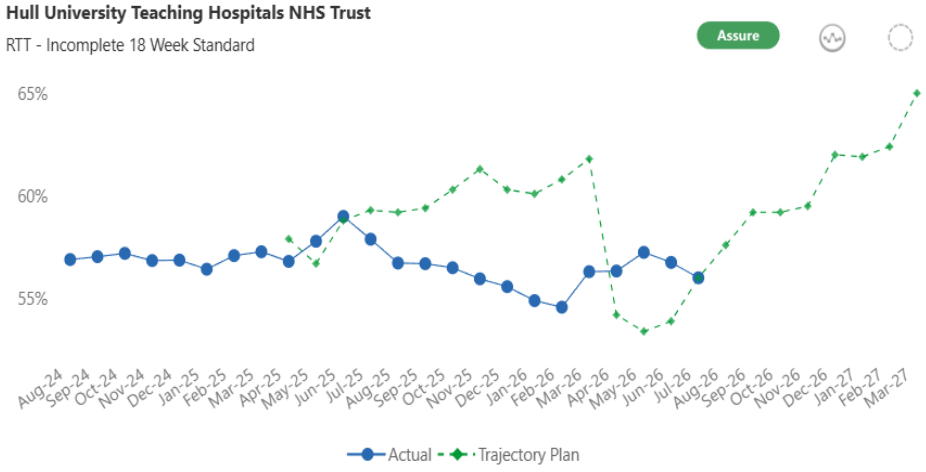
v. RTT Incomplete Performance

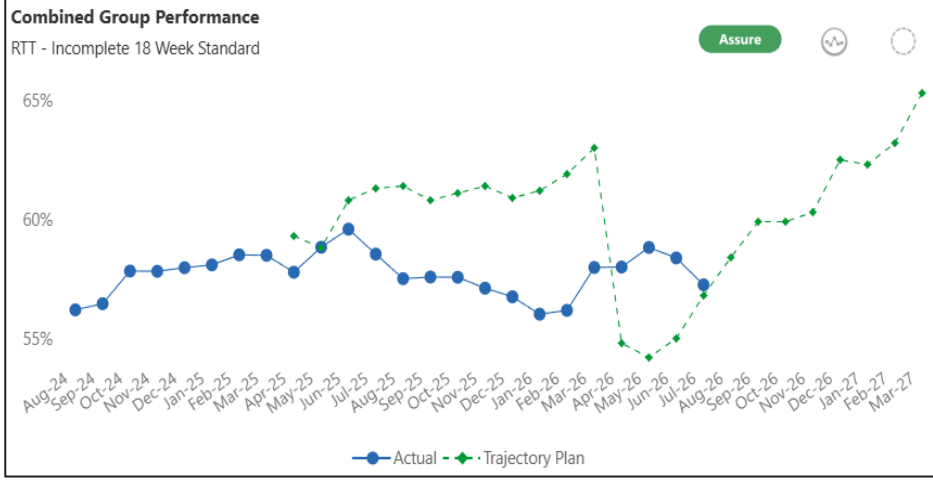
RTT - Incomplete 18 Week Standard

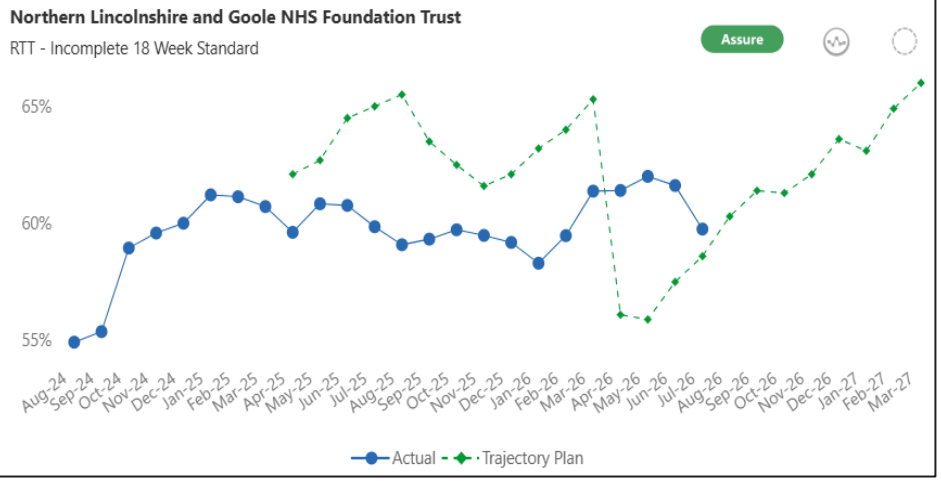
Summary:
RTT fell by 0.8 points at HUTH to 56% and by 1.8 points at NLAG to 59.8% as start of year PTL growth and reduced Outpatient activity begin to tip into > 18wks. PTL size is now >2.5k at each Trust.

Progress:
Outpatient transformation, demand-and-capacity and scheduler work was planned to improve flow; June shows that improvement has not yet been sustained.

Action:
Complete Care Group demand-and-capacity reviews and SPOA/GIRFT changes. Support required: accountable specialty plans, validated data and executive action on capacity gaps.







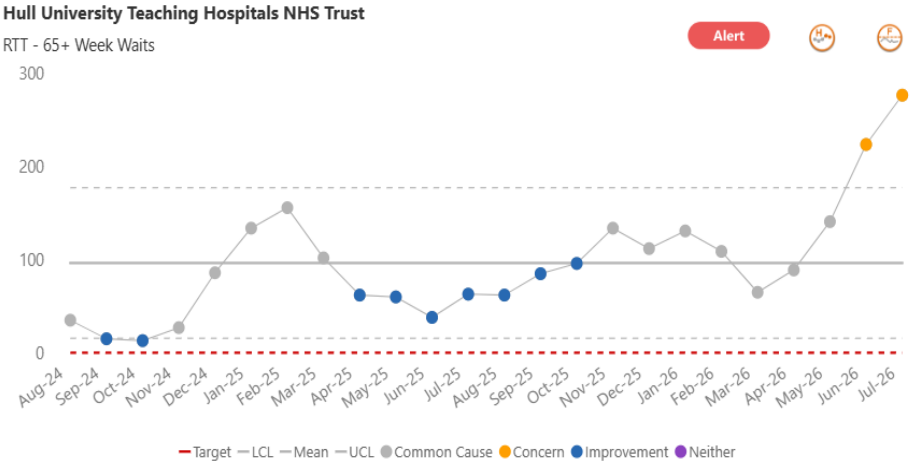
vi. RTT 65 week waits

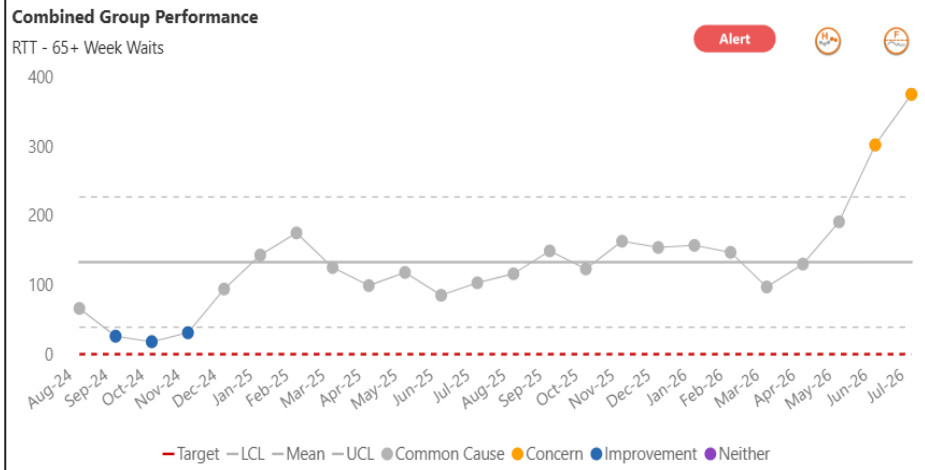
RTT - 65+ Week Waits

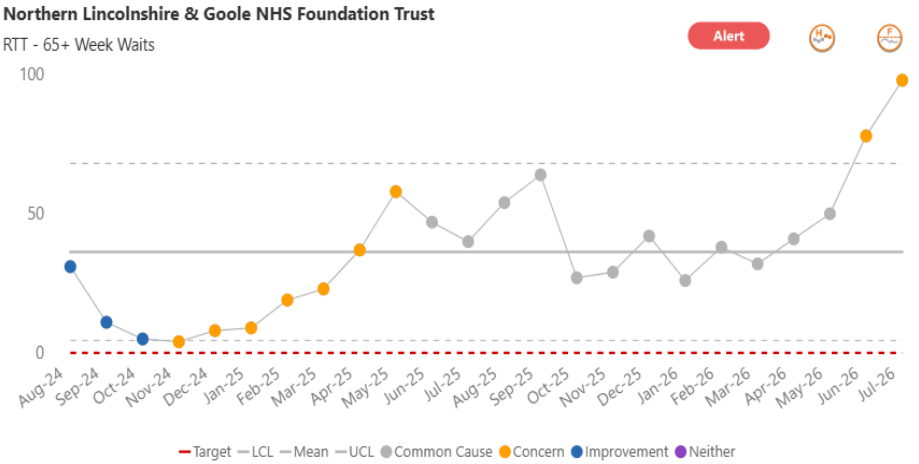
Summary:
65-week waits increased to 277 at HUTH and 98 at NLAG. This sharp deterioration reflects the underlying long wait volumes and capacity restraints.

Progress:
Validation and specialty oversight are established, but replenishment from the 52-week cohort is outstripping treatment capacity.

Action:
Maintain weekly dated-patient plans and protect capacity. Support required: executive escalation of unresolved outpatient, diagnostic, theatre, workforce and mutual-aid gaps.







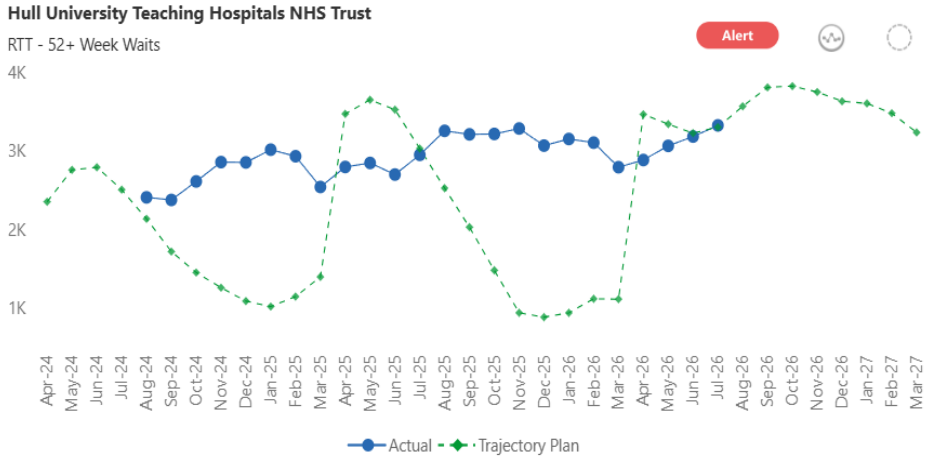
vii. RTT 52 week waits

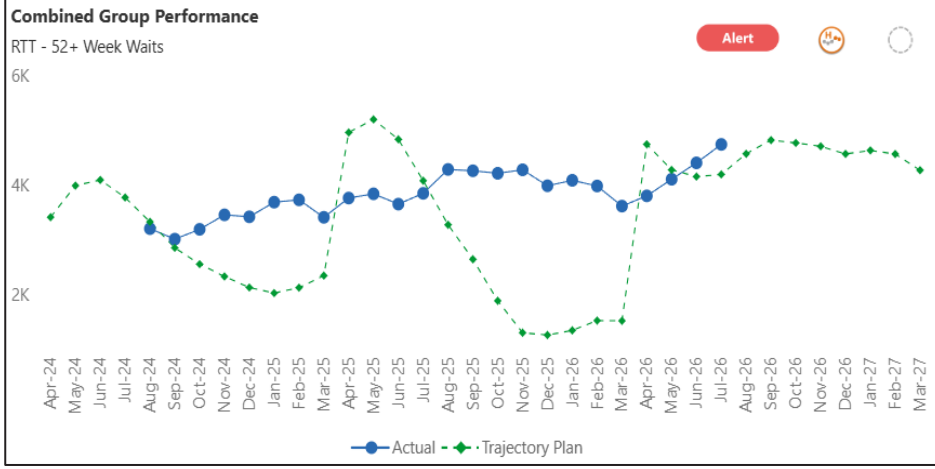
RTT - 52+ Week Waits

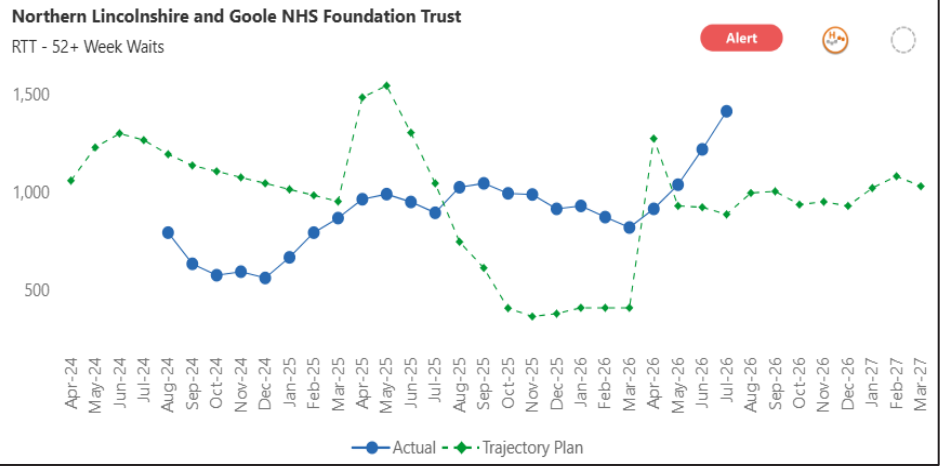
Summary:
52-week waits increased by 141 at HUTH to 3,331 and by 94 at NLAG to 1,412. Growth was not expected; HUTH remains on its plan line, while NLAG is above trajectory.

Progress:
Validation and specialty oversight are in place, but planned recovery has not prevented replenishment of the 65-week cohort.

Action:
Set weekly specialty trajectories and date highest-risk patients. Support required: Care Group ownership and aligned outpatient, diagnostic and treatment capacity.







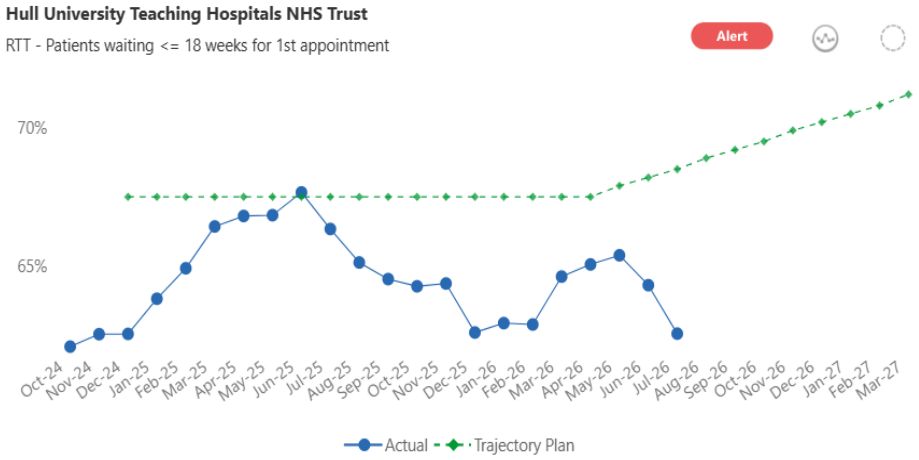
viii. Enabler Metric 1: Time to First Appointment (%)

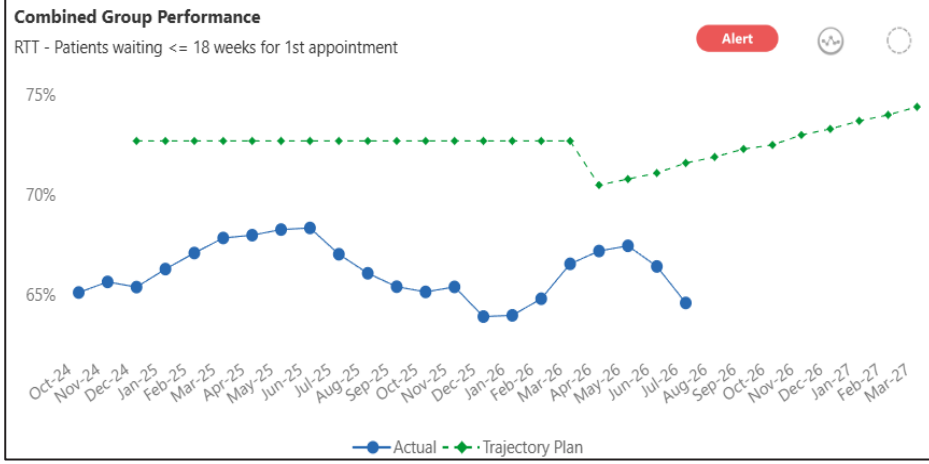
RTT - Patients waiting <= 18 weeks for 1st appointment

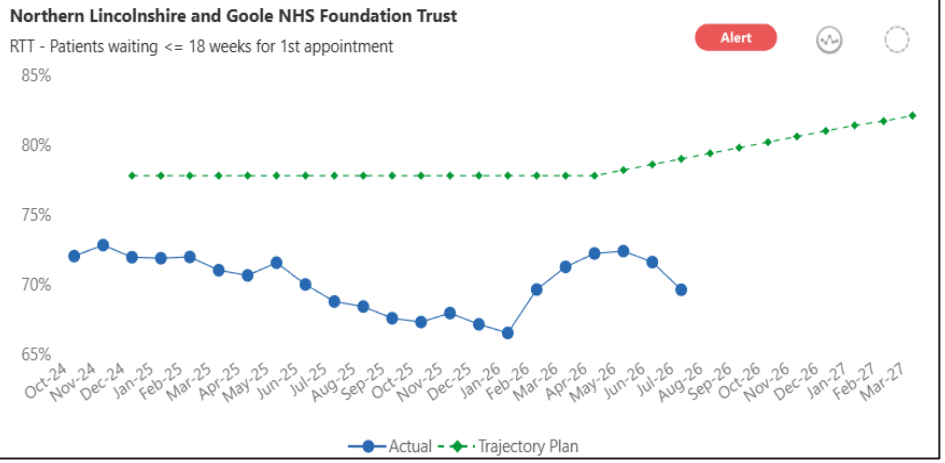
Summary:
Time to First Appointment fell for the second month at HUTH to 62.6% and by 2 points at NLAG to 69.6%.

Progress:
Outpatient transformation and demand-and-capacity reviews were expected to improve access but have not yet generated the required change.

Action:
Improve slot fill, booking and SPOA pathways. Support required: specialty capacity plans, referral-demand controls and executive resolution of workforce gaps.







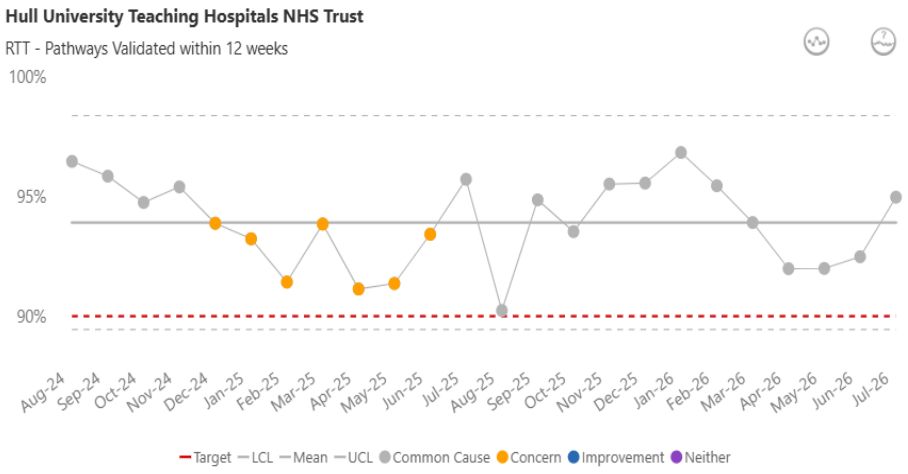
ix. Enabler Metric 2: RTT Data Quality

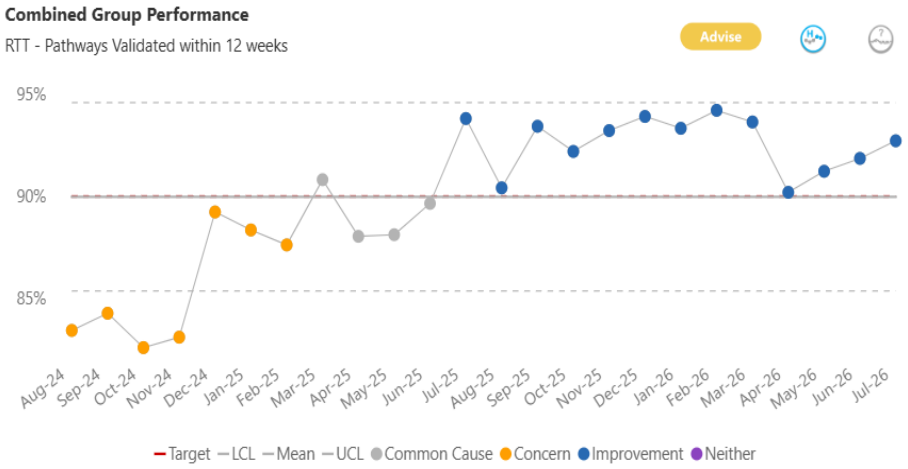
RTT - Pathways Validated within 12 weeks

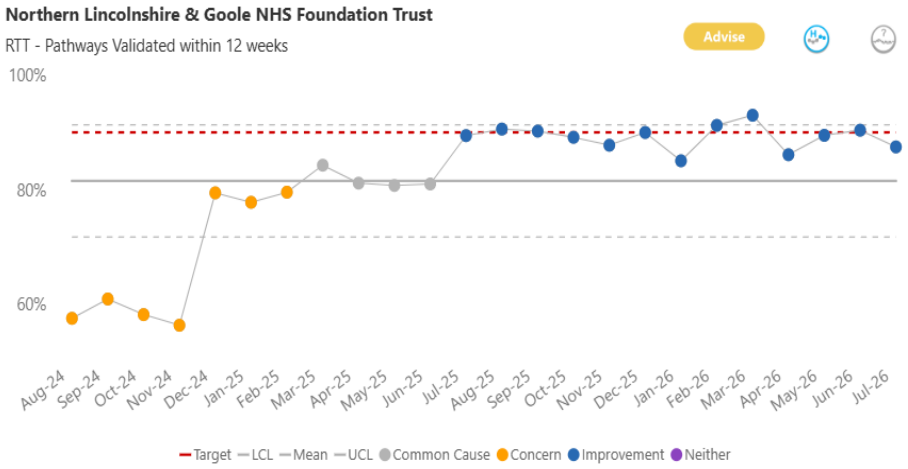
Summary:
Validation improved at HUTH to 95% but fell to 87.4% for NLAG.

Progress:
Communication-partner, completeness and GIRFT work is generating the intended direction of change.

Action:
Sustain weekly validation and confirm methodology. Support required: reliable patient-contact capacity, consistent pathway recording and rapid correction of data-quality exceptions.







x. Enabler Metric 3: Capped Theatre Utilisation

Theatres - Capped Theatre Utilisation

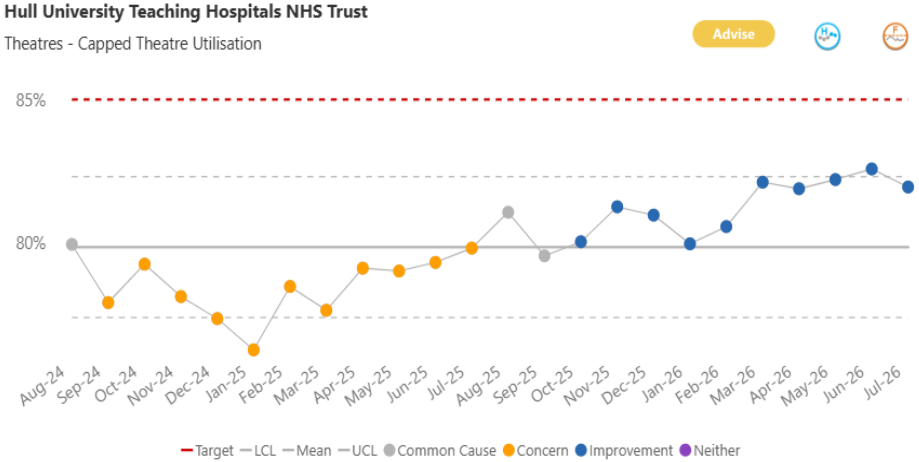
Summary:
Utilisation dropped at HUTH at 82% and 81.5% at NLAG, compounded Non Admitted delays with reduced Elective Admitted throughput.

Progress:
Scheduler access and productivity oversight are sustaining performance above 80%, but have not yet generated sufficient improvement. Theatre improvement works and prioritisation of emergencies continued to impact delivery.

Action:
Improve session fill, starts, finishes and cancellations. Support required: Care Group grip, workforce availability and allocation of capacity to long waits.

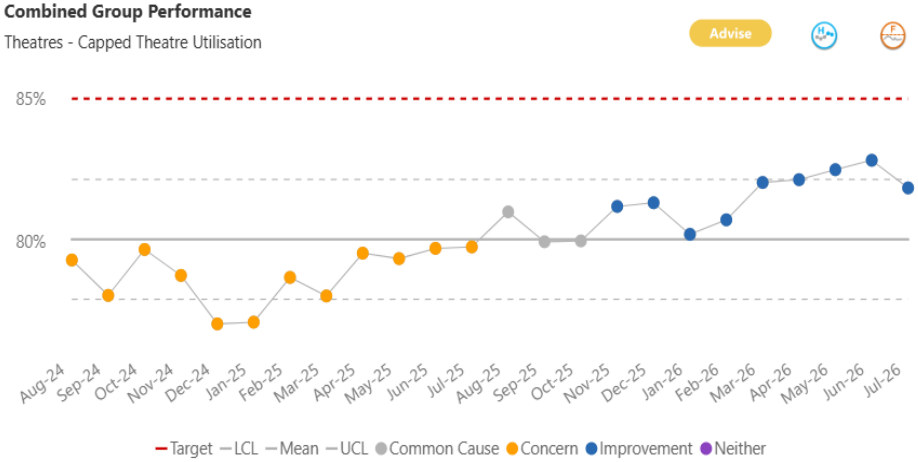
Hull University Teaching Hospitals NHS Trust

Theatres - Capped Theatre Utilisation



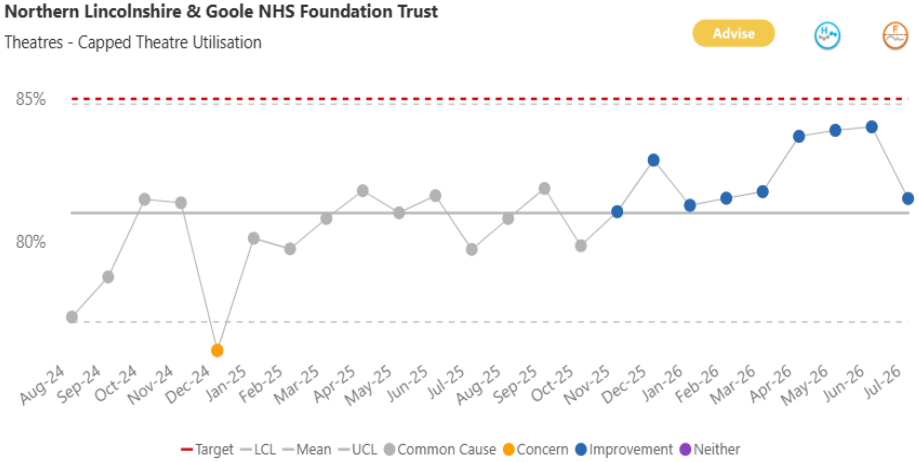
Combined Group Performance

Theatres - Capped Theatre Utilisation



Northern Lincolnshire & Goole NHS Foundation Trust

Theatres - Capped Theatre Utilisation



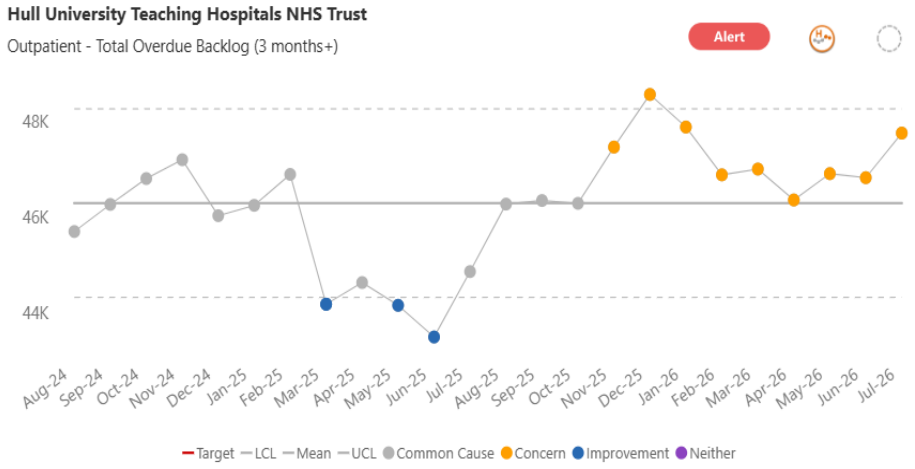
xi. Enabler Metric 4: Outpatient Follow Up Backlog

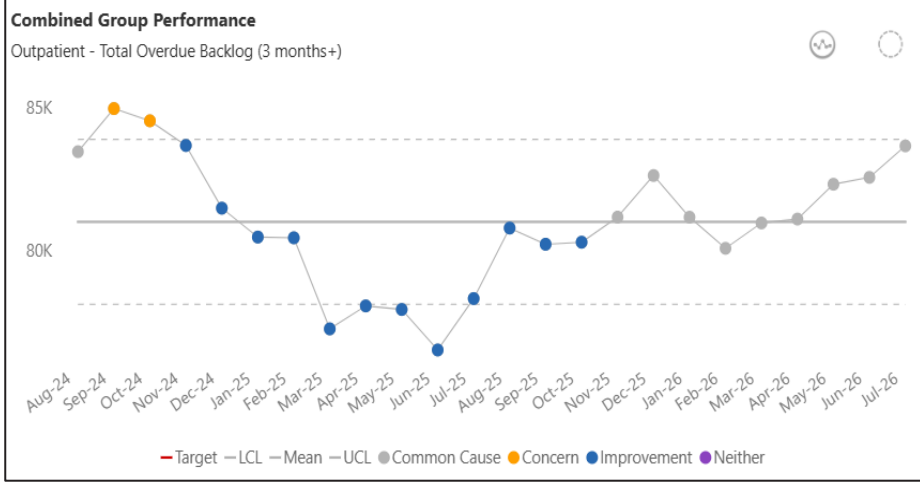
Outpatient - Total Overdue Backlog (3 months+)

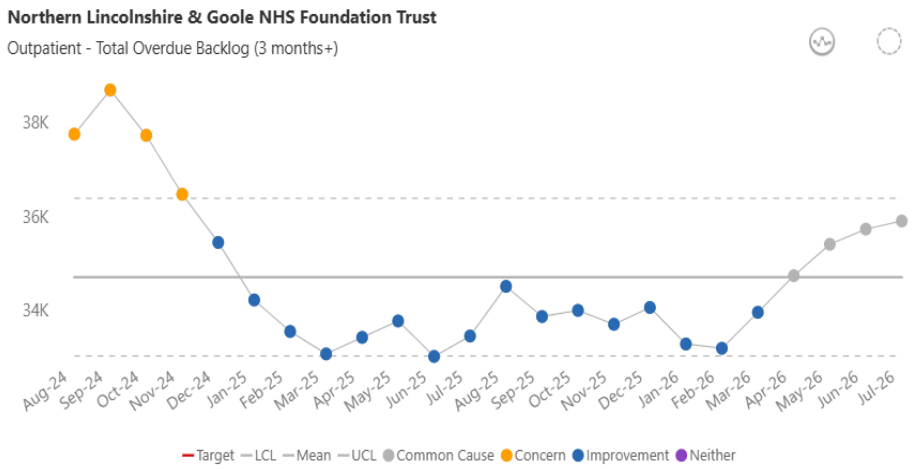
Summary:
The backlog has grown by 1,100 across the Partnership, with HUTH to 47,753 and NLAG to 35,902.

Progress:
Validation and pathway changes are beginning to stabilise HUTH,but have not generated a Group-wide reduction.

Action:
Risk-stratify and assign specialty owners. Support required: clinical validation time, PIFU/discharge adoption and funded capacity where demand exceeds supply.







xii. Enabler Metric 5: Cancelled Operations – 28-day Breaches

Inpatient - Cancelled Operations 28 Day perfomance

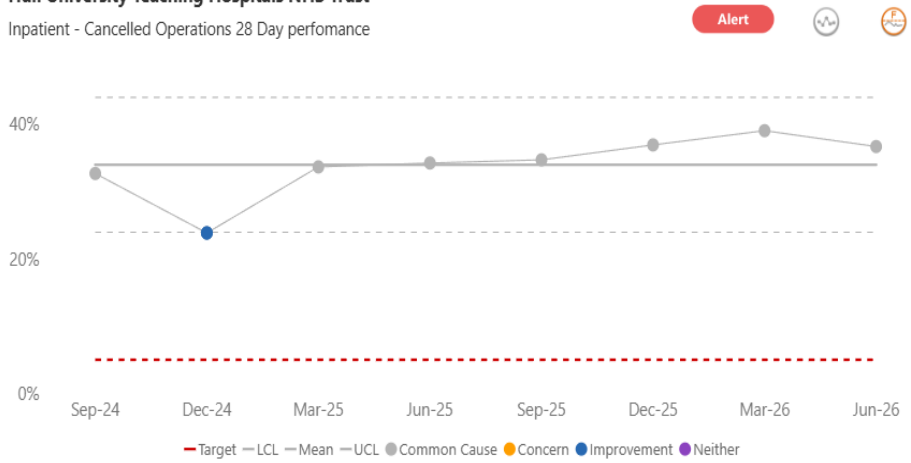
Summary:
The latest quarterly position deteriorated: HUTH rose to 39.1% and NLAG to 16.7% of cancelled patients not rebooked within 28 days. The increase was not expected and is contrary to the recovery aim.

Progress:
Scheduler and productivity oversight should improve identification but has not yet generated reliable rebooking within the guarantee.

Action:
Maintain a daily cancellation PTL. Support required: named specialty owners, protected rebooking capacity and executive escalation before the 28-day deadline.

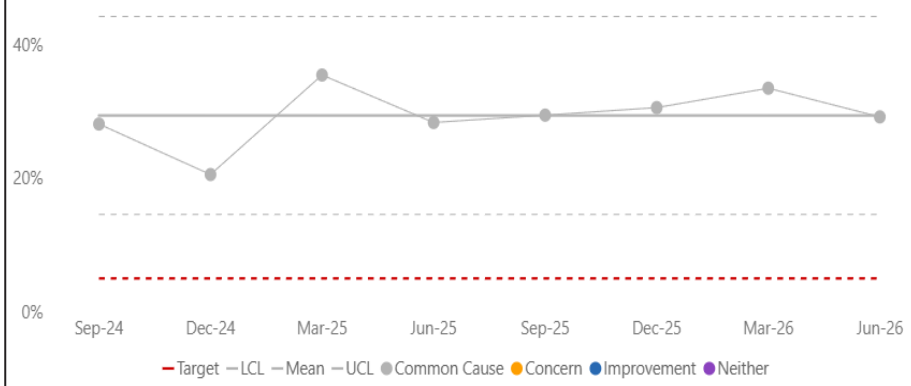
Hull University Teaching Hospitals NHS Trust

Inpatient - Cancelled Operations 28 Day perfomance



Combined Group Performance

Inpatient - Cancelled Operations 28 Day perfomance



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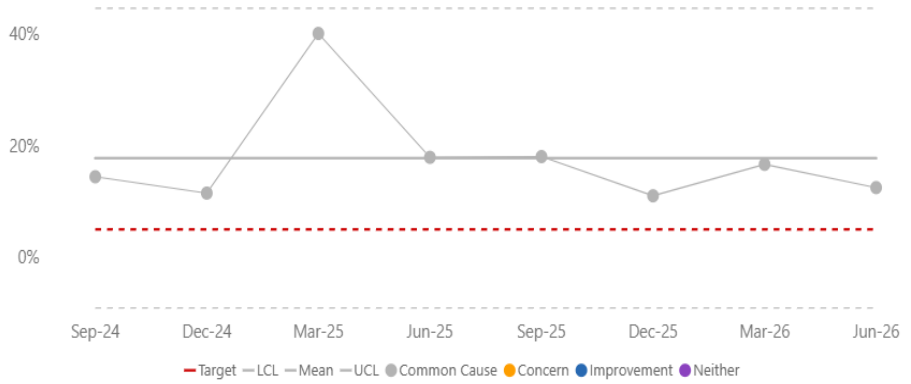
Inpatient - Cancelled Operations 28 Day perfomance



Sample pages only – awaiting further Lead review

5. HHP Group Executive Summary – Quality

Executive Lead: Hilda Gwilliams, Group Chief Patient Safety Officer

Accountable to: Quality Safety Committee

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
Care Hours per Patient Day - Overall	Apr-26	≥ 9.0	7.6		
Complaints - 60 day compliance	Jul-26	≥ 85.0%	64.4%		
Falls - per 1,000 bed days	Jul-26		7.88		
Falls - Serious harm or death	Jul-26		2		
Friends & Family - A&E Score	Jun-26	≥ 85.0%	100.0%		
Friends & Family - Antenatal Score	Jun-26	≥ 95.0%	82.4%		
Friends & Family - Inpatient Score	Jun-26	≥ 95.0%	96.9%		
Friends & Family - Outpatient Score	Jun-26	≥ 95.0%	97.9%		
Infections - C.Difficile (Cumulative)	Jun-26		34		
Infections - E.Coli (Cumulative)	Jun-26		53		
Infections - Klebsiella (Cumulative)	Jun-26		19		
Infections - MRSA (Cumulative)	Jun-26		0		
Inpatient - Corridor Care on Wards	Jul-26		41.1		
Inpatient - Emergency Readmissions within 30 days	Jun-26		10.0%		
Mortality - SHMI	Mar-26	≤ 1.0	1.047		
Never Events	Jul-26		0		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Jul-26		1.84		
Pressure Ulcers - Category 3	Jul-26		3		
Pressure Ulcers - Category 4	Jul-26		0		
Pressure Ulcers - Hospital acquired	Jul-26		135		
VTE Risk Assessment 14 Hour Standard	Jun-26	≥ 95.0%	92.2%		

Northern Lincolnshire and Goole NHS Foundation Trust

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

Metric	Month	Target	Result	Var	Asr
Care Hours per Patient Day - Overall	Apr-26	≥ 9.0	9.5		
Complaints - 60 day compliance	Jul-26	≥ 85.0%	62.1%		
Falls - per 1,000 bed days	Jul-26		6.29		
Falls - Serious harm or death	Jul-26		3		
Friends & Family - A&E Score	Jun-26	≥ 85.0%	76.0%		
Friends & Family - Antenatal Score	Jun-26	≥ 95.0%	66.7%		
Friends & Family - Inpatient Score	Jun-26	≥ 95.0%	98.6%		
Friends & Family - Outpatient Score	Jun-26	≥ 95.0%	97.9%		
Infections - C.Difficile (Cumulative)	Jun-26		12		
Infections - E.Coli (Cumulative)	Jun-26		67		
Infections - Klebsiella (Cumulative)	Jun-26		18		
Infections - MRSA (Cumulative)	Jun-26		5		
Inpatient - Corridor Care on Wards	Jul-26		1.9		
Inpatient - Emergency Readmissions within 30 days	Jun-26		11.0%		
Mortality - SHMI	Mar-26	≤ 1.0	0.993		
Never Events	Jul-26		0		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Jul-26		2.70		
Pressure Ulcers - Category 3	Jul-26		16		
Pressure Ulcers - Category 4	Jul-26		1		
Pressure Ulcers - Hospital acquired	Jul-26		207		
VTE Risk Assessment 14 Hour Standard	Jun-26	≥ 95.0%	94.5%		

Group Chief Patient Safety Officer Update – Quality Overview (July 2026)

Quality performance presents a mixed position across HUTH and NLAG, with the most material oversight risks sitting within patient safety and infection prevention, alongside continuing variation in patient experience and effectiveness indicators. The NOF Quality briefing confirms Patient Safety as a distinct provider oversight domain, combining scored metrics for clinical audit outliers, MRSA, E. coli, C. difficile and the staff survey raising-concerns sub-score with contextual indicators for falls causing harm, pressure ulcers and incidents causing harm.

Patient Experience shows improving grip on 60-day complaint response compliance since October 2025, but complaints received and PALS activity remain variable, indicating that earlier resolution, responsiveness and thematic learning are not yet consistently reducing patient concern activity across services.

Safety remains the principal quality risk area. Care Hours per Patient Day requires continued triangulation with acuity, staffing fill and ward-level risk. Infection prevention indicators are particularly important because MRSA, E. coli and C. difficile are NOF scoring metrics. The latest FYTD position records C. difficile at HUTH 26 and NLAG 12, MRSA at HUTH 0 and NLAG 5, and E. coli at HUTH 17 and NLAG 67, requiring sustained IPC grip, case review, antimicrobial stewardship and targeted improvement where recurrence or adverse variation is identified.

Effectiveness is broadly stable but requires continued governance oversight. VTE assessment compliance remains variable and will be affected by the national change to emergency admission timing from DTA in Quarter 3. SHMI should continue to be handled as a statistical indicator through established clinical governance and coding assurance, while emergency readmissions within 30 days appear broadly stable but should remain subject to specialty-level review of discharge quality, follow-up arrangements and avoidable readmission themes.

Executive focus should be on creating a unified Quality Foundation Scorecard that brings together scored and contextual NOF measures with local quality indicators, providing clear targets, trajectories and accountability. This should enable consistent oversight from Board to care group and ward level, with escalation focused on infection prevention, safe staffing, complaint responsiveness, VTE compliance, SHMI assurance and avoidable readmissions.

a. Hull University Teaching Hospital Quality AAA Summary

Count: 12

Alert

- Care Hours per Patient Day - Overall
- Care Hours per Patient Day - Unregistered
- Complaints - 60 day compliance
- Duty of Candour - Verbal apology
- PALS - Complaints
- Pressure Ulcers - Category 2
- Pressure Ulcers - Community acquired
- Pressure Ulcers - Hospital acquired
- Pressure Ulcers - Hospital acquired (per 1,000 bed days)
- Pressure Ulcers - Unstageable
- VTE Risk Assessment
- VTE Risk Assessment 14 Hour Standard

Count: 6

Advise

- Complaints - Average response time
- Duty of Candour - Written apology within 10 working days
- Friends & Family - A&E Score
- Friends & Family - Birth Score
- Mortality - HSMR
- Mortality - SHMI

Count: 3

Assure

- Infections - E.Coli (Cumulative)
- Infections - Pseudomonas aeruginosa (Cumulative)
- Patient Safety Incidents - Low harm

b. Northern Lincolnshire & Goole Hospitals Quality AAA Summary

Count: 6

Alert

- Care Hours per Patient Day - Unregistered
- Duty of Candour - Written apology
- Friends & Family - A&E Score
- Infections - MRSA
- Infections - MRSA (per 1,000 bed days)
- PALS - Complaints

Count: 1

Advise

- Friends & Family - Postnatal Community Score

Count: 5

Assure

- Care Hours per Patient Day - Registered
- Friends & Family - Community Score
- Friends & Family - Inpatient Score
- Infections - Klebsiella (Cumulative)
- Mortality - HSMR

Experience

Experience narrative updated for June 2026.

Summary

Patient Experience performance remains variable across HUTH and NLAG. The scorecards scope complaints 60-day compliance, complaints received and PALS complaints as the core measures of responsiveness to patient concerns. The strongest improvement signal is complaints 60-day compliance, which has trended positively since October 2025, although performance remains below the stated compliance level. Complaints received and PALS complaints continue to show variation, indicating the need for ongoing review of themes, hotspots and early resolution.

Progress

Since October 2025, both Trusts have shown improved grip on 60-day complaint response timeliness, but further consistency is required to meet the standard reliably. Complaints received remain variable with no clear sustained reduction, and PALS complaints also remain variable across the period. The pattern suggests that while response timeliness is improving, earlier resolution and thematic learning are not yet consistently reducing formal complaint or PALS activity.

Action

Sustain the improvement in 60-day complaint compliance through divisional ownership, overdue case escalation and routine review of response quality. Strengthen early resolution of concerns to reduce avoidable escalation from PALS to formal complaints, with service-level hotspot review, repeat-theme analysis and evidence of learning embedded through patient experience governance.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Caring	Experience	Friends & Family - A&E Score	≥ 85.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	72.4%	70.8%	90.0%	71.4%	66.7%	100.0%	
		Friends & Family - Antenatal Score	≥ 95.0%	100.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	81.8%	50.0%	93.8%	100.0%	82.4%	
		Friends & Family - Birth Score	≥ 95.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
		Friends & Family - Inpatient Score	≥ 95.0%	98.8%	94.8%	97.8%	98.8%	97.2%	96.2%	96.5%	97.1%	96.1%	96.9%	89.0%	96.9%	
		Friends & Family - Outpatient Score	≥ 95.0%	98.8%	98.8%	96.7%	97.8%	96.7%	94.1%	98.6%	97.1%	96.1%	96.2%	96.2%	97.9%	
		Friends & Family - Postnatal Score	≥ 95.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	66.7%	85.7%	100.0%	100.0%	75.0%	
Responsive	Experience	Complaints - 60 day compliance	≥ 85.0%	66.7%	68.2%	71.0%	24.6%	35.4%	51.9%	40.0%	53.5%	50.0%	64.5%	48.8%	57.6%	64.4%
		Complaints - Average response time	≤ 40.0	141.4	164.4	122.8	116.6	112.1	76.6	77.5	65.2	69.9	47.5	65.8	60.6	48.7
		Complaints - Received		42	36	47	51	56	36	31	35	26	18	49	29	28
		Complaints - Received (per 1,000 bed days)		1.19	1.04	1.37	1.32	1.63	1.11	0.99	1.22	0.69	0.51	1.60	0.93	0.90
		Complaints - Reopened		2	3	3	2	1	4	2	2	4	3	1	0	1
		PALS - Complaints	≤ 1	320	280	250	397	272	241	254	216	140	64	219	159	130
		PALS - Complaints compliance within 5 working days		55.5%	49.6%	46.9%	52.5%	42.9%	42.0%	38.3%	47.4%	41.1%	46.6%	55.3%	33.0%	36.4%

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

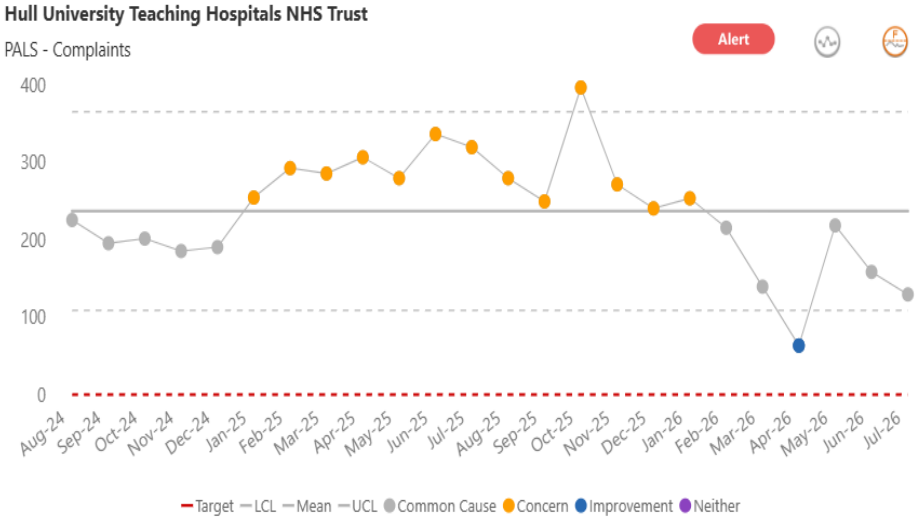
Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Caring	Experience	Friends & Family - A&E Score	≥ 85.0%	81.9%	82.0%	75.6%	75.6%	75.6%	75.0%	76.8%	76.8%	76.4%	79.4%	74.3%	76.0%	
		Friends & Family - Antenatal Score	≥ 95.0%	80.7%	82.8%	65.6%	65.6%	76.2%	75.8%	68.0%	96.3%	87.0%	100.0%	66.7%	66.7%	
		Friends & Family - Birth Score	≥ 95.0%	100.0%	91.7%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	
		Friends & Family - Inpatient Score	≥ 95.0%	98.7%	95.8%	97.4%	97.4%	97.5%	97.2%	97.5%	98.2%	98.7%	98.5%	98.4%	98.6%	
		Friends & Family - Outpatient Score	≥ 95.0%	95.5%	95.1%	96.9%	96.9%	95.9%	97.7%	95.1%	96.9%	95.5%	97.9%	96.3%	97.9%	
		Friends & Family - Postnatal Score	≥ 95.0%	100.0%	92.9%	100.0%	100.0%	92.9%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	66.7%	
Responsive	Experience	Complaints - 60 day compliance	≥ 85.0%	73.3%	36.6%	50.0%	37.1%	53.1%	67.9%	48.3%	63.9%	71.8%	78.6%	59.2%	72.2%	62.1%
		Complaints - Average response time	≤ 40.0	47.3	69.3	59.5	74.2	67.2	43.8	63.3	55.3	40.8	45.8	48.6	42.4	48.8
		Complaints - Received		29	28	27	20	26	19	47	45	43	46	34	26	45
		Complaints - Received (per 1,000 bed days)		1.45	1.44	1.39	0.97	1.29	0.91	2.22	2.33	2.12	2.30	1.63	1.29	2.21
		Complaints - Reopened		5	3	1	1	7	0	5	4	2	6	1	0	0
		PALS - Complaints	≤ 1	259	221	247	278	228	240	262	208	233	253	226	248	263
		PALS - Complaints compliance within 5 working days		65.2%	59.6%	60.9%	59.0%	56.1%	57.3%	61.4%	63.4%	64.8%	66.9%	63.3%	54.0%	59.9%

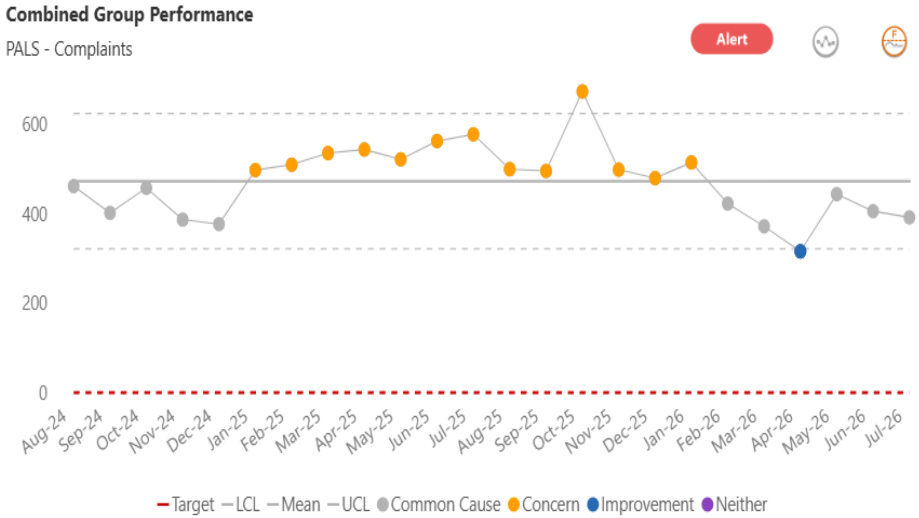
i. PALS Concerns

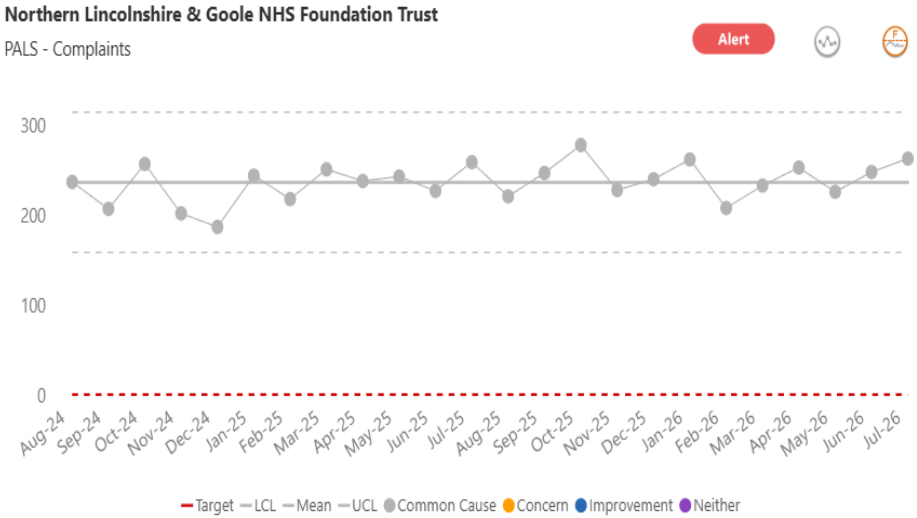
PALS - Complaints

HUTH:
PALS complaints show continued variation across the period, with the latest position requiring ongoing review of themes and service-level hotspots. The trend should be interpreted alongside formal complaints received and complaints 60-day compliance to understand whether concerns are being resolved early or escalating into formal complaint routes.

NLAG:
NLAG also shows variation in PALS complaints, with no clear sustained improvement evident from the chart. Continued focus is required on early resolution, responsiveness to patient concerns and thematic learning, particularly where repeat issues are identified across services.







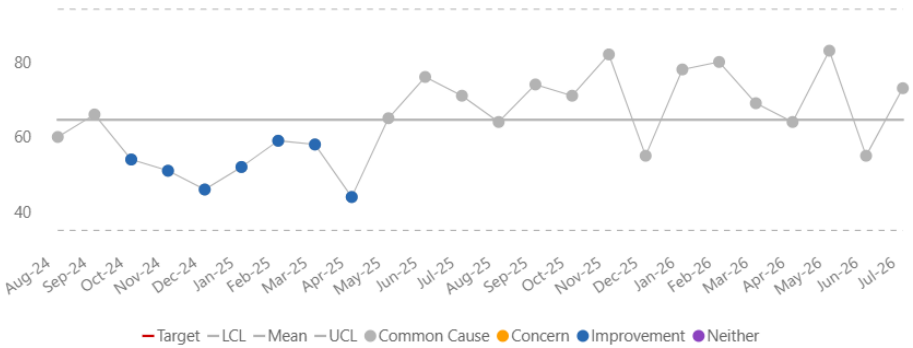
Sample pages only – awaiting further Lead review

ii. Complaints Received

Complaints - Received

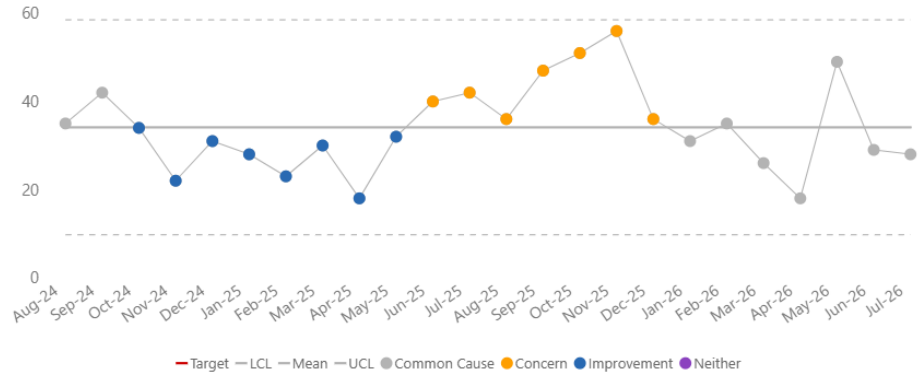
Complaints received show variation across the period, with the latest trend not clearly demonstrating sustained improvement.

Continued focus is required on complaint themes, service-level hotspots and early resolution, particularly where repeated issues are driving formal complaints.



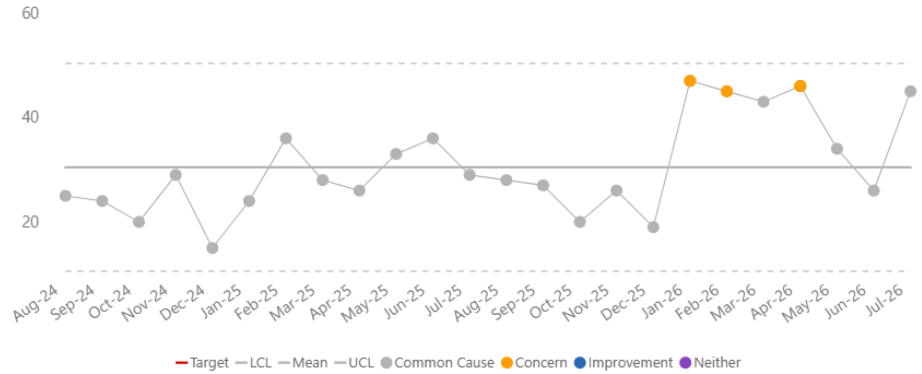
Hull University Teaching Hospitals NHS Trust

Complaints - Received



Northern Lincolnshire & Goole NHS Foundation Trust

Complaints - Received



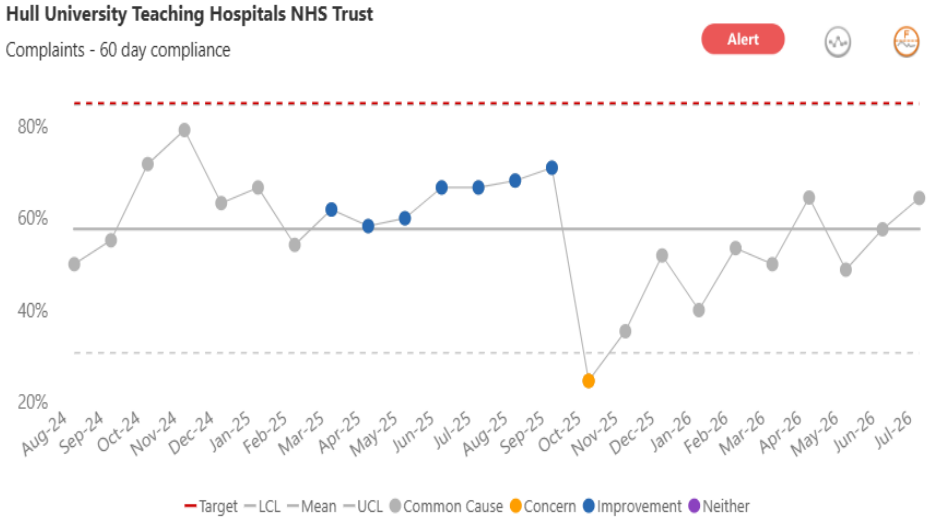
Sample pages only – awaiting further Lead review

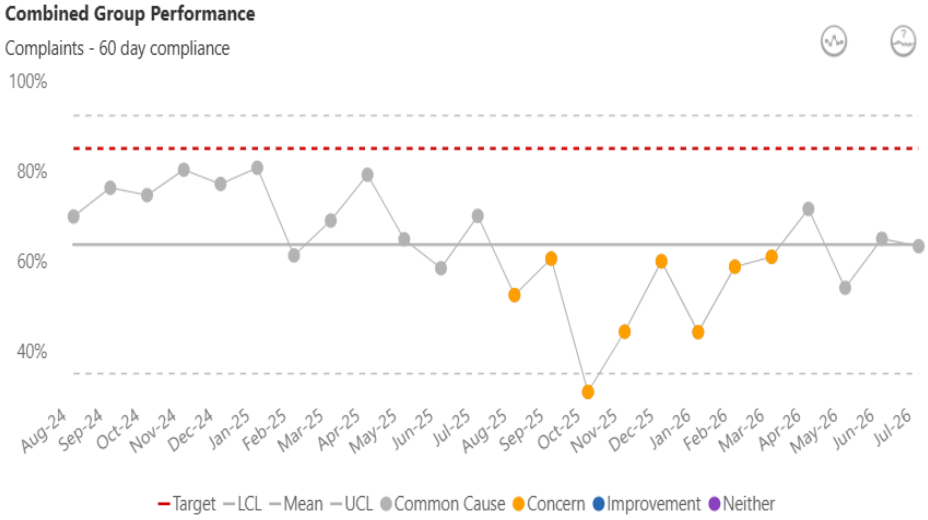
iii. Complaints 60 Day Compliance

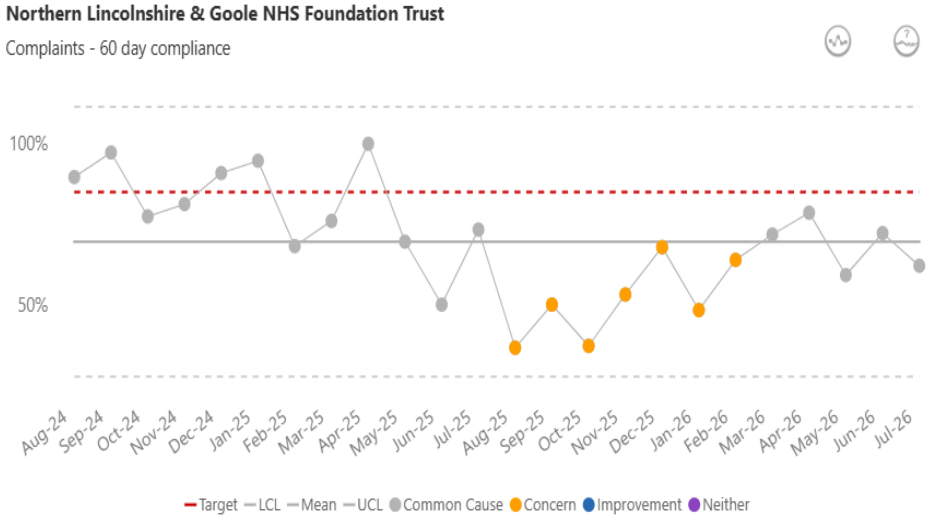
Complaints - 60 day compliance

Overall improving trend since October 2025, with recent performance indicating better grip on complaint response timeliness but ultimately underneath stated compliance levels.

Continued focus is required to sustain this improvement, reduce variation and ensure responses remain within the 60-day standard.







c. Safety

Summary

Safety performance remains mixed. HUTH's overall Care Hours per Patient Day remains under target at 7.6, driven by the unregistered staff group. NLAG also has pressure in unregistered staffing, but stronger registered staffing keeps the overall CHPPD position above target. Infection prevention remains a key safety risk, with C. difficile, MRSA and E. coli requiring continued oversight.

Progress

For infection indicators, the latest FYTD position is C. difficile: HUTH 26 and NLAG 12, with the latest reported month showing HUTH 10 and NLAG 3. MRSA is HUTH 0 YTD and 0 latest month, while NLAG is 5 YTD with 3 in the latest reporting period. E. coli is HUTH 17 FYTD and NLAG 67 FYTD, showing a materially greater burden at NLAG.

Action

Maintain ward-level safe staffing review, with specific focus on HUTH unregistered fill and NLAG skill-mix balance. Continue systematic IPC case review, thematic learning, antimicrobial stewardship and targeted improvement plans for C. difficile, MRSA and E. coli, with particular executive focus on NLAG MRSA and E. coli and HUTH C. difficile latest-month activity.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

Oversight | CQC

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

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Safe	Patient Safety	Care Hours per Patient Day - Overall	≥ 9.0	7.4	7.3	7.2	7.6	7.6	7.5	7.4	7.3	7.4	7.6			
		Care Hours per Patient Day - Registered	≥ 5.0	5.0	4.9	4.9	5.0	5.2	5.2	5.1	5.0	5.1	5.2			
		Care Hours per Patient Day - Unregistered	≥ 4.0	2.4	2.4	2.3	2.6	2.4	2.3	2.3	2.3	2.3	2.4			
		Falls - Serious harm or death		5	3	4	1	0	5	4	4	3	1	2	2	2
		Falls - Total incidents		262	260	279	286	258	271	308	262	284	222	235	214	244
		Infections - C.Difficile		11	6	8	6	6	8	16	9	11	16	10	8	
		Infections - E.Coli		22	20	19	17	14	13	12	16	14	23	17	13	
		Infections - Klebsiella		16	0	3	7	10	5	7	3	10	6	5	8	
		Infections - MRSA		0	0	0	0	0	1	0	0	1	0	0	0	
		Infections - MSSA		7	6	8	12	7	5	8	11	8	11	3	5	
		Infections - Pseudomonas aeruginosa		4	0	3	6	1	4	1	1	2	2	3	1	
		Medication Incidents		117	148	148	103	120	127	94	109	115	100	117	105	102
		Patient Safety Incidents - % Harmful		2.0%	2.3%	3.2%	3.8%	2.7%	3.2%	2.6%	2.1%	2.4%	1.5%	2.0%	1.8%	2.6%
		Patient Safety Incidents - Fatal		2	1	7	4	2	8	3	4	7	2	5	3	4
		Patient Safety Incidents - Moderate harm		35	37	49	63	44	51	43	32	44	29	34	28	50
		Patient Safety Incidents - Severe harm		5	7	9	12	5	5	8	6	5	2	2	5	3
		Pressure Ulcers - Category 3		0	0	0	4	1	2	2	1	1	0	1	1	3
		Pressure Ulcers - Category 4		0	0	0	0	0	0	0	1	0	0	1	0	0
		Pressure Ulcers - Community acquired		314	310	310	390	346	353	406	371	458	416	388	376	397
		Pressure Ulcers - Hospital acquired		63	43	59	109	110	132	129	114	129	146	148	116	135
		Pressure Ulcers - Suspected deep tissue injury		25	16	16	19	26	34	29	22	26	32	27	29	24

Sample pages only – awaiting further Lead review

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Safe	Patient Safety	Care Hours per Patient Day - Overall	≥ 9.0	9.4	10.0	9.5	9.2	9.3	9.0	9.2	9.1	9.7	9.5			
		Care Hours per Patient Day - Registered	≥ 5.0	5.7	6.0	5.7	5.5	5.7	5.6	5.6	5.6	6.0	5.8			
		Care Hours per Patient Day - Unregistered	≥ 4.0	3.7	4.0	3.8	3.7	3.7	3.4	3.6	3.5	3.8	3.7			
		Falls - Serious harm or death		2	1	0	2	0	3	2	0	0	0	0	2	3
		Falls - Total incidents		115	108	107	149	119	136	139	107	108	125	116	122	128
		Infections - C.Difficile		2	4	3	6	4	7	3	3	6	4	3	5	
		Infections - E.Coli		27	20	28	32	20	18	14	26	15	21	25	21	
		Infections - Klebsiella		16	9	6	12	8	10	6	13	9	7	5	6	
		Infections - MRSA		0	1	0	1	0	1	1	1	2	1	3	1	
		Infections - MSSA		3	6	6	9	6	10	6	3	4	3	10	7	
		Infections - Pseudomonas aeruginosa		6	5	3	3	4	4	1	2	2	0	4	3	
		Medication Incidents		79	65	58	69	89	76	82	78	76	65	71	76	79
		Patient Safety Incidents - % Harmful		3.2%	2.7%	3.2%	3.9%	3.9%	3.2%	2.9%	2.6%	3.2%	2.8%	2.7%	2.8%	3.4%
		Patient Safety Incidents - Fatal		3	2	0	1	1	3	1	3	0	0	0	1	2
		Patient Safety Incidents - Moderate harm		46	37	44	60	55	41	46	36	48	46	43	44	47
		Patient Safety Incidents - Severe harm		3	1	3	6	5	4	2	0	0	0	1	2	6
		Pressure Ulcers - Category 3		9	7	11	6	5	10	13	10	6	5	16	8	16
		Pressure Ulcers - Category 4		0	0	2	4	1	1	0	1	2	0	0	1	1
		Pressure Ulcers - Community acquired		392	341	298	382	368	359	390	364	357	405	399	398	377
		Pressure Ulcers - Hospital acquired		222	198	200	244	222	210	267	213	231	210	240	245	207
		Pressure Ulcers - Suspected deep tissue injury		47	34	43	42	40	45	59	54	48	35	51	46	34

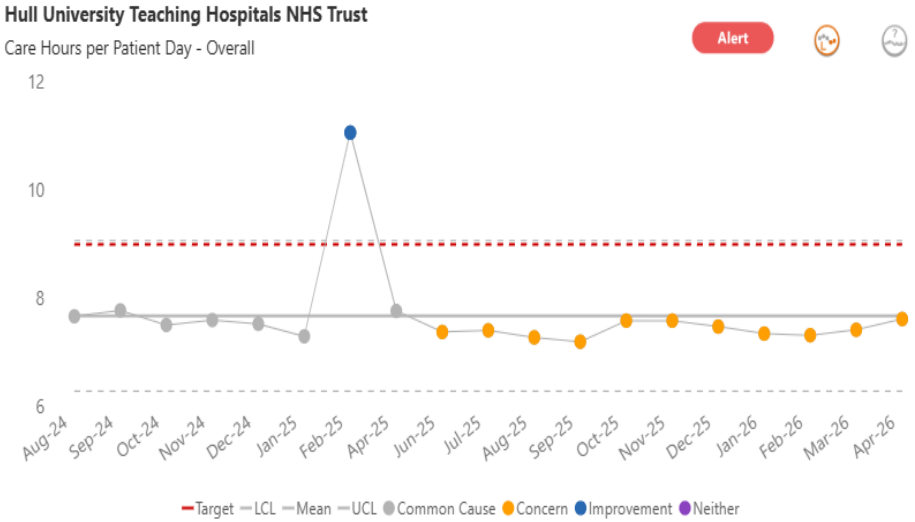
Sample pages only – awaiting further Lead review

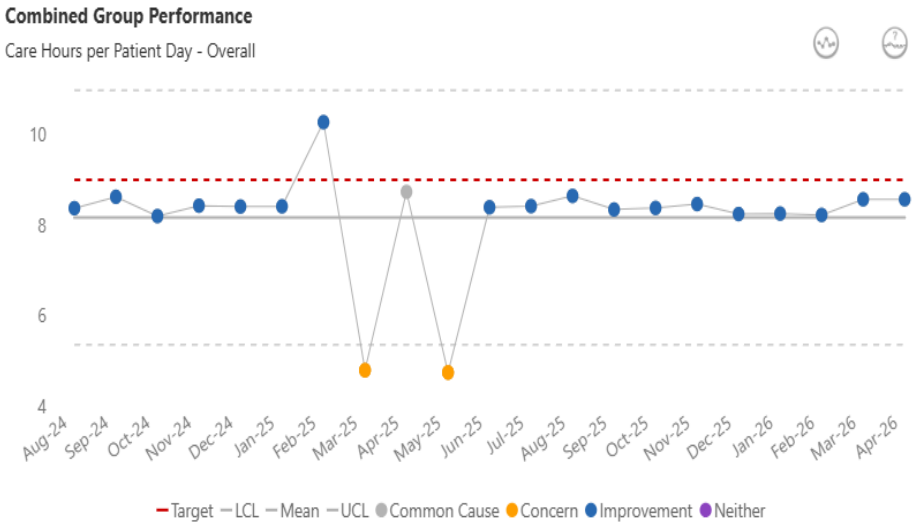
i. Care Hours per Patient Day

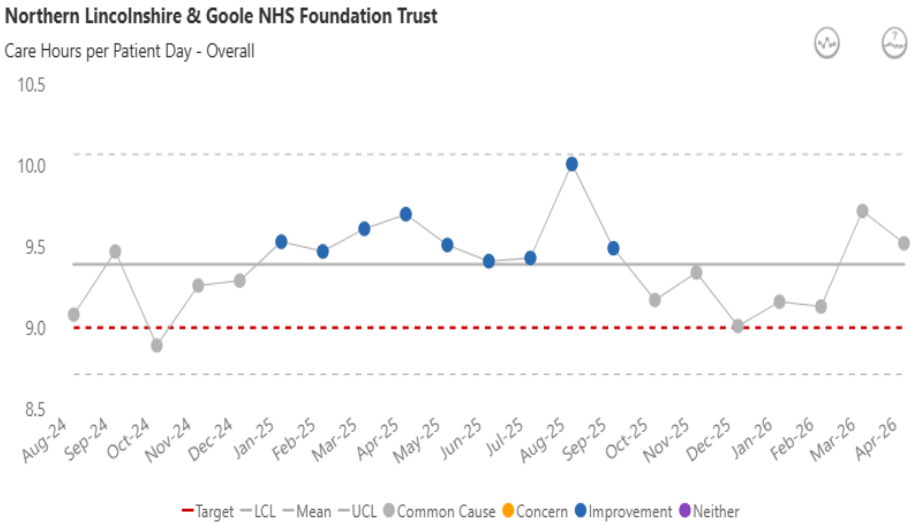
Care Hours per Patient Day - Overall

HUTH:
HUTH's overall Care Hours per Patient Day remains under target at 7.6, with the shortfall driven by the unregistered staff group. This indicates that the overall staffing position is being constrained by support workforce capacity, requiring continued ward-level review of roster fill, deployment and escalation where unregistered hours are below planned levels.

NLAG:
NLAG also shows pressure within the unregistered staff group, but this is offset by stronger registered staff performance, keeping the overall Care Hours per Patient Day position above target.







Sample pages only – awaiting further Lead review

ii. C.Difficile Cases

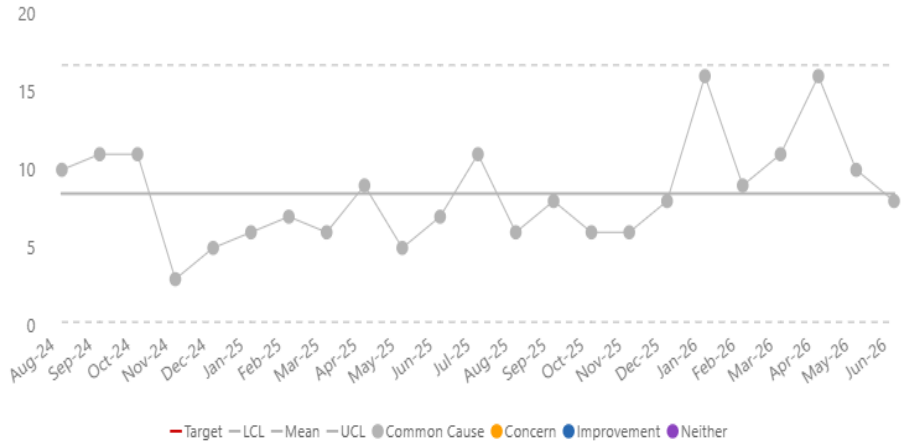
Infections - C.Difficile

HUTH:
C. difficile cases are 26 YTD with 10 confirmed in May

NLAG:
C. difficile cases are 12 YTD with 3 reported for May.

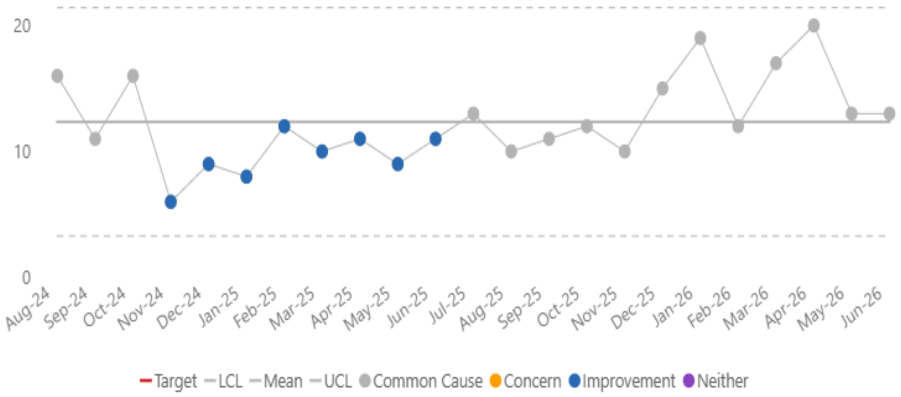
Hull University Teaching Hospitals NHS Trust

Infections - C.Difficile



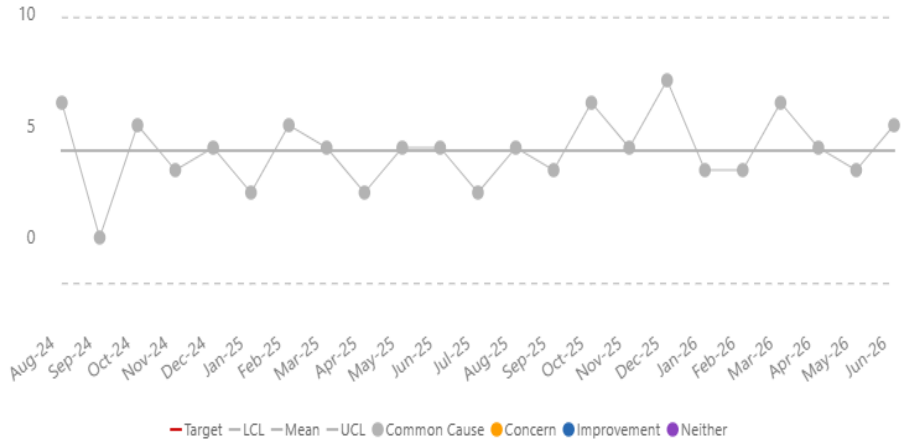
Combined Group Performance

Infections - C.Difficile



Northern Lincolnshire & Goole NHS Foundation Trust

Infections - C.Difficile

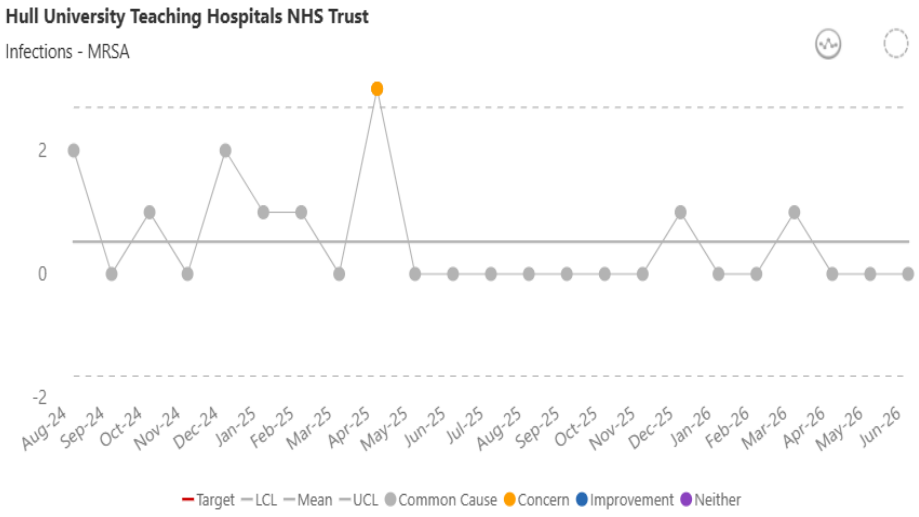


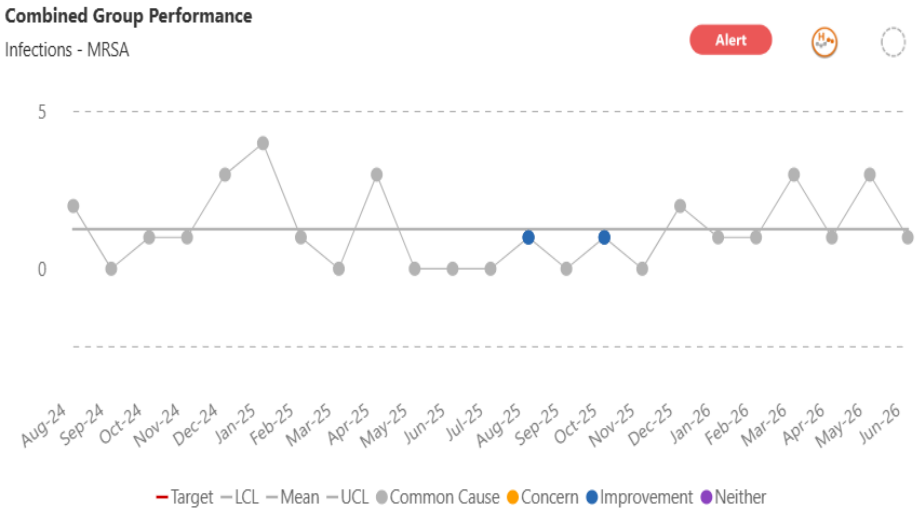
iii. MRSA Cases

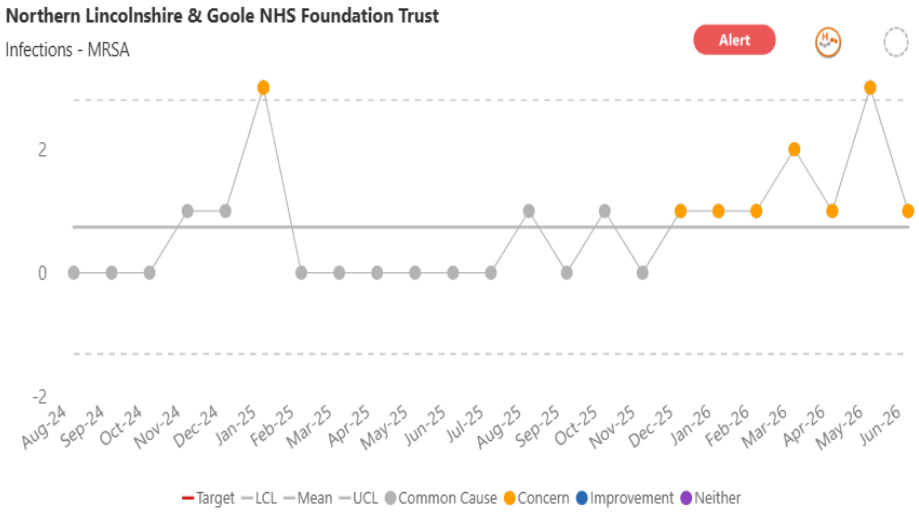
Infections - MRSA

HUTH:
MRSA cases are 0 YTD, with 0 cases in the latest month.

NLAG:
MRSA cases are 5 YTD, with 3 cases in the latest reporting period.



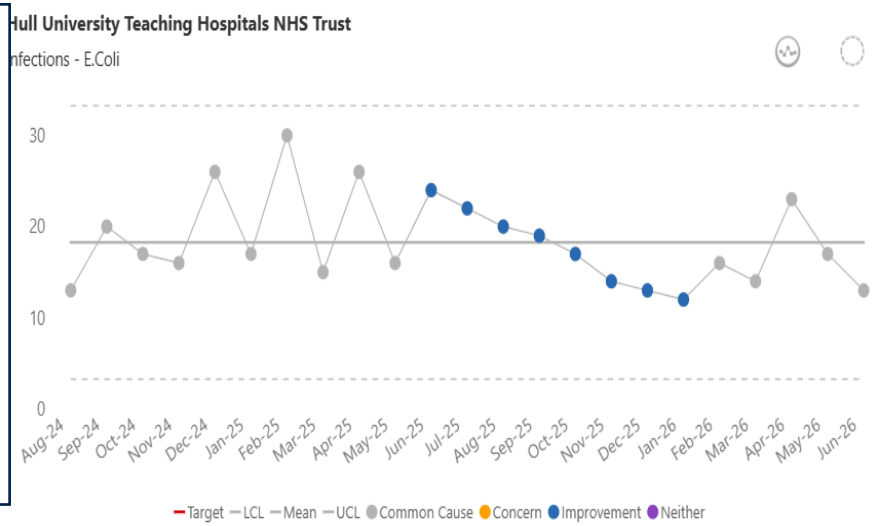


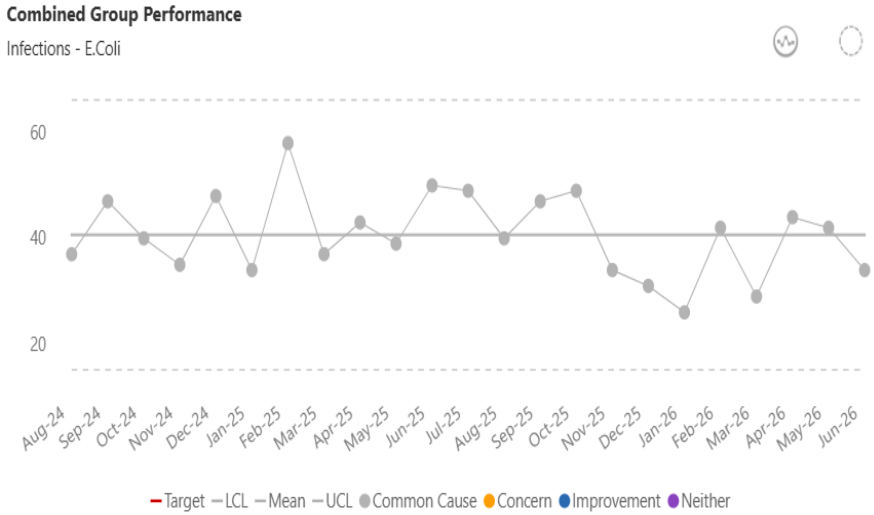


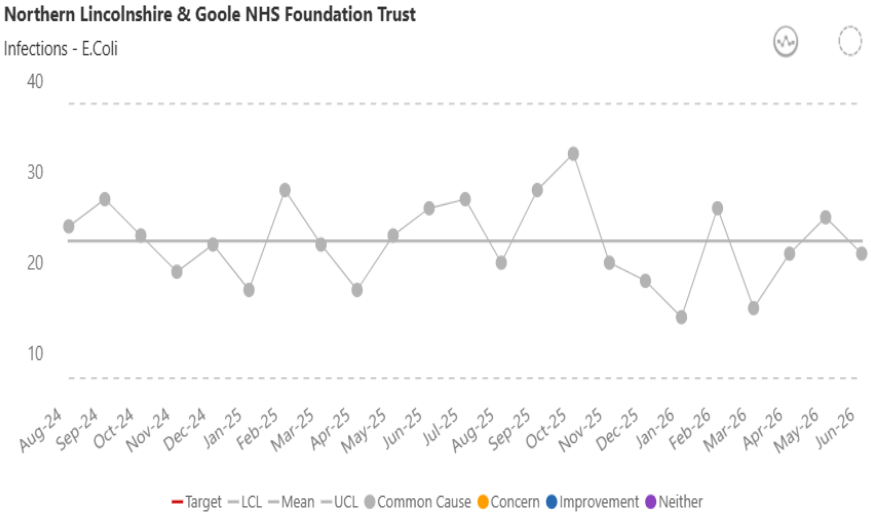
iv. E.Coli Case

HUTH:
E. coli cases are reported at 17 FYTD. The chart should be read as showing ongoing monthly variation, with the latest position materially lower than NLAG.

NLAG:
E. coli cases are reported at 67 FYTD. The chart indicates continued variation over time, but the overall FYTD position shows NLAG carries the greater E. coli burden across the Group and remains the primary focus for infection prevention oversight.







d. Effectiveness

Summary

Effectiveness performance is broadly stable overall, with continued monitoring required across VTE assessment, SHMI and emergency readmissions. VTE assessment compliance remains variable and requires consistent completion within the 14-hour standard. SHMI should be interpreted factually as a statistical indicator, with review focused on whether reported values remain within expected limits. Emergency readmissions within 30 days appear broadly stable at both Trusts, with no clear sustained deterioration indicated.

Progress

HUTH and NLAG both require continued operational grip on timely VTE assessment, particularly as national changes to emergency admission VTE assessment timing from DTA are expected to affect Quarter 3 performance. SHMI reporting continues through separate detailed releases to clinical leads, with clinical coding quality remaining an important factor in interpretation. Readmissions remain an effectiveness indicator for both Trusts and should continue to be reviewed alongside discharge quality, follow-up arrangements, frailty pathways and avoidable readmission themes.

Action

Maintain ward- and specialty-level oversight of VTE assessment compliance, with escalation where completion within 14 hours is inconsistent. Continue factual SHMI review through established clinical governance and coding assurance routes. For readmissions, strengthen specialty-level review of themes, discharge planning, post-discharge support and community interface actions where variation emerges.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Effective	Effectiveness	Inpatient - Emergency Readmissions within 30 days		10.6%	10.8%	10.3%	10.5%	10.1%	10.5%	10.2%	10.4%	10.4%	10.1%	10.2%	10.0%	
		Mortality - Crude Mortality (non-elective)		2.0%	2.5%	2.5%	2.8%	3.2%	3.2%	3.2%	3.2%	2.9%	2.6%	2.8%	2.4%	2.3%
		Mortality - HSMR	≤ 100.0	103.5	101.9	101.0	99.9	100.1	100.1	98.6	98.7	98.9	98.9			
		Mortality - SHMI	≤ 1.0	1.032	1.020	1.025	1.018	1.023	1.027	1.024	1.038	1.047				
		Mortality - Still Births (per 1,000 births)		7.833	2.625	2.439	7.979	2.632	5.115	7.444	2.890	7.853	10.526	0.000	0.000	11.655
Safe	Patient Safety	Clinical Harm Reviews - Cancer 104 day wait		55	83	71					0	0	0	0	0	0
		Clinical Harm Reviews - RTT 78 week wait		0	2	0									0	0
		VTE Risk Assessment	≥ 95.0%	94.2%	93.6%	93.5%	92.4%	92.1%	92.5%	91.8%	91.8%	92.0%	92.3%	92.6%	92.9%	91.8%
		VTE Risk Assessment 14 Hour Standard	≥ 95.0%	93.1%	92.0%	91.7%	90.5%	90.7%	90.9%	90.1%	90.8%	91.2%	91.8%	92.0%	92.2%	

Sample pages only – awaiting further Lead review

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Effective	Effectiveness	Inpatient - Emergency Readmissions within 30 days		11.1%	10.9%	11.7%	11.5%	10.9%	11.3%	11.2%	11.6%	11.0%	11.3%	11.0%	11.0%	
		Mortality - Crude Mortality (non-elective)		1.4%	1.6%	1.6%	1.6%	1.8%	2.4%	1.8%	1.9%	1.9%	1.9%	2.3%	1.9%	1.6%
		Mortality - HSMR	≤ 100.0	93.3	93.5	92.3	90.6	89.8	88.5	85.4	85.3	84.8	84.8			
		Mortality - SHMI	≤ 1.0	1.024	1.030	1.021	1.009	1.001	0.999	0.976	0.977	0.993				
		Mortality - Still Births (per 1,000 births)		0.000	6.135	0.000	9.804	6.024	0.000	3.413	6.645	6.452	3.401	0.000	0.000	0.000
Safe	Patient Safety	Clinical Harm Reviews - Cancer 104 day wait													0	
		Clinical Harm Reviews - RTT 78 week wait													0	
		VTE Risk Assessment	≥ 95.0%	96.0%	96.2%	96.5%	95.5%	92.2%	95.6%	96.1%	95.8%	95.7%	96.9%	96.8%	96.7%	96.6%
		VTE Risk Assessment 14 Hour Standard	≥ 95.0%	93.0%	93.0%	93.7%	93.1%	88.1%	92.6%	93.6%	93.2%	93.3%	94.8%	94.8%	94.5%	

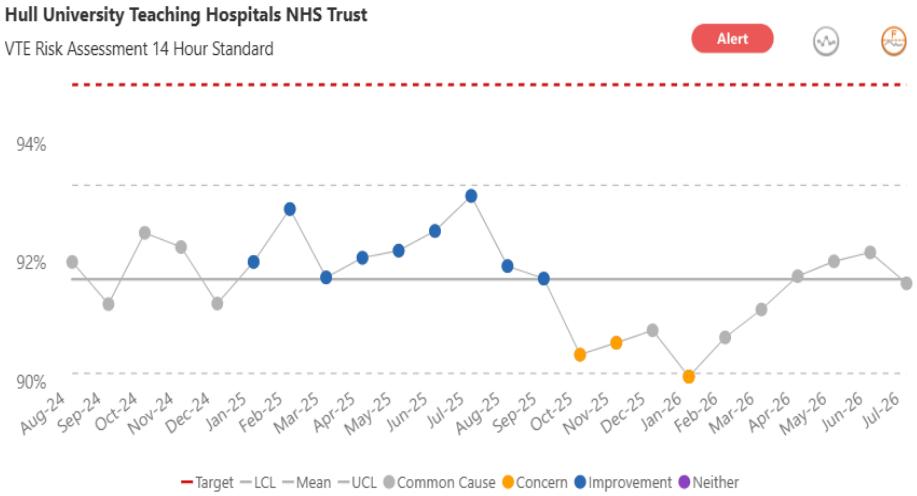
i. VTE Assessment within 14hrs

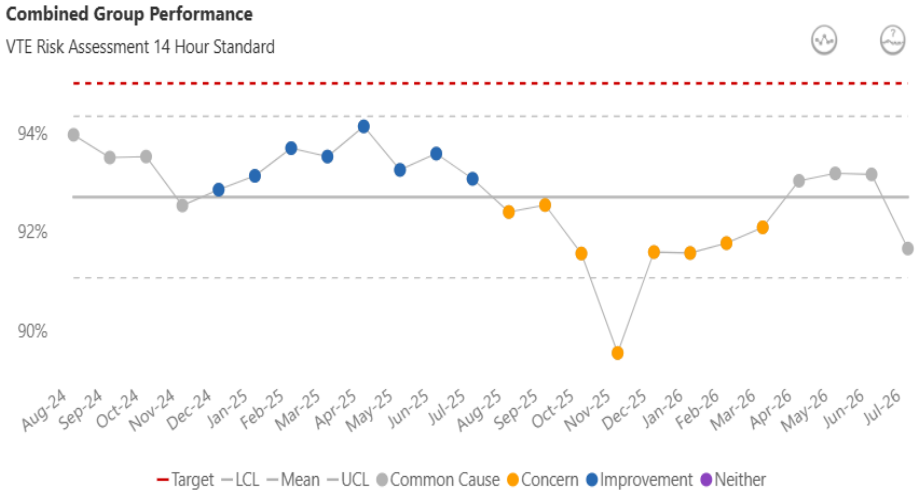
VTE Risk Assessment 14 Hour Standard

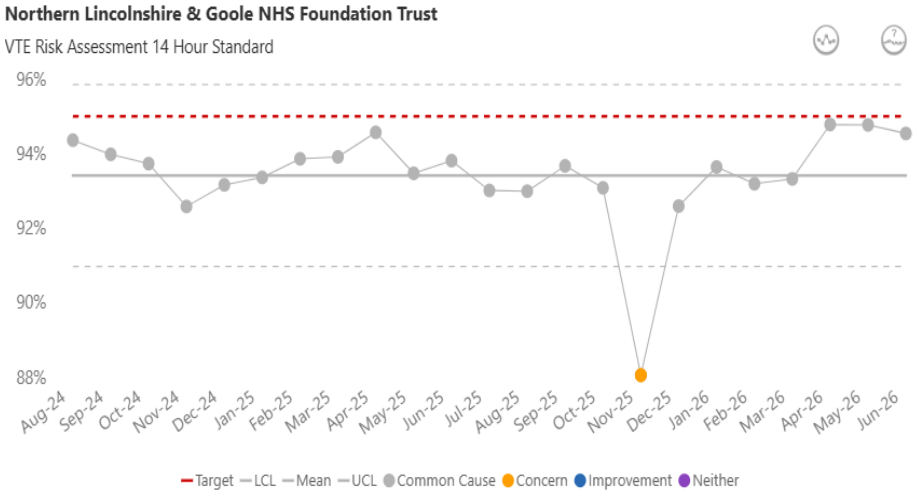
Compliance should continue to be monitored closely, with focus on consistent completion within the required 14-hour standard and follow-up of any areas falling below expected practice.

Continued operational oversight is required to ensure timely VTE assessment completion, with escalation where ward or specialty-level compliance is inconsistent.

National changes to VTE Risk Assessments for Emergency Admissions needing to include time from DTA will have a material impact upon our performance in Quarter 3.





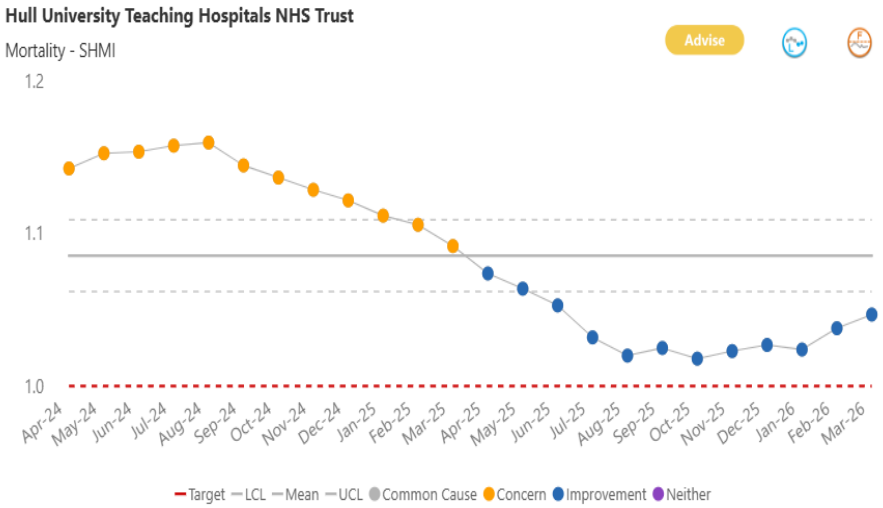


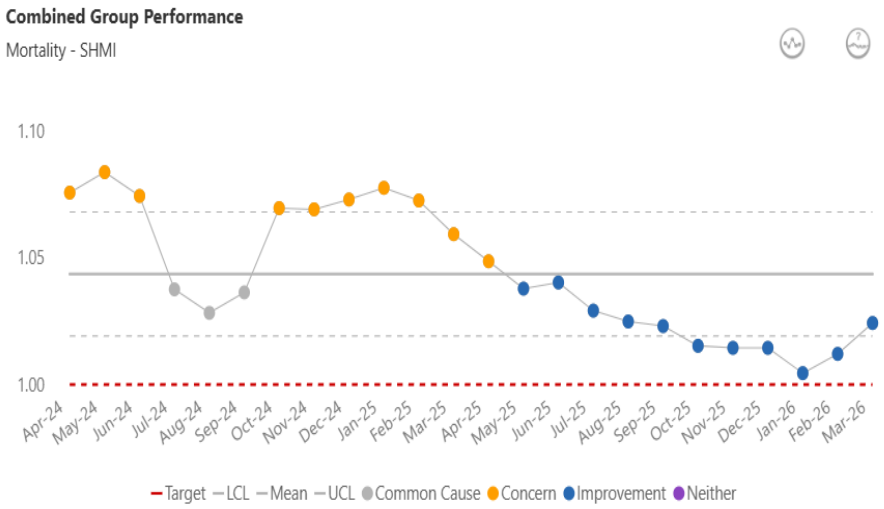
ii. Summary Hospital Mortality Indicator

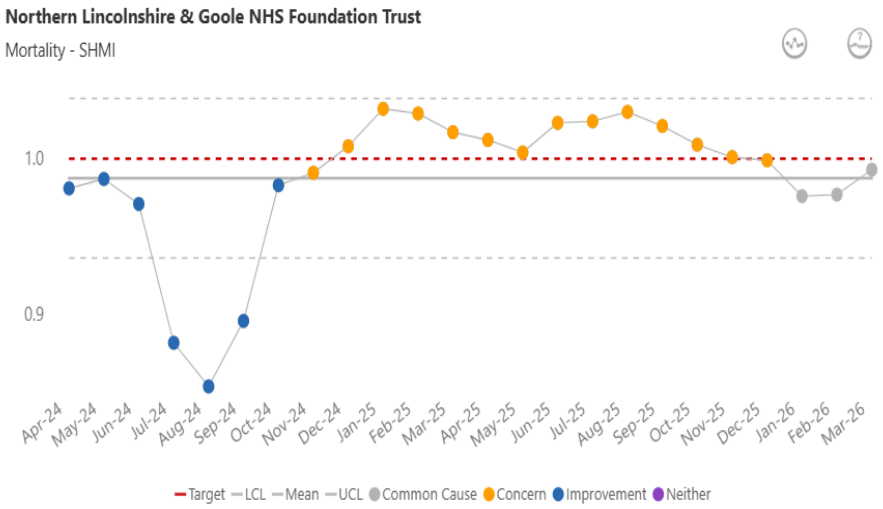
The recent data points should be interpreted as a statistical trend position only, with review focused on whether the indicator remains within expected limits or shows any sustained variation.

Separate and detailed SHMI reporting is providing to Clinical Leads upon each release of national data.

Several factors can impact and influence the SHMI score, with the ability to host well resourced Clinical Coding services crucial for accuracy.







iii. Emergency Readmissions within 30 Days

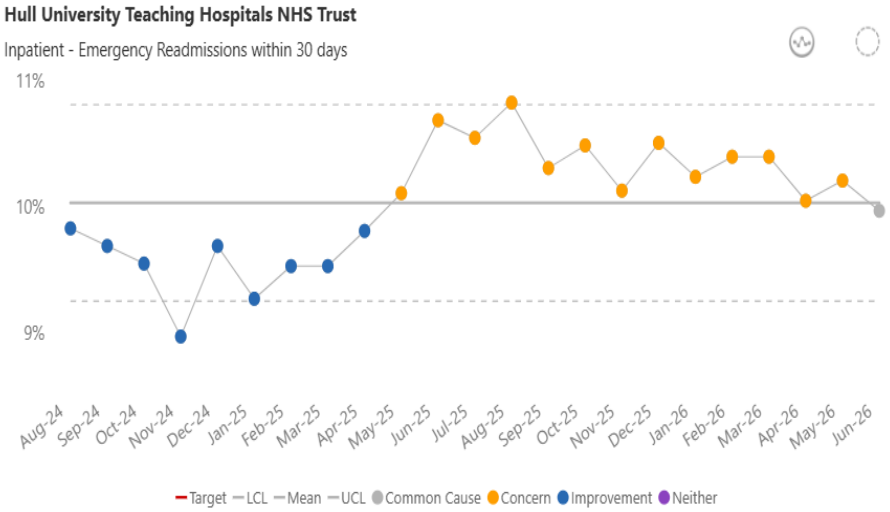
Inpatient - Emergency Readmissions within 30 days

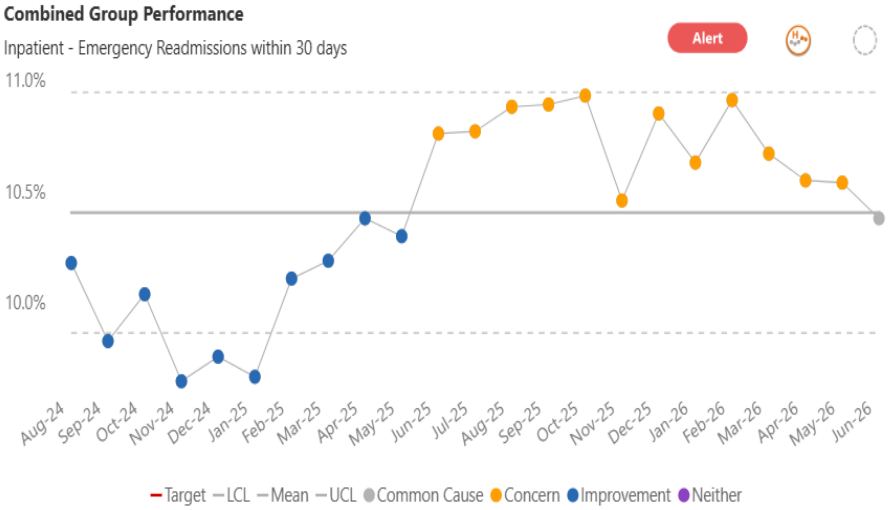
HUTH:

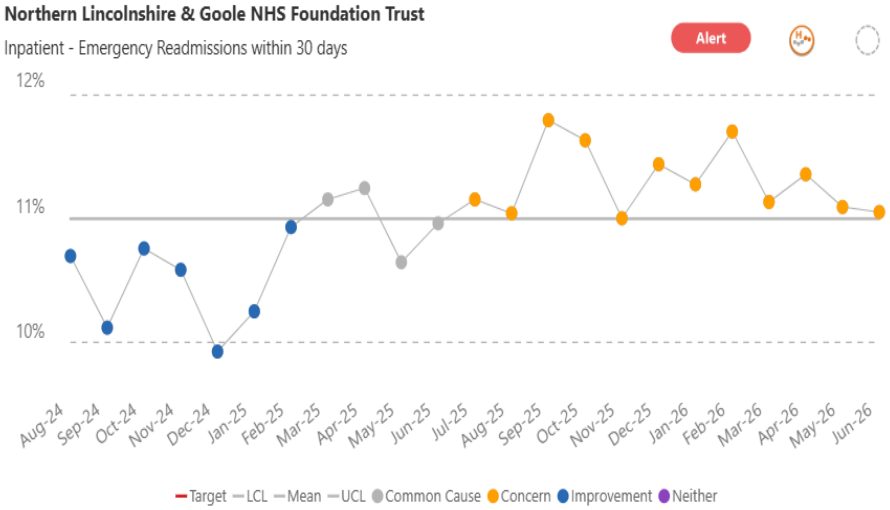
Emergency readmissions within 30 days show a relatively stable trend, with recent performance appearing to remain within expected variation rather than demonstrating a sustained improvement or deterioration. The position should continue to be monitored through specialty-level review, with focus on discharge quality, follow-up arrangements and readmission themes where variation emerges.

NLAG:

NLAG also appears broadly stable, with no clear sustained shift evident in the recent data. While the trend does not suggest an immediate deterioration, readmissions remain an important effectiveness indicator and should continue to be reviewed alongside discharge planning, frailty, community support and avoidable readmission analysis.







Sample pages only – awaiting further Lead review

6. HHP Group Executive Summary – Workforce

Executive Lead: Helen Marks, Group Chief People Officer

Accountable to:

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
Healthcare Worker Flu Vaccination Rate	Apr-26	≥ 60.0%	51.0%		
Staff Appraisal Rate (AfC)	Jun-26	≥ 85.0%	82.2%		
Staff e-Job Planning	Jul-26	≥ 95.0%	94.3%		
Staff Mandatory Training - Core	Jun-26	≥ 85.0%	88.5%		
Staff Mandatory Training - Role Specific	Jun-26	≥ 85.0%	83.5%		
Staff Sickness Absence Rate	Jun-26	≤ 4.0%	4.4%		
Staff Survey - Raising Concerns sub-score	Jul-26		6.1		
Staff Time to Employment Checks	Jul-26	≤ 20.0	21.0		
Staff Time to Offer	Jul-26	≤ 2.0	2.4		
Staff Time to Shortlist	Jul-26	≤ 5.0	7.6		
Staff Turnover Annual FTE Rate	Jun-26	≤ 8.0%	12.2%		

Northern Lincolnshire and Goole NHS Foundation Trust

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

Metric	Month	Target	Result	Var	Asr
Healthcare Worker Flu Vaccination Rate	Apr-26	≥ 60.0%	51.1%		
Staff Appraisal Rate (AfC)	Jun-26	≥ 85.0%	81.4%		
Staff e-Job Planning	Jul-26	≥ 95.0%	94.3%		
Staff Mandatory Training - Core	Jun-26	≥ 85.0%	85.5%		
Staff Mandatory Training - Role Specific	Jun-26	≥ 85.0%	82.0%		
Staff Sickness Absence Rate	Jun-26	≤ 4.0%	5.4%		
Staff Survey - Raising Concerns sub-score	Jul-26		6.1		
Staff Time to Employment Checks	Jul-26	≤ 20.0	21.6		
Staff Time to Offer	Jul-26	≤ 2.0	7.4		
Staff Time to Shortlist	Jul-26	≤ 5.0	7.5		
Staff Turnover Annual FTE Rate	Jun-26	≤ 8.0%	11.9%		

Chief People Officer Update – Workforce Overview (July 2026)

Summary

The workforce position remains mixed across the Group, with the clearest risk in workforce availability and recruitment responsiveness. HUTH sickness absence is showing a deteriorating signal, with the latest four data points above the mean, indicating a sustained adverse shift rather than normal variation. NLAG sickness absence is more stable, remaining around the mean. Across both Trusts, appraisal and role-specific mandatory training remain variable without evidence of sustained improvement. Recruitment timeliness is also variable, with NLAG **Staff Time to Offer** in **Alert**, highlighting a specific risk in converting recruitment activity into timely offers.

Progress

HUTH's workforce culture and experience position is most affected by the sickness absence trend, while appraisal and role-specific mandatory training require continued grip to improve consistency. NLAG does not show the same deterioration in sickness absence, but appraisal and role-specific training completion remain inconsistent. In recruitment and retention, HUTH appears broadly stable but variable across shortlist, offer and employment check stages, with no clear sustained improvement. NLAG shows greater risk across the recruitment pathway, particularly at the offer stage, where the alert status indicates delay against trajectory. Employment checks at both Trusts appear broadly stable but remain a potential later-stage recruitment bottleneck if not actively managed.

Action

Executive focus should remain on targeted sickness absence intervention at HUTH, including divisional hotspot review, attendance management and wellbeing support. Across both Trusts, strengthen workforce governance for appraisal and role-specific mandatory training completion, with routine escalation of areas below trajectory. Recruitment actions should focus on end-to-end pathway grip from vacancy review to start date, including manager shortlisting, interview outcome turnaround, offer approvals and employment check completion. Priority escalation is required for NLAG Time to Offer, with named ownership of delays and routine monitoring of bottlenecks to protect workforce supply.

Sample pages only – awaiting further Lead review

a. Hull University Teaching Hospital Workforce AAA Summary

Count: 6

Alert

Healthcare Worker Flu Vaccination Rate
Staff Appraisal Rate (AfC)
Staff Mandatory Training - Role Specific
Staff Sickness Absence Rate
Staff Time to Shortlist
Staff Turnover Annual FTE Rate

Count: 1

Advise

Staff Time to Offer

Count: 2

Assure

Staff Mandatory Training - Core
Staff Survey - Raising Concerns sub-score

b. Northern Lincolnshire & Goole Hospitals Workforce AAA Summary

Count: 6

Alert

Healthcare Worker Flu Vaccination Rate
Staff Appraisal Rate (AfC)
Staff Mandatory Training - Role Specific
Staff Sickness Absence Rate
Staff Time to Offer
Staff Turnover Annual FTE Rate

Count: 1

Advise

Staff Time to Shortlist

Count: 1

Assure

Staff Survey - Raising Concerns sub-score

c. Staff Culture & Experience

Summary

Staff Culture and Experience remains mixed, with no consistent improvement across the three supporting indicators. The key adverse signal is HUTH sickness absence, where the latest four data points sit above the mean, indicating a recent deterioration. NLAG sickness absence remains around the mean, while appraisal and role-specific mandatory training performance at both Trusts remain variable without sustained improvement.

Progress

HUTH has a clear sickness absence deterioration requiring focus, alongside appraisal and role-specific training trends that remain variable rather than improving. NLAG does not show the same sickness deterioration, with absence broadly around the mean, but appraisal and role-specific training completion remain inconsistent and require continued management grip.

Action

Prioritise targeted action on HUTH sickness absence through divisional hotspot review, attendance management and wellbeing support. Across both Trusts, strengthen accountability for appraisal and role-specific mandatory training completion, with routine monitoring of areas below trajectory, escalation of non-compliance and evidence of recovery through workforce governance.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Safe	Patient Safety	Staff Survey - Raising Concerns sub-score		6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.1
	People & Workforce	Healthcare Worker Flu Vaccination Rate	≥ 60.0%				28.2%	41.5%	50.8%	51.7%	51.6%	51.3%	51.0%			
Well Led	People & Workforce	Staff Appraisal Rate (AfC)	≥ 85.0%	81.0%	79.2%	79.7%	80.7%	81.4%	82.3%	80.9%	80.8%	80.1%	81.5%	81.6%	82.2%	
		Staff Mandatory Training - Core	≥ 85.0%	86.4%	86.5%	86.6%	87.7%	88.2%	88.4%	89.4%	89.0%	89.8%	89.8%	87.8%	88.5%	
		Staff Mandatory Training - Role Specific	≥ 85.0%	82.4%	79.4%	80.4%	82.6%	82.0%	82.7%	83.0%	82.0%	82.8%	83.1%	83.3%	83.5%	
		Staff Sickness Absence Rate	≤ 4.0%	4.1%	4.1%	4.2%	4.2%	4.2%	4.3%	4.1%	4.4%	4.4%	4.4%	4.4%	4.4%	

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Safe	Patient Safety	Staff Survey - Raising Concerns sub-score		6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1
	People & Workforce	Healthcare Worker Flu Vaccination Rate	≥ 60.0%				26.9%	43.0%	50.7%	51.7%	51.7%	51.4%	51.1%			
Well Led	People & Workforce	Staff Appraisal Rate (AfC)	≥ 85.0%	82.0%	82.1%	79.4%	77.9%	78.6%	79.3%	79.3%	78.9%	77.7%	79.1%	79.8%	81.4%	
		Staff Mandatory Training - Core	≥ 85.0%	85.3%	84.9%	86.4%	86.9%	87.5%	84.6%	87.1%	86.9%	89.1%	89.2%	85.1%	85.5%	
		Staff Mandatory Training - Role Specific	≥ 85.0%	85.6%	85.0%	84.7%	83.4%	84.2%	82.7%	80.9%	80.8%	81.5%	80.9%	79.5%	82.0%	
		Staff Sickness Absence Rate	≤ 4.0%	5.6%	5.6%	5.6%	5.5%	5.5%	5.5%	5.5%	5.3%	5.4%	5.4%	5.4%	5.4%	

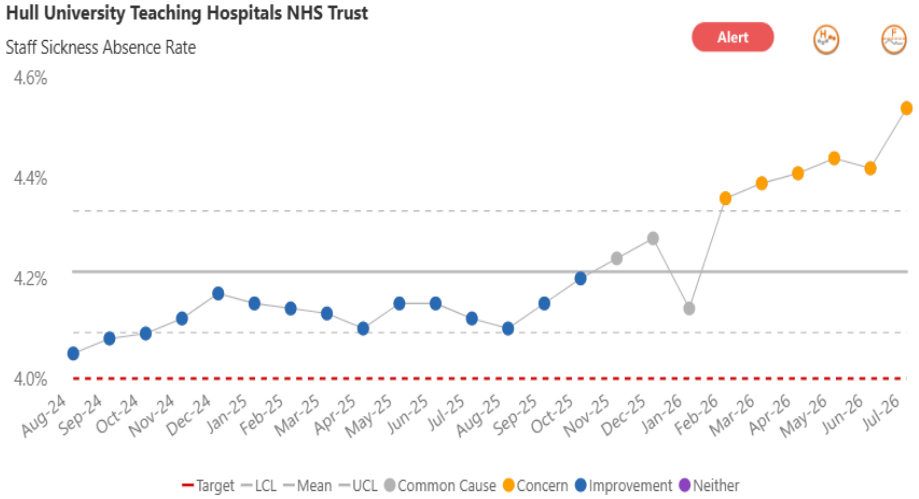
Sample pages only – awaiting further Lead review

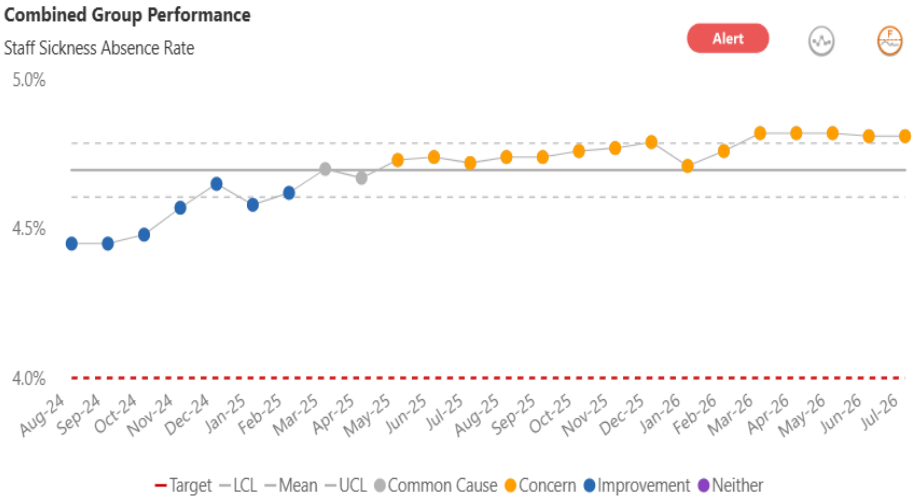
i. Staff Sickness Absence Rate

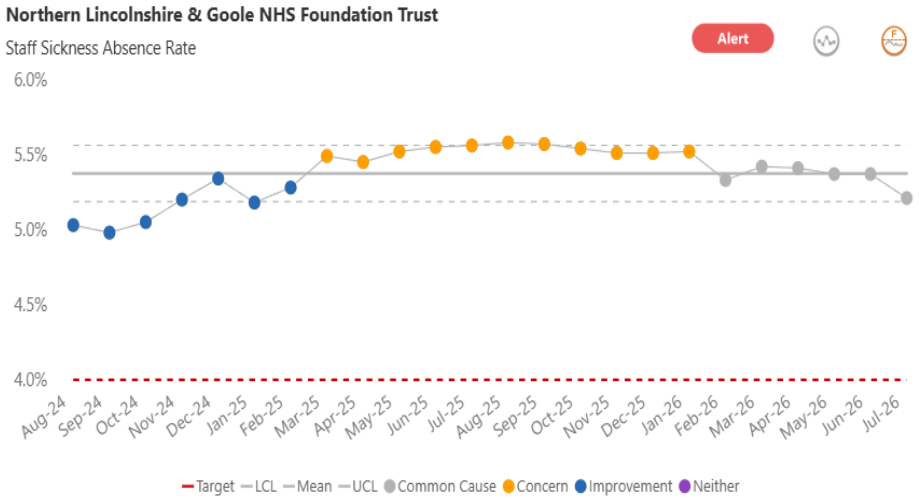
Staff Sickness Absence Rate

HUTH:
Staff sickness absence shows a recent sustained increase, with the latest four data points sitting above the mean. This indicates a deterioration rather than common-cause variation and suggests sickness absence has become a worsening workforce pressure requiring targeted divisional review, hotspot analysis and strengthened attendance management.

NLAG:
NLAG sickness absence remains broadly around the mean, with the latest data points showing normal variation rather than a sustained shift. While absence continues to require active management, the trend does not indicate the same recent deterioration seen at HUTH.







ii. Staff Appraisal Rate (AfC)

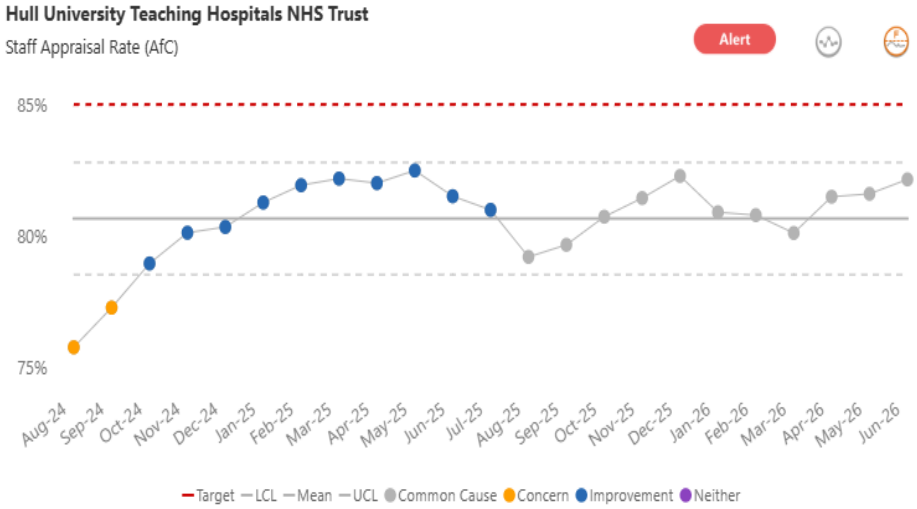
Staff Appraisal Rate (AfC)

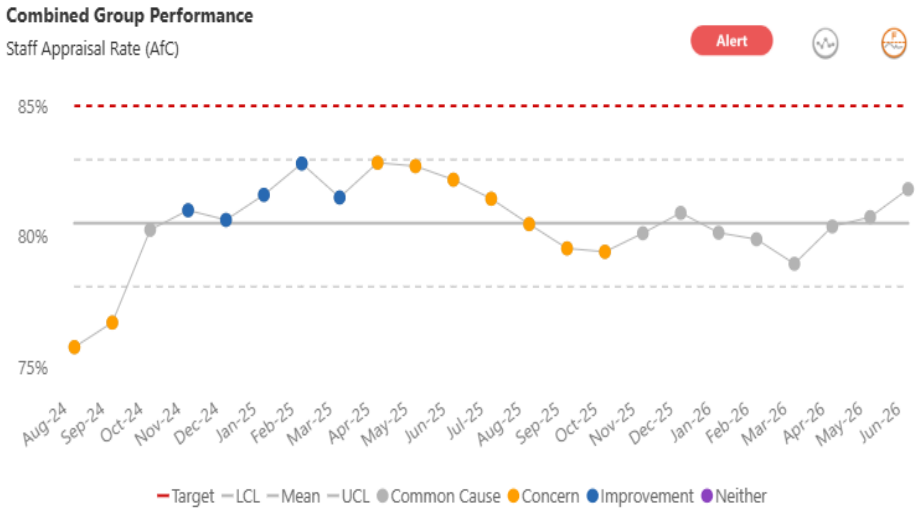
HUTH:

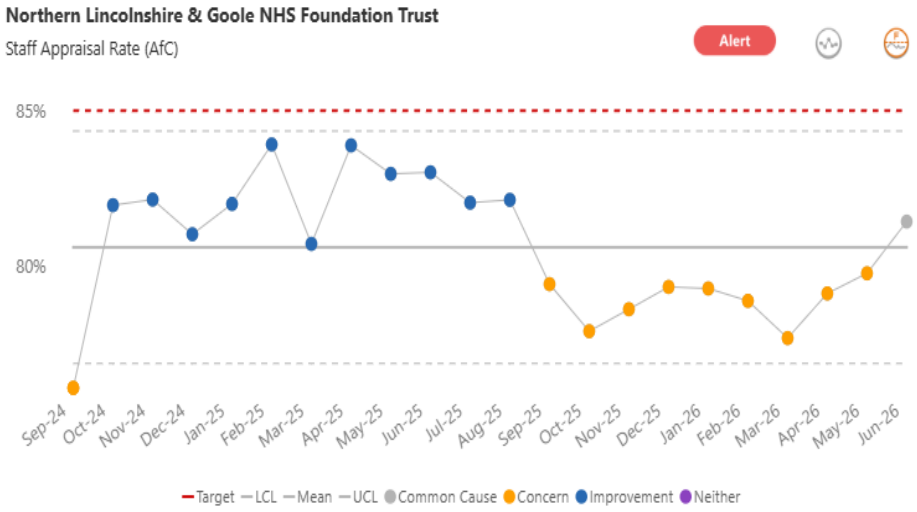
Staff appraisal performance remains variable and does not show a sustained improving trend. Recent data points appear to continue around the mean, indicating normal variation rather than clear recovery. Continued divisional focus is required to improve completion rates and ensure appraisal compliance is delivered consistently.

NLAG:

NLAG appraisal performance also remains variable, with the most recent position not demonstrating sustained improvement. The trend suggests appraisal completion remains inconsistent, requiring tighter management oversight, targeted follow-up of areas below expected compliance and clearer accountability for completion.







iii. Staff Mandatory Training – Role Specific

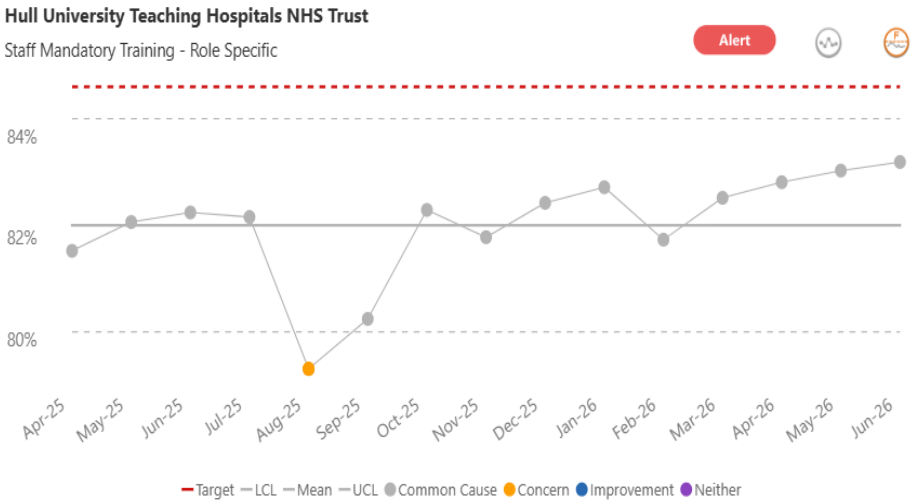
Staff Mandatory Training - Role Specific

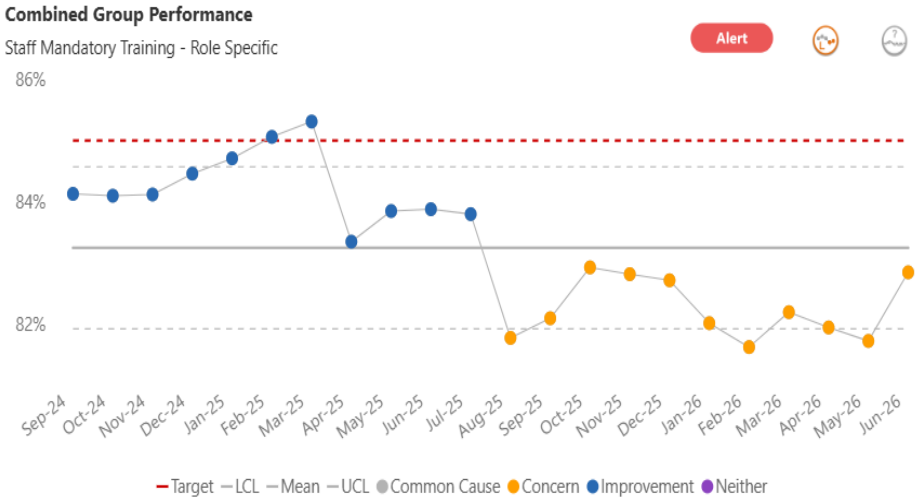
HUTH:

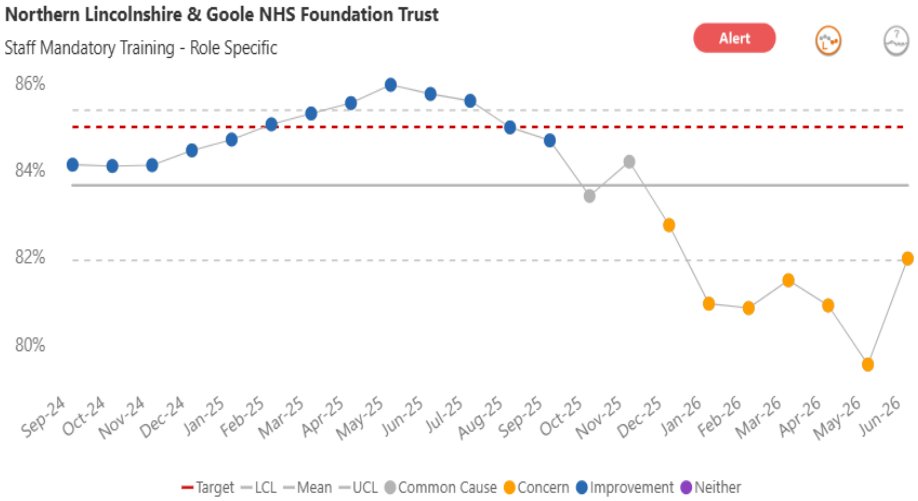
The latest position suggests compliance is not yet consistently improving at the required pace, requiring continued divisional grip, targeted follow-up with areas below trajectory and active monitoring through workforce governance.

NLAG:

NLAG shows a similarly variable trend, with performance not yet demonstrating sustained improvement. Continued focus is required on role-specific training completion, manager accountability and escalation of non-compliance to ensure training gaps do not present an ongoing workforce or assurance risk.







d. Recruitment & Retention

Summary

Recruitment process timeliness remains variable across HUTH and NLAG, with no clear sustained improvement across shortlisting, offer or employment checks. The greatest concern is NLAG Staff Time to Offer, which remains in **Alert**, indicating delays in progressing candidates to offer and a continuing risk to workforce supply.

Progress

HUTH shows broadly stable but variable performance across the recruitment pathway, with no sustained deterioration but limited evidence of improvement. NLAG also remains variable across the pathway, with particular risk at the offer stage. Employment checks at both Trusts appear broadly stable but continue to require oversight to prevent delays later in the recruitment process.

Action

Strengthen end-to-end recruitment grip through timely vacancy review, manager shortlisting, interview outcome confirmation, offer approval and employment check turnaround. Priority focus is required on NLAG Time to Offer, with escalation of overdue decisions, clearer ownership of recruitment delays and routine monitoring of pathway bottlenecks from advert close to start date.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Safe	People & Workforce	Staff Time to Employment Checks	≤ 20.0	30.2	35.0	38.8	38.5	36.4	27.7	48.2	13.8	12.6	13.6	16.0	18.9	21.0
		Staff Time to Offer	≤ 2.0	6.7	6.3	3.3	2.7	2.1	2.1	2.0	2.0	2.2	2.3	2.2	2.3	2.4
		Staff Time to Shortlist	≤ 5.0	10.0	9.2	9.4	8.6	9.0	8.2	8.5	7.1	7.2	7.0	6.6	7.6	7.6
Well Led	People & Workforce	Staff Turnover Annual FTE Rate	≤ 8.0%	6.9%	7.2%	6.4%	6.7%	6.4%	6.2%	5.8%	6.2%	6.4%	6.3%	6.5%	12.2%	

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Safe	People & Workforce	Staff Time to Employment Checks	≤ 20.0	25.7	28.7	41.2	34.6	41.2	41.3	37.4	27.5	27.0	22.0	17.3	17.8	21.6
		Staff Time to Offer	≤ 2.0	2.5	2.4	3.1	2.8	2.6	2.5	2.4	2.2	2.5	2.9	3.4	3.5	7.4
		Staff Time to Shortlist	≤ 5.0	39.0	40.0	50.6	68.2	95.7	110.8	52.3	48.8	47.8	6.1	6.8	6.9	7.5
Well Led	People & Workforce	Staff Turnover Annual FTE Rate	≤ 8.0%	8.9%	8.7%	8.4%	8.4%	8.3%	8.0%	8.0%	7.8%	7.6%	6.5%	7.2%	11.9%	

Sample pages only – awaiting further Lead review

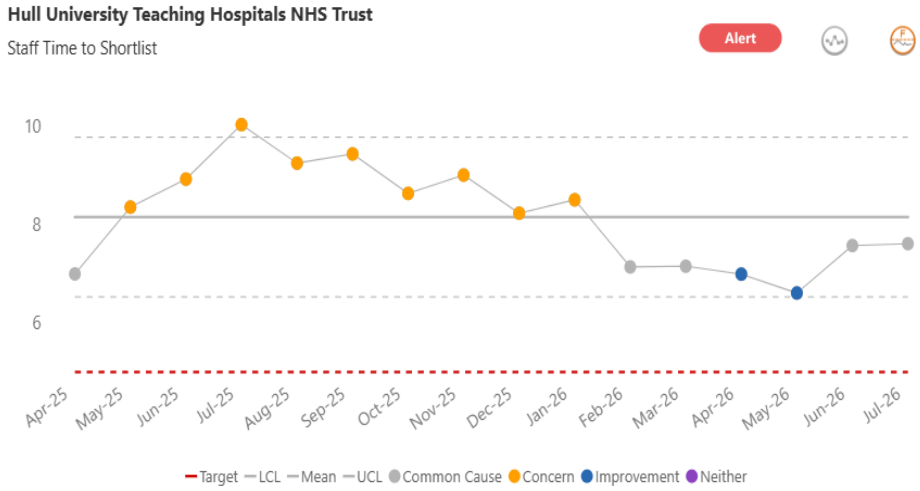
i. Staff Time to Shortlist

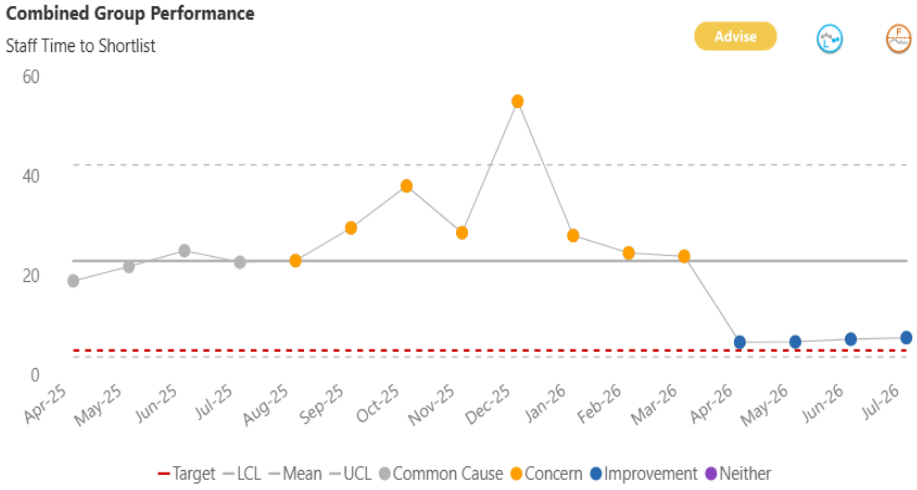
HUTH:

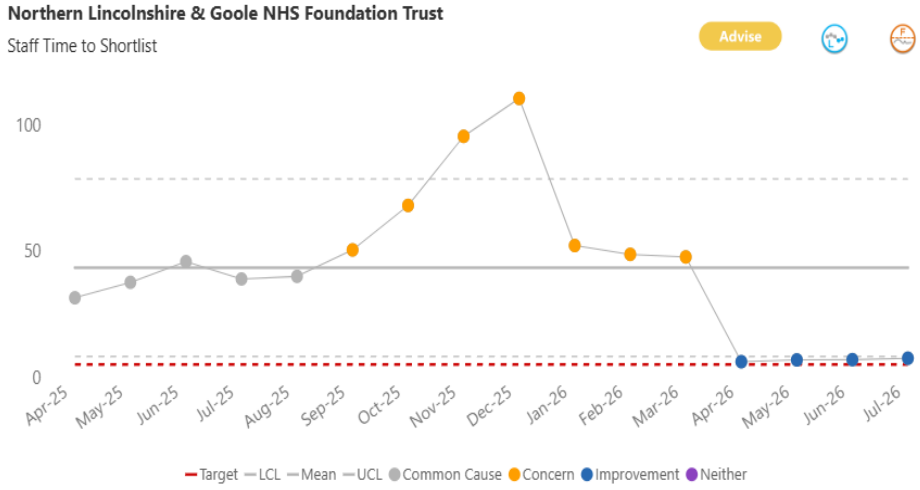
Staff Time to Shortlist shows continued variation across the period, with no clear sustained improvement. The latest position suggests the process remains vulnerable to delays at the early recruitment stage, requiring continued focus on timely vacancy review, manager shortlisting and recruitment team escalation where turnaround is off trajectory.

NLAG:

Staff Time to Shortlist also remains variable, with performance not yet demonstrating a consistent reduction. The trend indicates ongoing risk in progressing vacancies quickly from advert close to shortlist, requiring tighter operational grip on recruiting manager responsiveness, vacancy prioritisation and escalation of overdue shortlisting.







Sample pages only – awaiting further Lead review

ii. Staff Time to Offer

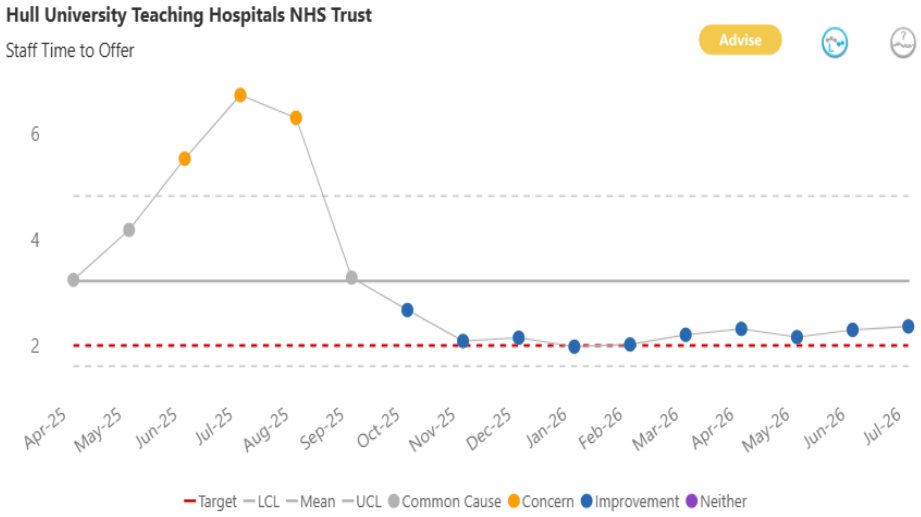
Staff Time to Offer

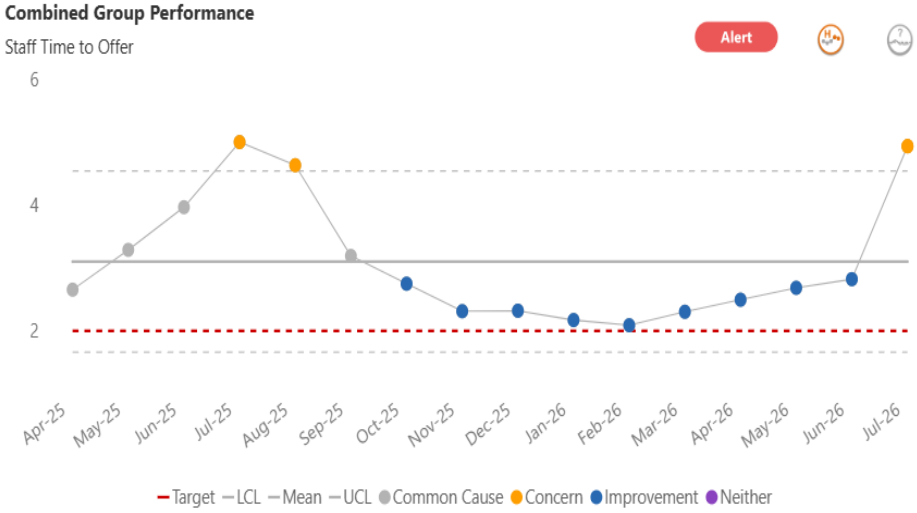
HUTH:

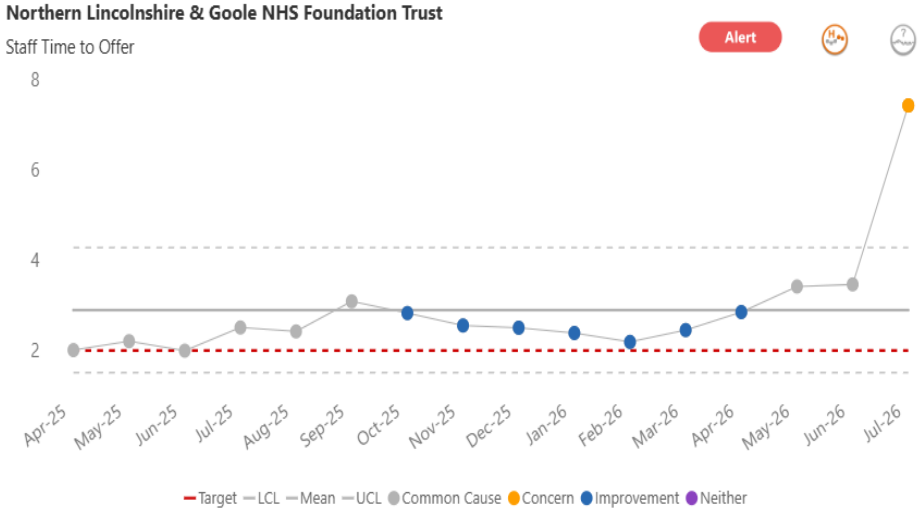
Staff Time to Offer shows variation across the period, with no clear sustained improvement. The recent position appears broadly stable but remains above the level required for consistent recruitment responsiveness, so continued focus is needed on timely interview outcomes, approval steps and offer processing.

NLAG:

Staff Time to Offer remains in Alert, reflecting a concerning position against trajectory. The trend shows continued variation without sustained recovery, indicating that delays in progressing candidates to offer remain a recruitment risk and require targeted operational grip on vacancy management, panel decision turnaround and offer approval processes.







iii. Staff Time to Employment Checks

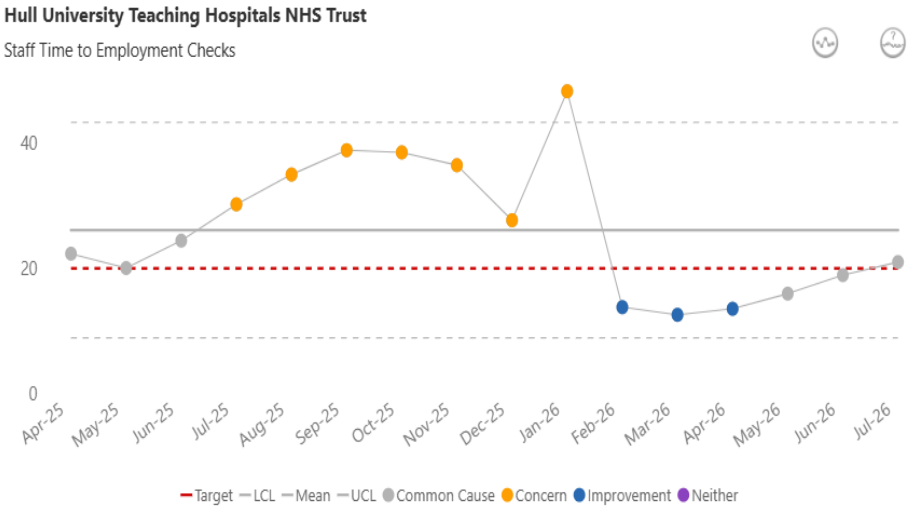
Staff Time to Employment Checks

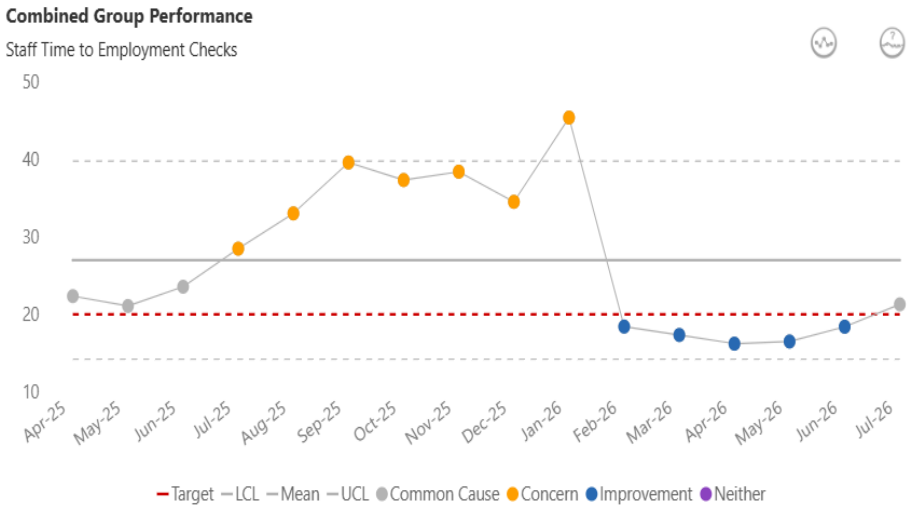
HUTH:

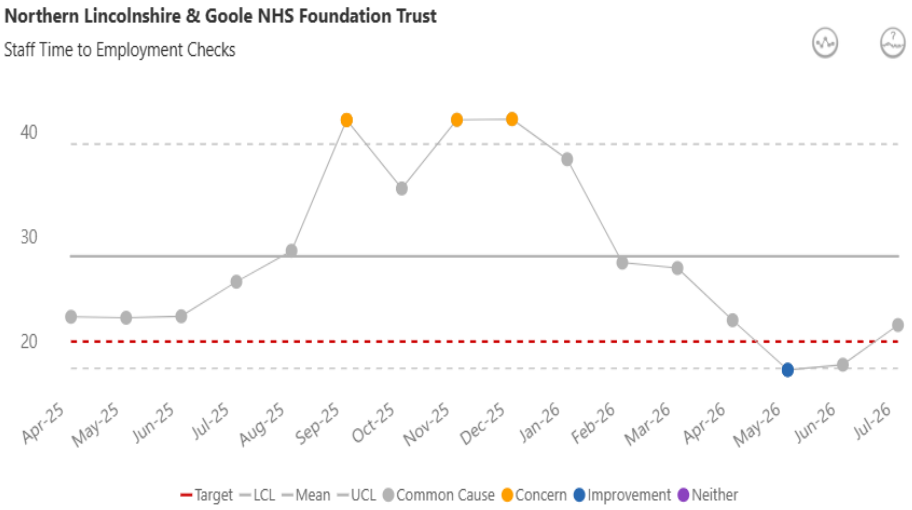
Time to employment checks shows a broadly stable trend with no clear sustained improvement; performance remains variable and should continue to be monitored to ensure checks do not become a recruitment delay point.

NLAG:

NLAG also shows variation across the period, with the position not yet demonstrating a sustained reduction. Continued focus is required on pre-employment check turnaround, escalation of delays and consistent recruitment process grip.







Appendices

1. Key to Statistical Process Control (SPC) Charts

SPC GUIDE

A guide to understanding Statistical Process Control (SPC) charts, variation and assurance icons

Statistical Process Control (SPC) charts help us understand how processes perform over time, distinguishing between normal and special cause variation. These charts follow best practice principles aligned with the **Making Data Count** (MDC) approach. Further details of Making Data Count principles can be found as follows:

https://www.england.nhs.uk/publication/making-data-count/

WHAT YOU'LL SEE

SPC Chart

Each point represents a data value over time. The chart helps you understand how the process is performing, highlighting whether variation is expected (*common cause*) or unusual (*special cause*).
Blue dots indicate improvement (special cause variation); **Amber dots** indicate concern (special cause variation); **Grey dots** indicate expected variation (common cause).

Variation Icons

These summarise the type of variation at a glance.
Blue indicates improvement; **Amber** indicates concerning variation that may require action; **Grey** indicates no significant change (common cause variation).

Assurance Icons

These indicate how reliably the target is being met.
Blue indicates target is consistently achieved; **Amber** indicates target is not consistently achieved; **Grey** indicates target is inconsistently achieved due to random variation.

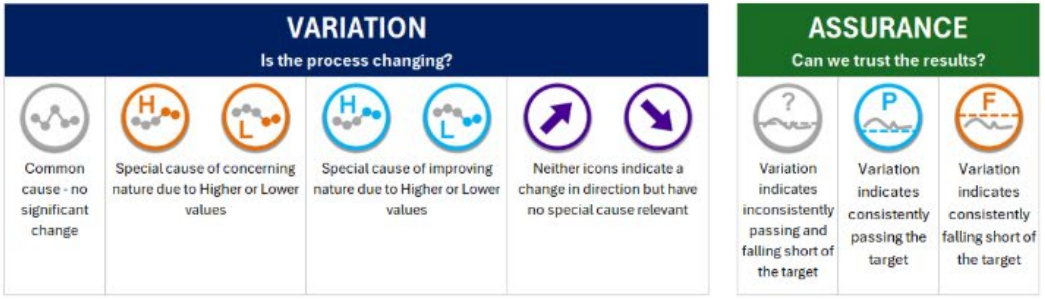
Triple-A Status

Combines variation and assurance to give an overall rating:
Assure, **Advise**, or **Alert**.

Variation	Plan / Assurance	AAA Status
Improving	Meeting	Assure
Normal	Meeting	Assure
Improving	Missing	Advise
Concerning	Meeting	Advise
Concerning	Missing	Alert
Normal	Missing	Alert

SPC Chart

Variation and Assurance Icons



2. National Oversight Framework Definitions

Establishing Average Scores

Step one: score individual metrics

Metric	Value	Score
% of patients waiting over 52 weeks	0.7%	1.00
% of patients waiting less than 18 weeks	59%	2.62
% of urgent cancer referrals diagnosed in 4 weeks	81.5%	1.00
% of cancer treatments within 62 days	82.6%	1.00
% of patients managed in A&E within four hours	80.4%	1.00
% of patients spending over 12 hours in A&E	3.1%	1.4
Planned surplus or deficit	£0.00	1.00
Latest surplus or deficit	-0.73%	3.00
NHS staff survey engagement score	7.17	1.36
NHS staff survey safety score	6.70	1.45
CQC safety rating	Good	2.00

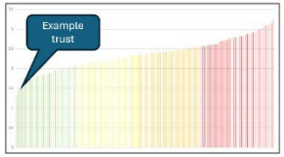
Step two: determine overall score

Sum total of metric scores
16.83

Total number of scores
11

Overall score (Sum total of metric scores / total number of scores)
1.53

Step three: Calculate initial delivery score



All raw domain scores for the organisation type are plotted and evenly quartiles. The example trust's raw score of 1.53 is in the lowest quartile giving a delivery score of 1

After this an adjustment is made for Financial Deficit:

Any provider with a segment of 1 or 2 based on its operational delivery score that is reporting a deficit or is in receipt of deficit support will automatically have its segment downrated to 3. This will be based on organisational not system-wide financial performance.

Then National segmentation is applied as follows:

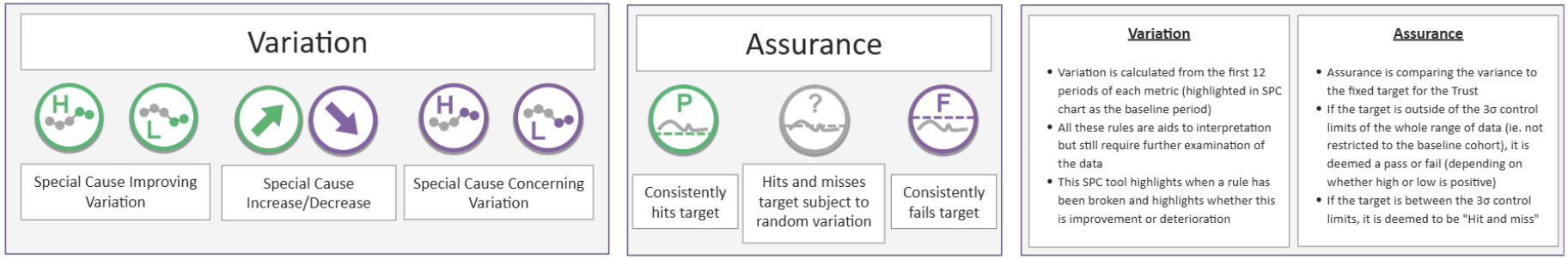
An organisation's organisational delivery score, adjusted if applicable for financial deficit, translates directly to the segment it is allocated. For some providers that are allocated to segment 4, the relevant NHS England region will consider their capability rating and determine whether they should be entered into the Provider Improvement Programme (PIP).

All providers in the PIP will be placed in segment 5.

3. Using Data Insights to identify Alert, Advise and Assure status

Making Data Count is a means to express the variation in trend and, somewhat separately, the achievement of a singular target (assurance).

In most cases, this will yield a continual 'Fail' throughout the year in terms of the MDC Assurance trigger (described below) as this wants a static target.



Equally, in the context of traditional 'National' compliance targets (e.g. ED 4hr =95%) being beyond reach, we require a focus upon what we have agreed to achieve over a performance cycle, with the Medium-Term Plan helping to set this in several key areas.

If the Trust has established a target, these are our Performance Measures for the year and if we have established a target, best practice would be to generate a trajectory to monitor its delivery.

'Assurance' would be better demonstrated by the combination of variation – still using SPC insight – and whether the latest reporting period is matching trajectory.

Using this approach, we will identify the AAA status of each Performance Measure every month based upon the matrix below.

Variation status	Status v Trajectory	AAA Group
Improving	Meeting	Assure
Improving	Missing	Advise
Concerning	Meeting	Advise
Concerning	Missing	Alert
Normal	Missing	Alert
Normal	Meeting	Assure

4. National Oversight Framework

HUTH Overview

Select a trust

Hull University Teaching Hospitals NHS Trust (RWA)

View the glossary page

Average score

3.19

Lower by 0.04 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).
Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

Yes

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

4 - Low performing

Previous quarter's segment: 4

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

134 out of 134

Previous quarter's rank: 134 out of 134

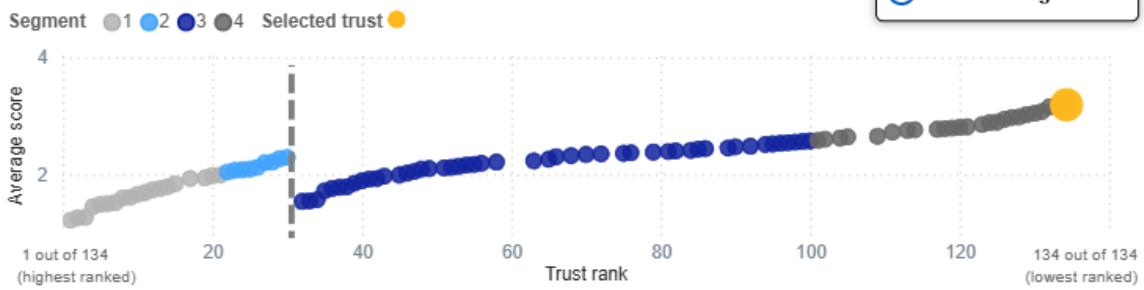
Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Access to services	4 - Low performing
Finance and productivity	4 - Low performing
Effectiveness and experience	2 - Above average
Patient safety	4 - Low performing
People and workforce	3 - Below average

Average score by trust rank placement

View full league table



Comparative League table in Appendices

NLAG Overview

Select a trust

Northern Lincolnshire and Goole NHS Foundation Trust (RJL)

View the glossary page

Average score

2.79

Lower by 0.07 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).
Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

Yes

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

4 - Low performing

Previous quarter's segment: 4

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

119 out of 134

Previous quarter's rank: 114 out of 134

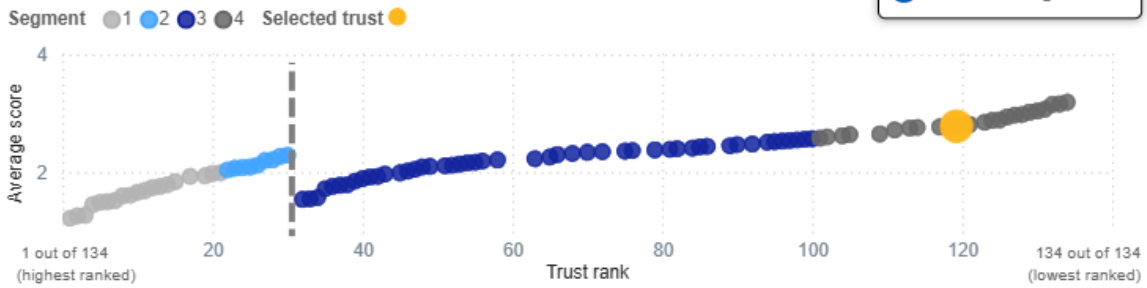
Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Access to services	4 - Low performing
Finance and productivity	4 - Low performing
Effectiveness and experience	1 - High performing
Patient safety	4 - Low performing
People and workforce	3 - Below average

Average score by trust rank placement

View full league table



Comparative League table in Appendices

Regional Context

Access to Services

Key Performance Indicator	Hull University Teaching Hospitals NHS Trust INDICATIVE DELIVERY SCORE 3.94	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.92	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 2.16	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.77
ACCESS TO SERVICES	MEAN SCORE 3.45	MEAN SCORE 3.30	MEAN SCORE 1.56	MEAN SCORE 3.18
Cancer - Patients treated within 62 of referral QTD Q1 26/27 75.00%	52.26% 3.88	64.41% 3.37	81.88% 1.00	71.15% 2.39
Cancer - Urgent referrals diagnosis within 4 weeks QTD Q1 26/27 80.0%	69.7% 3.60	62.0% 3.91	84.7% 1.00	73.6% 3.26
Community Services - Patients waiting over 52 weeks Jun 26	No Data	0.31% 2.27	2.53% 2.88	22.47% 3.69
ED - Attendances managed within 4 hours - Acute trust footprint QTD Q1 26/27 78.00%	70.67% 3.28	72.04% 3.13	73.36% 2.92	72.00% 3.16
ED - Attendances over 12 hours in department QTD Q1 26/27	7.5% 2.06	15.4% 3.63	2.4% 1.39	9.4% 2.43
RTT - Patients waiting 18 weeks or less Jun 26	56.76% 3.93	61.62% 3.40	75.88% 1.27	59.01% 3.82
RTT - Patients waiting over 52 weeks Jun 26 1.00%	3.79% 3.94	2.90% 3.79	0.01% 1.00	1.93% 3.19
RTT - Planned v actual 18 week performance Q4 25/26 0.0%	-5.5% 3.60	-3.7% 3.24	5.2% 1.00	-3.9% 3.33

Effectiveness & Experience

Key Performance Indicator	Hull University Teaching Hospitals NHS Trust INDICATIVE DELIVERY SCORE 3.94	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.92	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 2.16	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.77
EFFECTIVENESS & EXPERIENCE	MEAN SCORE 2.39	MEAN SCORE 1.96	MEAN SCORE 2.19	MEAN SCORE 2.00
Avg Days Ready Date to Discharge (inc 0 day delays) May 26	0.7 2.08	0.8 2.34	0.5 1.67	0.8 2.38
CQC inpatient survey satisfaction rate 2024	4.0 2.00	4.0 2.00	4.0 2.00	4.0 2.00
Community - Urgent response 2 hours performance QTD Q1 26/27 70.00%	No Data	97.88% 1.08	82.32% 2.48	79.01% 2.68
Summary Hospital Mortality Indicator Mar 26	1.05 2.95	0.99 2.41	0.98 2.26	0.88 1.38

Patient Safety

Key Performance Indicator	Hull University Teaching Hospitals NHS Trust INDICATIVE DELIVERY SCORE 3.94	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.92	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 2.16	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.77
PATIENT SAFETY	MEAN SCORE 2.95	MEAN SCORE 3.52	MEAN SCORE 1.72	MEAN SCORE 2.58
Number of MRSA bacteraemia cases Jun 26 0	2 2.24	5 3.13	1 2.00	5 3.13
Proportion of C-Difficile infections against threshold Jun 26 1.00	1.97 3.92	1.89 3.90	1.11 2.56	0.92 1.00
Proportion of E-Coli bacteraemia against threshold Jun 26 1.00	0.99 1.00	1.72 3.91	0.89 1.00	1.12 2.47
Staff Survey - Raising Concerns sub-score 2025	6.04 3.55	6.09 3.45	6.87 1.16	6.00 3.70

Finance & Productivity

Key Performance Indicator	Hull University Teaching Hospitals NHS Trust INDICATIVE DELIVERY SCORE 3.94	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.92	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 2.16	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.77
FINANCE & PRODUCTIVITY	MEAN SCORE 3.15	MEAN SCORE 3.17	MEAN SCORE 3.38	MEAN SCORE 3.40
Finance - Combined finance score Q4 25/26	4 4.00	4 4.00	4 4.00	4 4.00
Finance - Planned surplus/deficit Q4 25/26 0.00%	-1.36% 2.35	-2.42% 2.89	-1.39% 2.40	-1.91% 2.64
Finance - Variance year-to-date to financial plan Q4 25/26 0.00%	-2.13% 2.77	-2.25% 2.86	-5.70% 3.73	-3.50% 3.36
Productivity - Implied productivity level Mar 26	-1.0% 3.53	1.3% 2.98	-0.2% 3.35	-1.7% 3.64

People & Workforce

Key Performance Indicator	Hull University Teaching Hospitals NHS Trust INDICATIVE DELIVERY SCORE 3.94	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.92	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 2.16	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.77
PEOPLE & WORKFORCE	MEAN SCORE 2.73	MEAN SCORE 3.12	MEAN SCORE 1.96	MEAN SCORE 3.16
Sickness Absence Rate QTD Q1 26/27	4.21% 1.70	4.93% 2.65	4.82% 2.42	5.20% 2.96
Staff Survey - Engagement Theme Score 2025	6.40 3.75	6.46 3.59	7.07 1.50	6.51 3.36

5. Trust League Tables

a. HUTH – Filtered to Teaching Hospitals

Quarter	Select trust type(s)	Select trust(s)
Q4 2025/26	Acute - Teaching	All

Statistics methodology | Return to overview

Trust type	Trust	Average score	Segment	Trust in financial deficit?	Rank	Likely range of rank	Previous quarter's rank
Acute - Teaching	Hull University Teaching Hospitals NHS Trust (RWA)	3.19	4	Yes	134	114 to 134	134
Acute - Teaching	James Paget University Hospitals NHS Foundation Trust (RGP)	3.07	4	Yes	131	113 to 134	127
Acute - Teaching	Nottingham University Hospitals NHS Trust (RX1)	3.04	4	Yes	130	103 to 134	132
Acute - Teaching	York and Scarborough Teaching Hospitals NHS Foundation Trust (RCB)	3.02	4	Yes	129	108 to 134	131
Acute - Teaching	East Kent Hospitals University NHS Foundation Trust (RVV)	2.97	4	Yes	127	90 to 134	124
Acute - Teaching	University Hospitals of Derby and Burton NHS Foundation Trust (RTG)	2.89	4	Yes	125	92 to 132	97
Acute - Teaching	Barking, Havering and Redbridge University Hospitals NHS Trust (RF4)	2.88	4	Yes	124	73 to 134	99
Acute - Teaching	Wirral University Teaching Hospital NHS Foundation Trust (RBL)	2.85	4	Yes	123	80 to 133	124
Acute - Teaching	Lancashire Teaching Hospitals NHS Foundation Trust (RXN)	2.81	4	Yes	121	80 to 131	129
Acute - Teaching	University Hospitals Sussex NHS Foundation Trust (RYR)	2.81	4	Yes	121	79 to 132	121
Acute - Teaching	University Hospitals of Morecambe Bay NHS Foundation Trust (RTX)	2.77	4	Yes	117	76 to 130	95
Acute - Teaching	Blackpool Teaching Hospitals NHS Foundation Trust (RXL)	2.72	4	Yes	111	66 to 131	106
Acute - Teaching	Northern Care Alliance NHS Foundation Trust (RM3)	2.72	4	Yes	111	76 to 128	115
Acute - Teaching	Liverpool University Hospitals NHS Foundation Trust (REM)	2.65	4	Yes	109	60 to 128	113
Acute - Teaching	Mid Yorkshire Teaching NHS Trust (RXF)	2.64	4	Yes	105	57 to 129	112
Acute - Teaching	University Hospitals of Leicester NHS Trust (RWE)	2.64	4	Yes	105	64 to 128	99
Acute - Teaching	University Hospitals Plymouth NHS Trust (RK9)	2.64	4	Yes	105	63 to 126	119

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b. NLAG – Filtered to Medium

Quarter	Select trust type(s)	Select trust(s)
Q4 2025/26	Acute - Medium	All

Statistics methodology | Return to overview

Trust type	Trust	Average score	Segment	Trust in financial deficit?	Rank	Likely range of rank	Previous quarter's rank
Acute - Medium	Northampton General Hospital NHS Trust (RNS)	2.98	4	Yes	128	94 to 134	126
Acute - Medium	North Cumbria Integrated Care NHS Foundation Trust (RNN)	2.80	4	Yes	120	81 to 131	130
Acute - Medium	Northern Lincolnshire and Goole NHS Foundation Trust (RJL)	2.79	4	Yes	119	76 to 131	114
Acute - Medium	Medway NHS Foundation Trust (RPA)	2.76	4	Yes	114	64 to 132	116
Acute - Medium	Great Western Hospitals NHS Foundation Trust (RN3)	2.75	4	Yes	113	77 to 129	85
Acute - Medium	Wrightington, Wigan and Leigh NHS Foundation Trust (RRF)	2.56	3	Yes	99	57 to 124	117
Acute - Medium	Gateshead Health NHS Foundation Trust (RR7)	2.53	3	Yes	96	54 to 122	65
Acute - Medium	Croydon Health Services NHS Trust (RJ6)	2.45	3	Yes	89	51 to 118	97
Acute - Medium	Royal United Hospitals Bath NHS Foundation Trust (RD1)	2.40	3	Yes	82	47 to 114	102
Acute - Medium	Sherwood Forest Hospitals NHS Foundation Trust (RK5)	2.40	3	Yes	82	49 to 112	60
Acute - Medium	Surrey and Sussex Healthcare NHS Trust (RTP)	2.35	3	Yes	72	41 to 118	63
Acute - Medium	The Shrewsbury and Telford Hospital NHS Trust (RXW)	2.35	3	Yes	72	41 to 117	78
Acute - Medium	Bedfordshire Hospitals NHS Foundation Trust (RC9)	2.26	3	Yes	65	41 to 104	52
Acute - Medium	Bolton NHS Foundation Trust (RMC)	2.23	3	Yes	63	39 to 103	76
Acute - Medium	The Dudley Group NHS Foundation Trust (RNA)	2.21	3	Yes	58	39 to 96	68
Acute - Medium	Ashford and St Peter's Hospitals NHS Foundation Trust (RTK)	2.16	3	Yes	54	38 to 97	54
Acute - Medium	Stockport NHS Foundation Trust (RWJ)	2.09	3	Yes	48	35 to 89	45

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6. HHP Foundation Scorecards

Embedded in the HHP NOF Scorecard are 4 Foundation Scorecards:

- Quality (CQC: Caring, Safe, Effective),
- Performance (CQC: Responsive)
- Finance (CQC: Effective, Well-led)
- Workforce (CQC: Effective, Well-led)

Each Foundation Scorecard will contain every relevant metric signed off by lead Exec.

Subject to available thresholds each metric will be RAG rated. All RAG rated metrics will be used to derive sub-domain and domain assessment scores

Each metric will also be identified as a defined or enabling NHSE NOF Indicator along with the defined Subject Area (Elective Care, Cancer, UEC, Financial Balance, Productivity).

Each metric will be allocated a unique identifier allowing any combination of summary scorecards to be generated

Every Metric has clear definitions and SPC graphs to support further understanding and act as presentational templates for Care Group performance updates

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committees-in-Common Front Sheet

Agenda Item No: CIC(26) 4.2

Name of Meeting	**Workforce Education and Culture Committees-in-Common**
Date of the Meeting	22nd July 2026
Director Lead	Paul Bunyan, Group Deputy Chief People Officer
Contact Officer / Author	Lauren Wilkinson, Group Head of Workforce Intelligence & Systems
Title of Report	**Workforce Integrated Performance Report**
Executive Summary	The purpose of this report is to provide an overview of the Group's workforce performance for June 2026, highlighting key workforce metrics, risks, and progress against the Workforce Operational Plan, including recruitment, vacancies, workforce utilisation, workforce performance, retention, wellbeing, and temporary staffing. **Alert** • Overall sickness absence remains above the Group target at 4.8%, with NLaG reporting the highest rate (5.4%). Mental health-related absence continues to be the leading cause of sickness. • Consultant vacancies remain a key workforce risk, with a vacancy rate of 16.7% (including Specialists), particularly within Theatres, Anaesthetics and Critical Care, Specialist Cancer and Support Services, and Acute and Emergency Medicine. • Recruitment time to hire remains above the agreed KPI, primarily due to staffing pressures within the Recruitment Team. • Progress against the Workforce Operational Plan remains positive; however, only 10% of the planned 30% workforce reduction has been achieved, and continued delivery will be required to meet the overall target **Assure** • The overall Group vacancy rate remains relatively low at **5.2%**, reducing to an adjusted vacancy factor of **1.6%** when bank and agency utilisation is taken into account.

	• Agency utilisation has reduced by **23.4 WTE** since the previous reporting period, with a corresponding reduction in monthly agency expenditure of **£74k**. Year-to-date agency expenditure remains below plan, with Executive and Care Group controls continuing to support delivery. • Recruitment activity continues to improve, with **30 Consultants** and **5 Specialist Doctors** in the recruitment pipeline. Registered Nurse vacancies remain low at **1.4%**, with Newly Qualified Nurses expected to return the Group to full establishment. • HR Business Partners continue to work with Care Groups to improve compliance with mandatory training, appraisals and job planning through targeted KPI meetings and action plans. **Advise** • Recruitment process improvements are being implemented to reduce time to hire, alongside measures to address recruitment capacity challenges. • Continued monitoring of workforce performance, sickness absence, compliance, agency usage and delivery of the Workforce Operational Plan will remain a priority to ensure financial and operational workforce objectives are achieved **Recommendation** • Note the Workforce Integrated Performance Report for June 2026.
Background Information and/or Supporting Document(s) (if applicable)	The report is presented as part of normal monthly business
Prior Approval Process	Not Applicable
Financial Implication(s) (if applicable)	Vacancy position is responsible for the majority of Agency spend and remains a priority
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	No specific considerations within this report, however as part of future reporting EDI data sets will be made more available.
Recommended action(s) required	☐ Approval by CiC ☐ Information ☐ Endorse for approval by ✓ Assurance

	Trust Board(s) ☐ Other – please detail below:

BAF to which the paper relates:	Tick all those appropriate
Our Patients - Access	☐
Our Patients - Safety	☐
Our People	✓
Our Partnerships	☐
Our Pioneers	☐
Our Public Purse	☐

NHS
Humber Health
Partnership

JUNE 2026

Workforce Integrated Performance Report

People Directorate

nlg-tr.twworkforcedatareqs@nhs.net

Exception Repoert

Vacancy Rate

The Group's overall vacancy rate is 5.2%, representing an increase of 1.1 percentage points compared with the previous reporting period. Vacancy levels remain higher at NLaG (7.5%), while HUTH reports a lower rate of 3.4%. When adjusted for bank and agency utilisation, the Group's vacancy factor reduces to 1.6% (264.6 WTE). NLaG accounts for 113.7 WTE of the adjusted vacancy position, primarily reflecting the use of bank staff within registered and unregistered nursing roles. The overall Medical and Dental vacancy rate is 7.2%, remaining within the agreed target. Consultant vacancies, however, stand at 16.7% (including Specialists), reflecting recent increases in the established workforce. Despite this, the number of staff in post continues to improve, supported by ongoing recruitment activity and the employment of Specialist Doctors.
The Medical and Dental workforce continues to be a significant driver of agency expenditure, particularly within NLaG, and remains a key area of focus for targeted recruitment and workforce planning.

Recruitment to Consultant roles remains a key priority. There are currently 30 Consultants in the recruitment pipeline awaiting commencement. The Consultant vacancy position is further mitigated by the employment of Specialist Doctors, with 43 currently in post and a further 5 in the recruitment pipeline, helping to reduce the overall Consultant vacancy gap.
The greatest Consultant workforce pressures continue to be within Theatres, Anaesthetics and Critical Care, Specialist Cancer and Support Services, and Acute and Emergency Medicine.
Registered Nurse vacancies remain low at 1.4%. With a cohort of Newly Qualified Nurses due to commence in September, the Group is expected to return to full establishment, with vacancy levels anticipated to remain low over the coming months. This is expected to contribute to a further reduction in agency an d bank usage within this staff group.
Allied Health Professionals, Scientific and Technical vacancies currently stand at 11.3%, with the most significant workforce pressures relating to Sonographers and Radiographers within Specialist Cancer and Support Services. The Care Group is being supported to develop and implement targeted recruitment and retention plans to address these shortages.

Recruitment time to hire remains above the KPI for both medical and general recruitment. This reflects both the recent reduction in recruitment staffing and pressures within the Recruitment Team, which have impacted processing times. Despite these challenges, process improvements and streamlined ways of working are beginning to be reviewed.

Workforce Utilisation and Retention Overview

The latest validated data (June 2026) shows agency utilisation at 110 WTE across the Group, representing a reduction of 23.4 WTE compared with the previous reporting period. This has resulted in a month-on-month reduction in agency expenditure of £74k. Year-to-date agency spend is £25.7m, which is £10.7m below the planned trajectory. Agency controls continue to be rigorously applied through Care Group and Executive-level oversight to ensure agency usage is appropriately challenged and expenditure remains tightly controlled.

Sickness absence remains above the Group target of 4%, with an overall rate of 4.8%. NLaG continues to report the higher absence rate at 5.4%, compared with 4.4% at HUTH. The most common reason for absence remains anxiety, stress, depression and other psychiatric illnesses. The highest levels of sickness absence are recorded within the Nursing and Midwifery Registered and Additional Clinical Services staff groups, particularly across the Acute and Emergency Medicine, Community, Major Trauma and Pathology Care Groups. HR Business Partners will continue to work with Care Groups to support attendance improvement through targeted interventions and regular performance monitoring.

Staff turnover remains below the Group target of 10%, with an overall turnover rate of 6.8% (NLaG 7.3% and HUTH 6.6%). The highest turnover continues to be seen within the Additional Clinical Services, Administrative and Clerical, and Estates and Ancillary staff groups. The most common reasons for leaving within these staff groups are voluntary resignation due to relocation and 'Other – Not Known.

Performance Overview

Mandatory and Role Specific Training compliance for Medical and Dental staff continues to report the lowest levels of compliance across all staff groups. At HUTH, Core Compliance is 89.7% (an increase of 0.8 percentage points from the previous reporting period), while Role Specific Compliance is 84.3% (an increase of 2.4 percentage points). At NLaG, Core Compliance is 84.6% (a decrease of 2.4 percentage points), while Role Specific Compliance has improved to 84.7% (an increase of 3.9 percentage points). HR Business Partners will continue to work with Care Groups to improve compliance through targeted action plans and performance monitoring.

The current appraisal completion rate for Agenda for Change (AfC) staff is 81.7%. The lowest completion rates continue to be within the Additional Clinical Services, Administrative and Clerical, and Healthcare Scientist staff groups.
HR Business Partners continue to work closely with Care Groups through regular KPI meetings to improve compliance.

The current Job Planning completion rate across the Group is 93%. Whilst this remains below the 100% compliance target, it is in line with the interim trajectory towards achieving a minimum of 95% by March 2027. Continued focus will be required to meet this target.

Workforce Position

This slide represents the Group workforce of Humber Health Partnership. It includes details related to Staff in Post, Headcount and Establishment

June 26 Workforce Position

Headcount 19,633
HUTH 11,005 - NLAG 8,658
↓
May 26 **19,729**
HUTH 11,031 NLAG 8,698
↓
April 26 **19,750**
HUTH 11,016 NLAG 8,734

Est WTE 16,668.6
HUTH 9,445.9 NLAG 7222.7
↓
May 26 **16,678.2**
HUTH 9448.6 NLAG 7229.6
↓
April 26 **16,689**
HUTH 9469.7 NLAG 7219.3

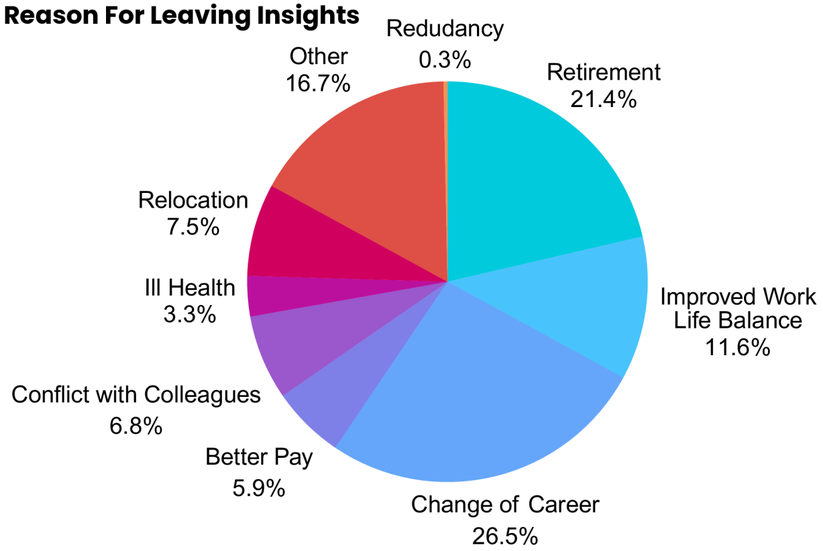
SIP WTE 15,800.3
HUTH 9121.5 NLAG 6678.7
↑
May 26 **15,798.2**
HUTH 9109.9 NLAG 6703.7
↓
April 26 **15,819.3**
HUTH 9106.8 NLAG 6712.6

Leavers WTE (12mAvg) 1685
HUTH 982.3 NLAG 702.7
↓
May 26 **944.9**
HUTH 520.6 NLAG 424.3
↑
April 26 **928.3**
HUTH 510.6 NLAG 427.7

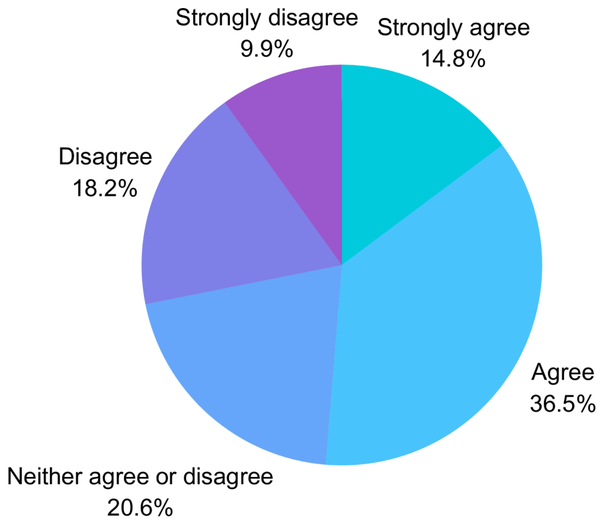
Starters WTE (12mAvg) 2091.0
HUTH 12694.4 NLAG 644.0
↑
May 26 **1981.0**
HUTH 1308.5 NLAG 672.5
↑
April 26 **1976.2**
HUTH 1293.6 NLAG 682.5

Exit Questionnaire Data (12 Months Roiling)

Reason For Leaving Insights



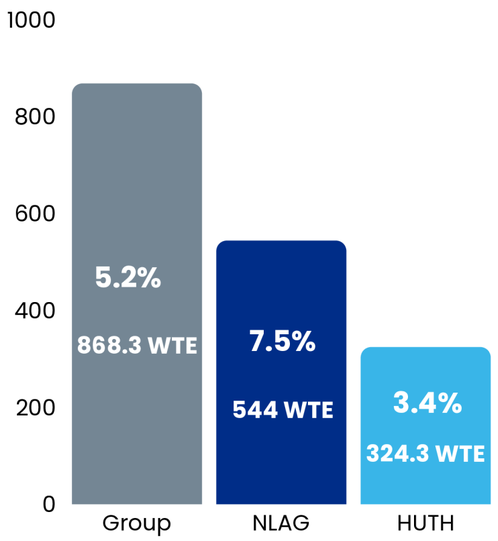
I looked forward to going to work



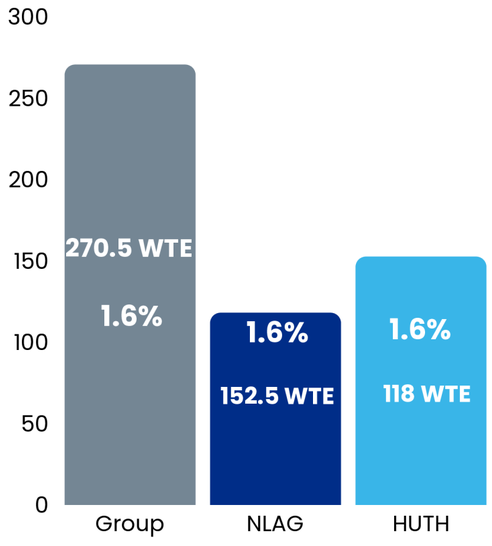
Vacancy and Recruitment Activity

The next two slides represents the vacancy and recruitment activity of Humber Health Partnership. It includes details related to specific staff groups and pipeline information.

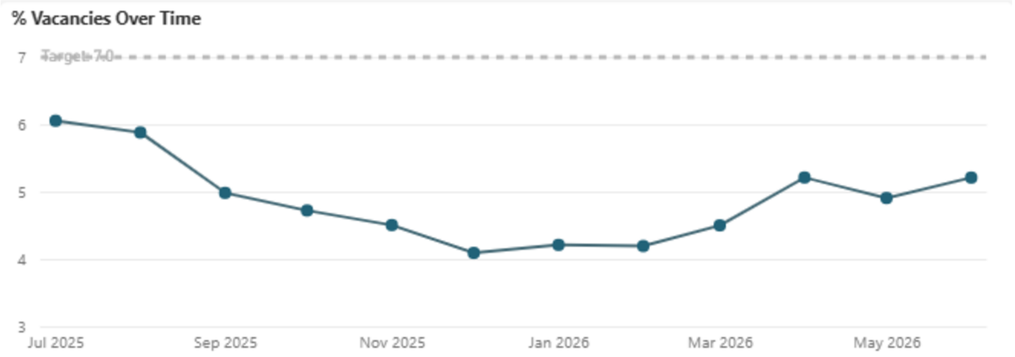
June 26 Group Overall Vacancy Position



Group Overall Adjusted Vacancy Position



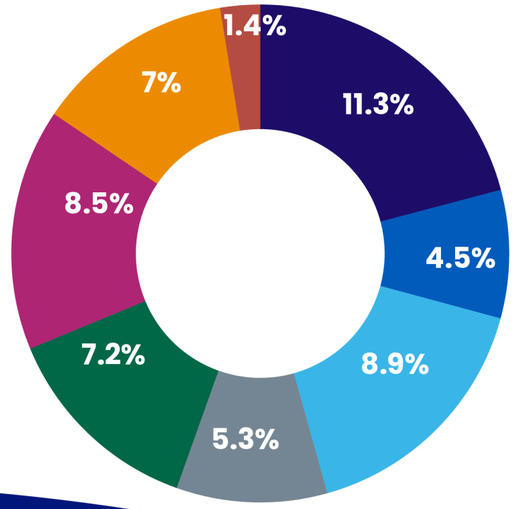
Group Overall Trend

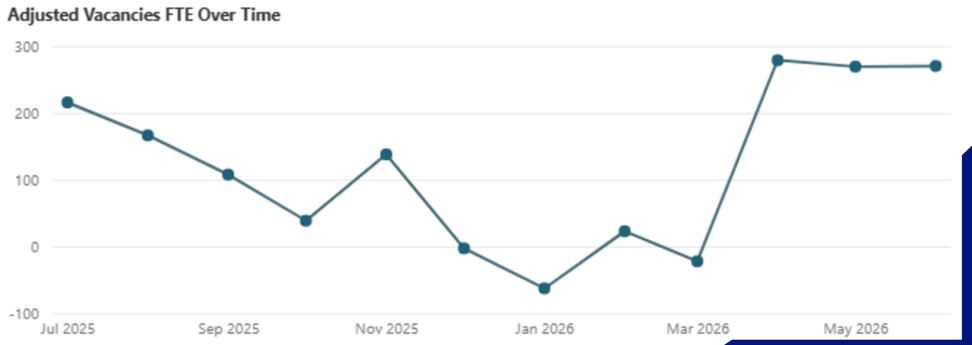


April 26	May 26	June 26
5.2%	**5.2%**	**5.2%**

Group Overall Vacancy by Staff Group

- Add Prof Scientific and Technic
- Additional Clinical Services
- Admin & Clerical
- Allied Health Professionals
- Estates and Anciallry
- Healthcare Scientists
- Medical & Dental
- Nursing and Midwifery Registered

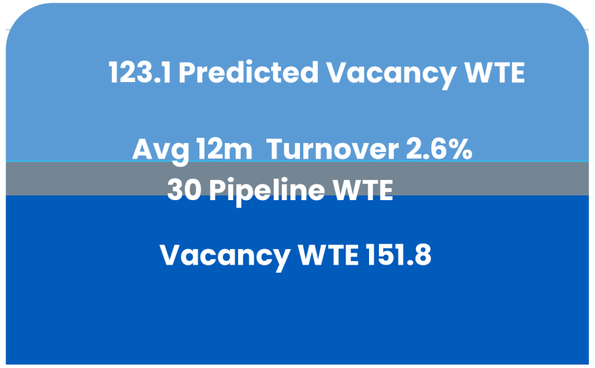




April 26	May 26	June 26
1.7%	**1.7%**	**1.6%**

Vacancy and Recruitment Activity

Group Consultant Vacancy 3 Month Predictions



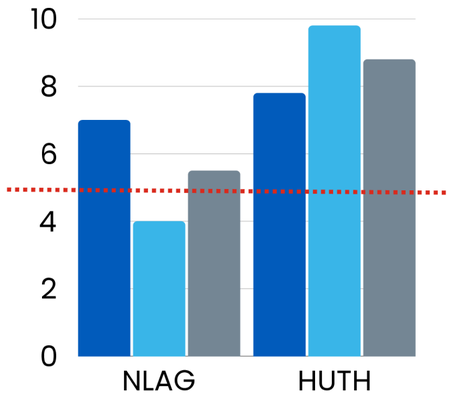
Vacancy Rate **16.7%** → Predicted Vacancy Rate **13.9%**

Group Recruitment KPI Overview

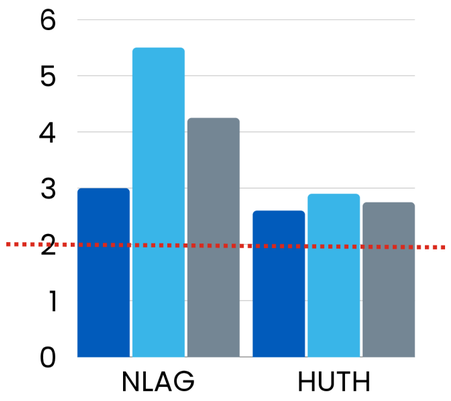
Recruitment KPI Overview	HUTH	NLAG	Total
Number of Active Vacancies	126	140	266
Number of Applications received	2288	4682	6970
Number of Conditional Offers Issued	382	285	667
Number of New Starters	141	108	249

Appointing Manager Metrics

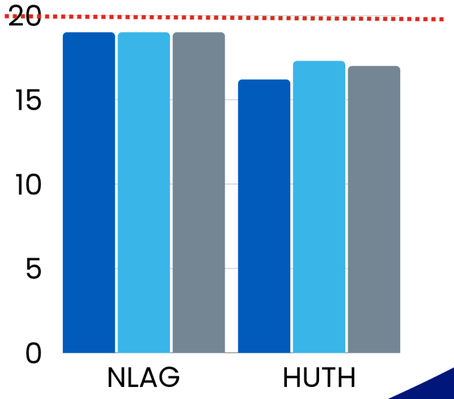
Time Taken to Shortlist (Target 5 Working Days)



Time taken to provide interview outcome (Target 2 Working days)



Time to Hire (Target 20 working days)



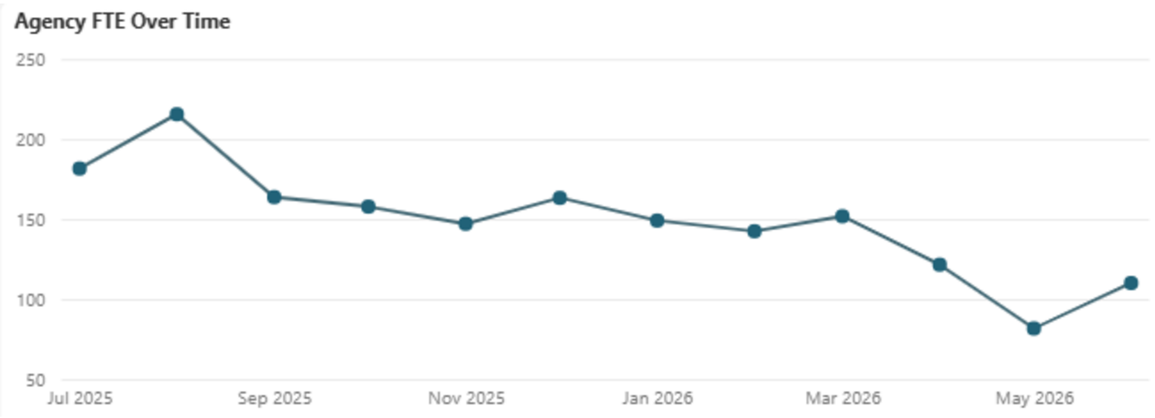
General Staffing

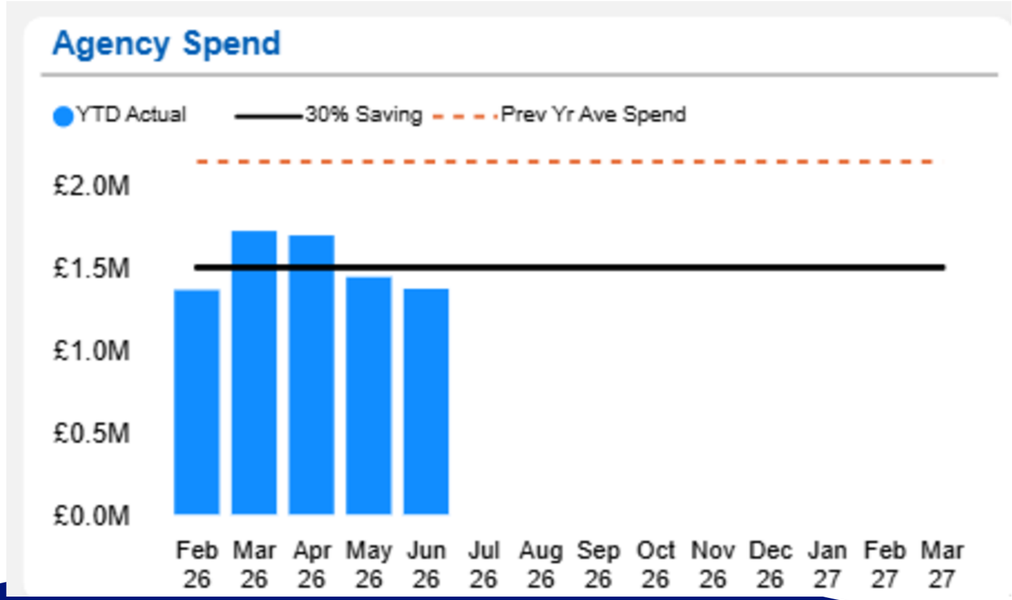
Medical Staffing

All Staffing

Agency

This slide represents the agency performance of Humber Health Partnership Group.





June Agency FTE Usage

Care Group	WTE
Acute and Emergency Medicine	48.8
Family Services	4.8
Specialist Medicine	5.4
Specialist Surgery	2.3
Specialist Cancer and Support Services	15.3
Digestive Diseases	3.6
Head and Neck	3.2
Community, Frailty and Therapy	12.3
Theatres, Anaesthetics and Critical Care	8.1
Neuroscience	4.6
Pathology Network Group	0
Site Management and Discharge Teams	0.1
Cardiovascular	1.7
Major Trauma	0
Cancer Network	0

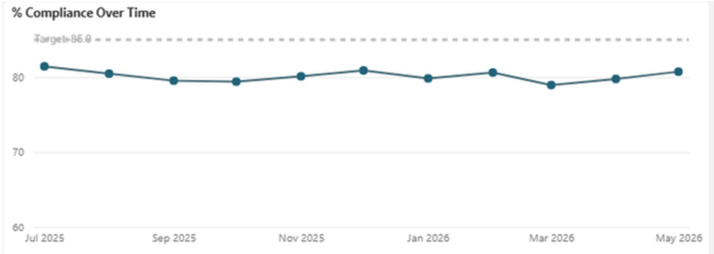
Agency target and opportunity by Staff Type

Staff Type	25/26 Agency	Prev YTD Agency	YTD Agency	YTD Change	30% Target Var, YTD
Medical	£19,670.5K	£5,489.6K	£3,538.3K	-36%	-£96.0K
Nursing	£4,180.1K	£1,198.5K	£543.4K	-55%	£188.1K
Allied Health Professional	£1,166.1K	£46.6K	£418.1K	796%	-£214.0K
Admin + Clerical	£77.0K	£5.8K	£6.9K	18%	£6.6K
Other Staff	£41.1K	£27.5K	£2.0K	-93%	£5.2K
Scientific + Technical	£568.3K	£421.5K	£0.0K		£99.4K
Total	**£25,703.0K**	**£7,189.7K**	**£4,508.8K**	**-37%**	**-£10.7K**

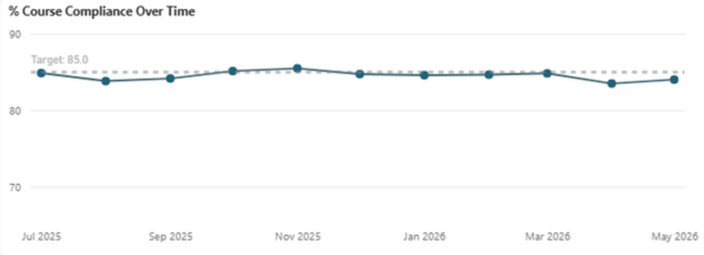
Training, Appraisals and Job Planning

The next slide represents the performance activity Humber Health Partnership Group. It includes details related to appraisals, training and Job Planning.

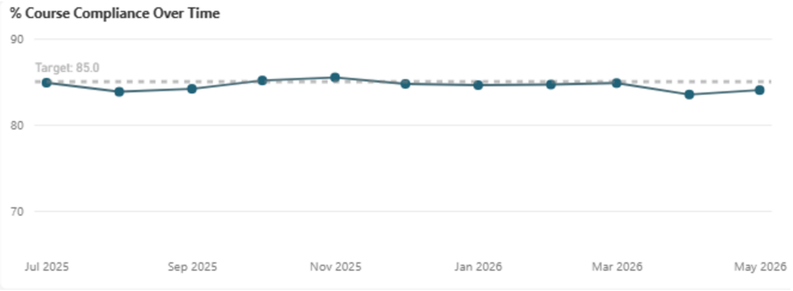
Appraisals AfC



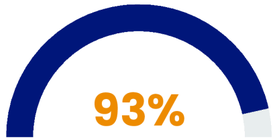
Core Mandatory Training

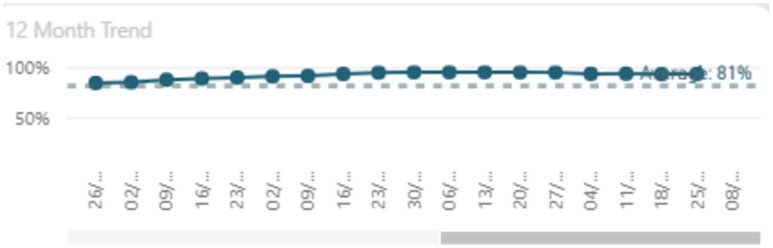


Role Specific Training

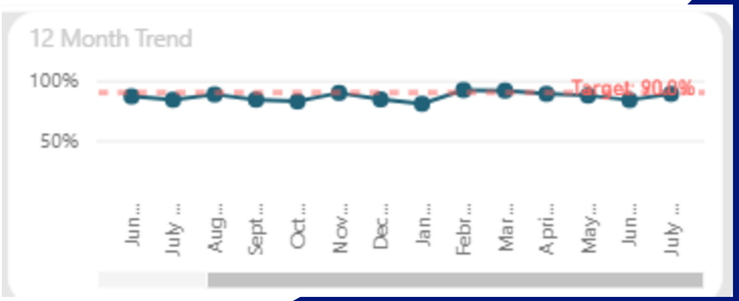


Job Planning





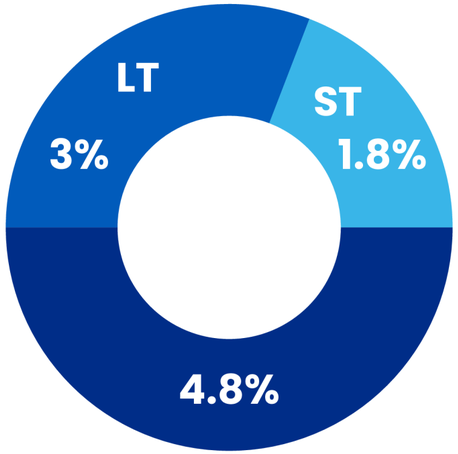
Appraisals Medical and Dental



Wellbeing and Retention

The next two slide represents the employee wellbeing and retention activity of Humber Health Partnership Group. It includes details related to Turnover, absence rates and retention.

Overall Sickness

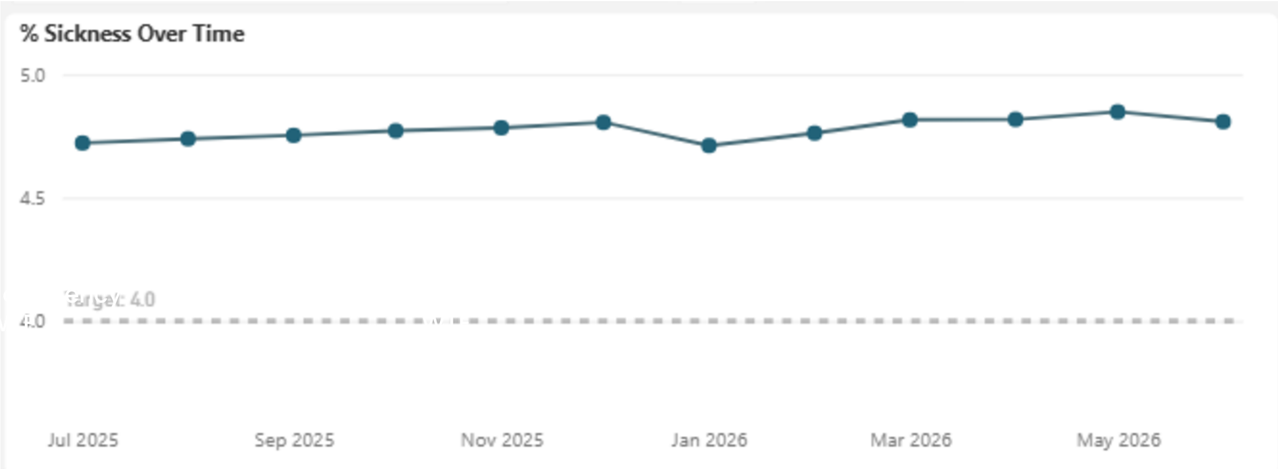


Workforce Summary

Staff Group	% Sickness	% ST	% LT	% Maternity	% Total Absence
Add Prof Scientific and Technic	4.7%	1.3%	3.4%	2.9%	7.7%
Additional Clinical Services	6.7%	2.5%	4.2%	2.1%	8.7%
Administrative and Clerical	4.4%	1.3%	3.1%	1.4%	5.8%
Allied Health Professionals	4.1%	1.8%	2.3%	2.9%	7.0%
Estates and Ancillary	6.5%	2.0%	4.5%	0.6%	7.1%
Healthcare Scientists	3.3%	1.4%	1.9%	1.7%	5.0%
Medical and Dental	2.0%	1.1%	1.0%	1.8%	3.8%
Nursing and Midwifery Registered	5.3%	2.1%	3.2%	4.2%	9.5%
Students	1.2%	0.9%	0.3%	1.8%	3.1%
Total	**4.8%**	**1.8%**	**3.0%**	**2.5%**	**7.3%**

Absence Reasons

Absence Reason	FTE Days Lost	Number of Episodes
S10 Anxiety/stress/depression/other psychiatric illnesses	58,908.53	3,153.00
S98 Other known causes - not elsewhere classified	30,998.36	4,634.00
S25 Gastrointestinal problems	23,013.37	8,248.00
S13 Cold, Cough, Flu - Influenza	21,840.72	9,181.00
S12 Other musculoskeletal problems	20,316.40	1,619.00
S28 Injury, fracture	14,585.44	987.00
S26 Genitourinary & gynaecological disorders	12,157.46	1,355.00
S11 Back Problems	11,781.14	1,335.00
S30 Pregnancy related disorders	11,171.46	1,760.00
S16 Headache / migraine	5,811.41	3,078.00
S15 Chest & respiratory problems	5,620.86	1,172.00
S17 Benign and malignant tumours, cancers	5,419.47	130.00
S19 Heart, cardiac & circulatory problems	5,200.89	370.00
S21 Ear, nose, throat (ENT)	3,762.46	1,084.00
S23 Eye problems	2,621.10	364.00
S29 Nervous system disorders	1,739.75	144.00
S99 Unknown causes / Not specified	1,413.17	60.00
S31 Skin disorders	1,239.49	225.00
S22 Dental and oral problems	1,236.93	474.00
S27 Infectious diseases	1,139.48	189.00
S24 Endocrine / glandular problems	872.69	113.00
S18 Blood disorders	629.79	48.00
S14 Asthma	393.55	67.00
S32 Substance abuse	189.99	5.00
S20 Burns, poisoning, frostbite, hypothermia	144.83	34.00
Total	**242,208.73**	**39,829.00**



Wellbeing and Retention

Overall Retention

Staff Group Summary

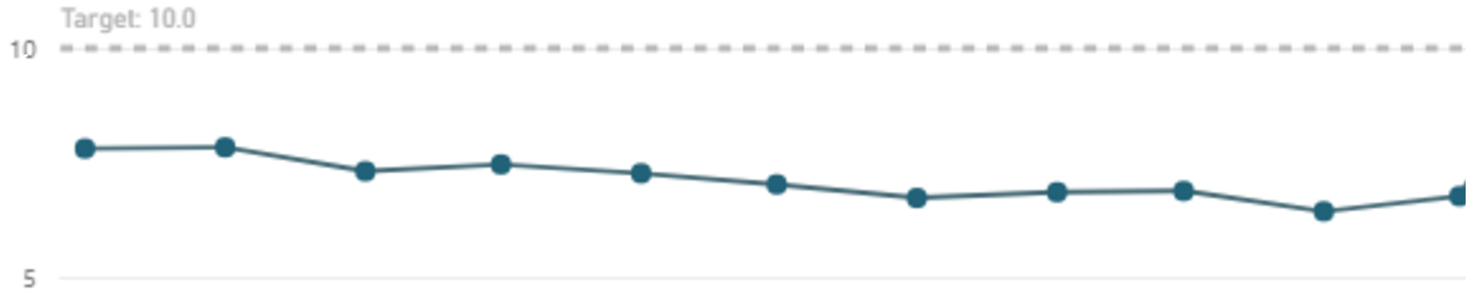
Staff Group	% Turnover	Leavers FTE (12m Avg)	Starters FTE (12m Avg)	First Year Termination FTE (12m Avg)	% First Year Termination
Add Prof Scientific and Technic	3.6%	10.3	16.2	1.0	9.8%
Additional Clinical Services	9.0%	239.2	417.2	64.3	26.9%
Administrative and Clerical	6.9%	198.2	289.5	45.6	23.0%
Allied Health Professionals	7.7%	95.7	87.4	14.7	15.3%
Estates and Ancillary	9.2%	100.1	111.4	22.1	22.1%
Healthcare Scientists	7.4%	28.0	39.3	2.0	7.1%
Medical and Dental	4.9%	43.7	937.5	6.0	13.7%
Nursing and Midwifery Registered	5.3%	247.9	180.6	18.8	7.6%
Students	0.0%	0.0	11.8	0.0	
Total	**6.8%**	**963.2**	**2091.0**	**174.5**	**18.1%**

Leavers does not include Fixed Term Contracts

Leave Reasons

Leave Reasons - Selected Month	FTE
End of Fixed Term Contract	613.42
Voluntary Resignation - Relocation	227.18
Voluntary Resignation - Other/Not Known	153.89
Retirement Age	147.68
Voluntary Resignation - Work Life Balance	137.66
Voluntary Resignation - Promotion	83.04
Voluntary Resignation - To undertake further education or training	68.42
Voluntary Resignation - Health	58.29
Employee Transfer	22.59
Voluntary Resignation - Child Dependants	19.34
Voluntary Resignation - Incompatible Working Relationships	18.85
Voluntary Resignation - Pay and Reward Related	17.28
Voluntary Resignation - Lack of Opportunities	14.23
End of Fixed Term Contract - Completion of Training Scheme	13.20
Dismissal - Capability	13.18
Death in Service	13.09
Retirement - Ill Health	12.72
End of Fixed Term Contract - Other	11.59
Voluntary Early Retirement - no Actuarial Reduction	8.84
Flexi Retirement	8.67
End of Fixed Term Contract - End of Work Requirement	7.25
Total	**1,710.67**

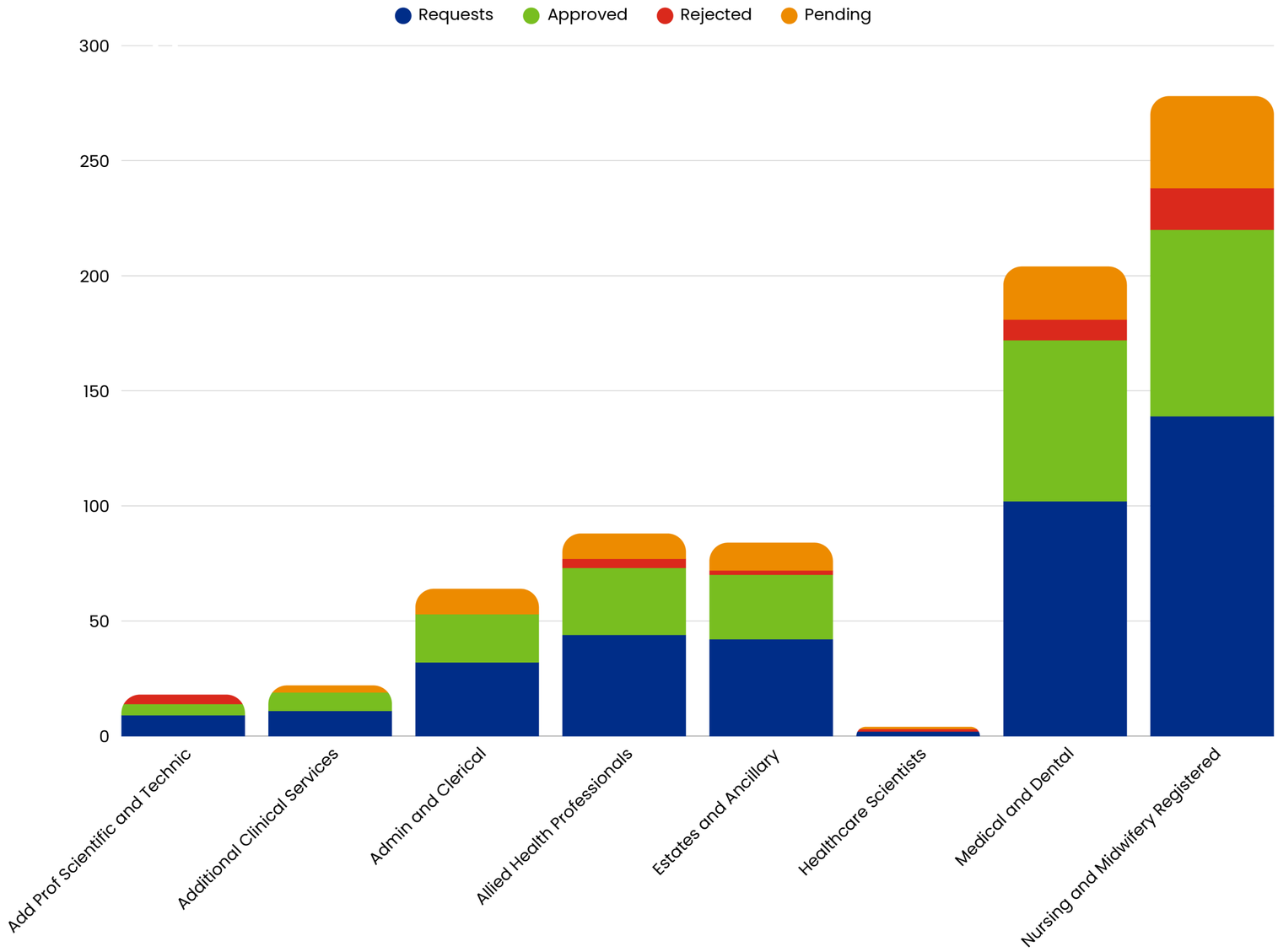
% Turnover Over Time



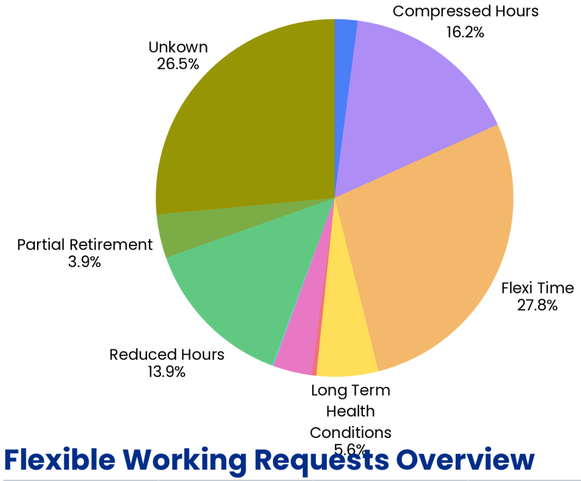
Wellbeing and Retention

This slide presents analysis of flexible working requests since the implementation of the new Group platform in November 2025, highlighting trends in requests and outcomes across staff groups.

Flexible Working Requests by Staff Group



Types of Flexible Working

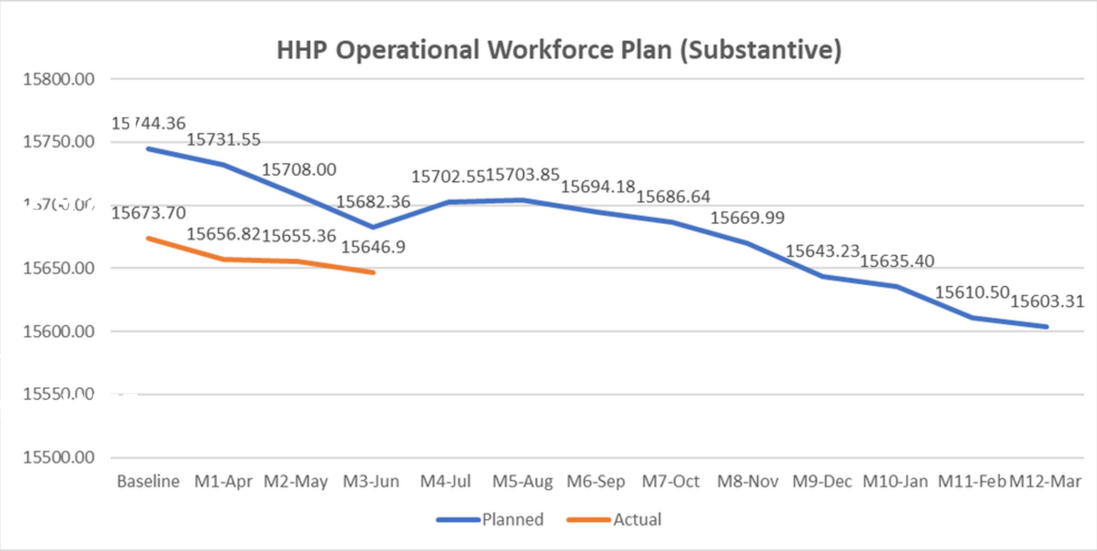


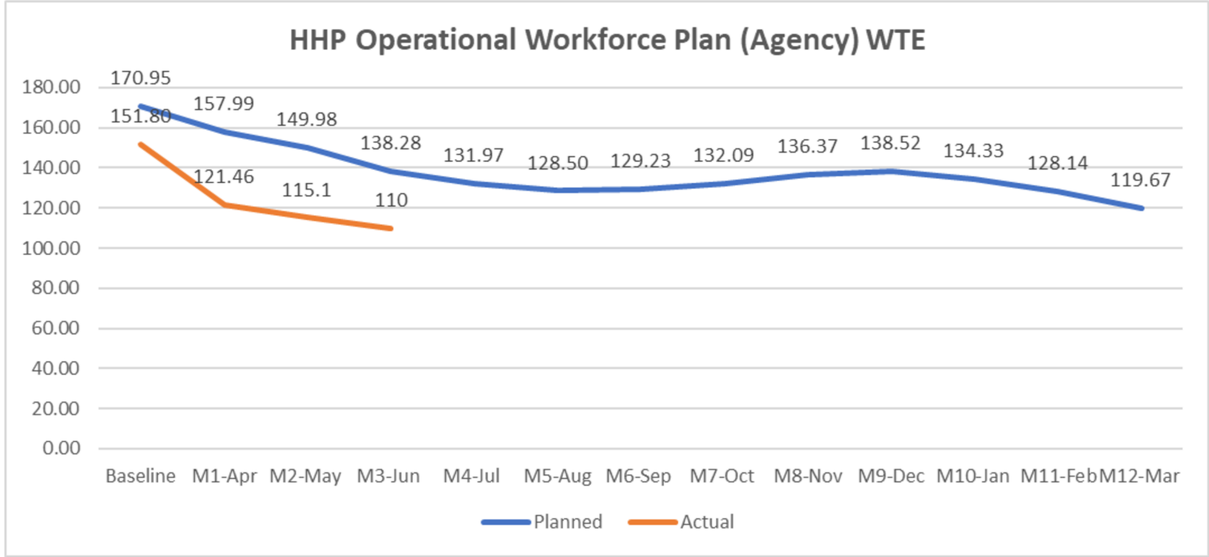
Flexible Working Requests Overview

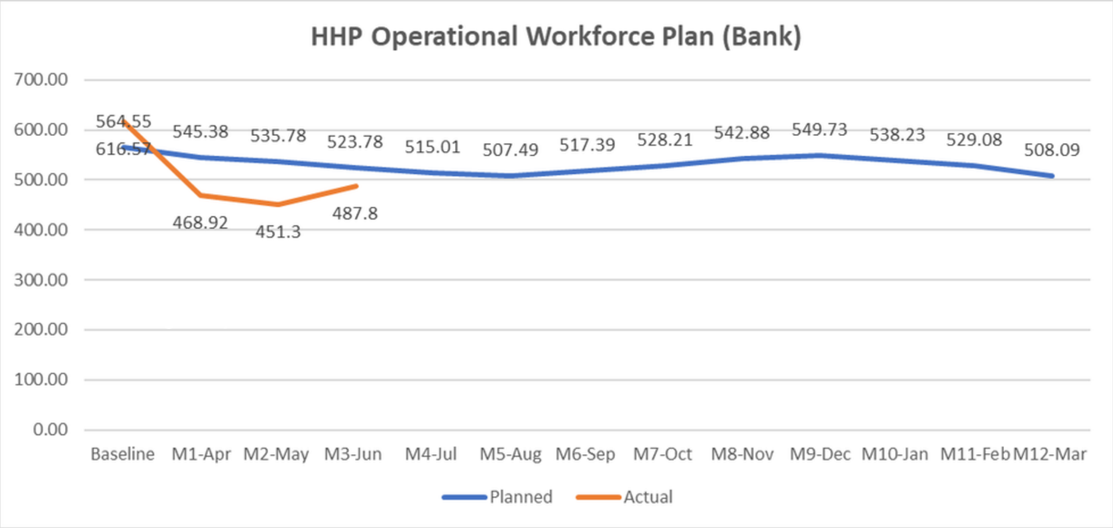
	Requests	Approved	Declined	Pending
Nov	9	7	1	1
Dec	53	36	9	8
Jan	132	94	24	14
Feb	137	91	8	38
March	129	110	18	1
April	135	113	14	8
May	119	92	14	13
June	144	90	21	33

Workforce Operational Planning - Headcount Reduction

This slide provides an overview of headcount reduction activity as part of Workforce Operational Planning







This analysis measures progress against the Workforce Operational Plan. While the data indicates positive progress and suggests we are moving in the right direction, further reductions are required to achieve the overall target. To date, approximately 10% of the planned reduction has been achieved against the overall target of 30%, and continued focus will be needed to deliver the remaining reductions.

Support & Further Information

For a more detailed view of workforce insights, Care Groups can access the HR Workforce Power BI Dashboard, which provides live data on:

- Establishment and vacancy position
- Temporary staffing usage (bank and agency)
- Turnover, sickness absence, and retention trends
- Workforce demographics and age profiles

HR Workforce Reports - Power BI Report Server

The dashboard allows you to explore data at both Trust and Care Group level, supporting ongoing monitoring and planning.

If you require any additional support with workforce data, or need help interpreting the information provided in this pack, please contact the Workforce Intelligence & Systems Team at:

GET IN TOUCH

nlg-tr.twworkforcedatareqs@nhs.net

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committees-in-Common Front Sheet

Agenda Item No: CIC(26) 4.1

Name of Meeting	Quality and Safety Committees-in-Common
Date of the Meeting	23 July 2026
Director Lead	Peter Sedman, Group Deputy Chief Medical Officer Jo Ledger, Interim Group Chief Nurse Hilda Gwilliams, Group Chief Patient Safety Officer
Contact Officer / Author	Richard Dickinson, Associate Director of Quality Governance Michela Littlewood, Associate Director of Quality Governance
Title of Report	**Quality Integrated Performance Report**
Executive Summary	The purpose of this report is to provide oversight of a range of quality indicators, with the latest data up to May 2026. **Alert** • Several Infection Control Alert Organism rates are over trajectory for both HUTH and NLAG, including C.difficile and E.Coli blood stream infections, with NLAG having a MRSA BSI case in June 2026. • VTE Risk Assessment rates are below Target for both Trusts at 14 hours and 24 hours at HUTH. • There was a never event, wrong site surgery at HRI in June 2026. **Advise** • The Safety Alert for medical beds and trolleys and equipment entrapment, at HUTH, has one of the outstanding action requirements. • SHMI rates for Septicaemia remain higher than expected across the group, with Gastrointestinal Haemorrage at HUTH also. • There have been no Never Events reported in June at NLAG and this year to date. • PALS and Complaints activity and process are being reviewed and revised in order to support more engagement and more effective learning, reduction in complaints and concerns. • The Business Intelligence charts have been updated to flag triggers for Alert, Advise and Assure, to assist with analysis, Commentary is provided where these triggers are shown. • A Publicview dashboard for the NOF 2026/27 is provided,

	although not all metrics from the revised framework are readily available to benchmark, assess or forecast at the time of reporting. **Assure** • Duty of Candour reliability is evidenced through continued improved compliance, 100% across the Group in prior months and 4 cases overdue in May, so >94% completed. • Sustained improvement of mortality indicators is found at NLAG, with group oversight of the higher than expected datasets. There are Quality Priority workstreams to address recognized quality risks as follows: • Sepsis and deterioration • Infection Control • Deconditioning • Surgical Safety • Insulin Safety **Recommendation** This report is provided for information and discussion.
Background Information and/or Supporting Document(s) (if applicable)	This report is also reported to the Patient Safety and Learning Group. The data is also used for drill down views for Care Group use, where the data can be presented to align.
Prior Approval Process	No prior reporting route.
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 by CiC ✓ Information ☐ Endorse for approval by Trust Board(s) ☐ Assurance ☐ Other – please detail below:

BAF to which the paper relates:	Tick all those appropriate
Our Patients - Access	☐
Our Patients - Safety	✓
Our People	☐
Our Partnerships	☐
Our Pioneers	☐
Our Public Purse	☐

NHS
Humber Health
Partnership

Quality Integrated Performance Report (IPR) and Performance Metrics

June 2026

United By Compassion: Driving For Excellence

Highlights and Lowlights

NHS Humber Health Partnership

The IPR is now published following development with the Information Team, building a refreshed reporting tool for the Group. There are some datasets being worked on as DQ issues identified through deployment. Most of the report used BI data from Information Services. A glossary is provided on the last slide.

	HUTH	NLAG
Highlights	• Duty of candour compliance has improved significantly, with improving timeliness. • The HSMR is improving and the downward trend tracks more recent data than SHMI, with a ratio of 99.4. • The FFT data collection was been interrupted with the contract ending and a new process has been successfully introduced.	• Duty of candour compliance has improved and demonstrates reliability and timeliness. • NLaG is identified as having a 'as expected' SHMI, with an overall SHMI of 0.9767. This is higher than last month's value of 0.9756. • There has been a statistically significant improvement with successive reduction in the HSMR over several months, now remains under 100 for 24 months, and at 85.2. This figure is the lowest level on record. • There were no Never Events in June 2026 with 4 in the rolling 12 months, and none in 2026.

Lowlights	• There has been a wrong site surgery Never Event at HRI. There have been 6 Never Events 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)
	• HUTH is identified as having a 'as expected' SHMI, with an overall SHMI of 1.0376. This is higher than last month's value of 1.0242.
	• For the conditions for which SHMI is calculated by NHS Digital - HUTH is identified as having a higher-than-expected SHMI for:
	  • Septicaemia
	  • Gastrointestinal heamorrhage
	• Patient complaint rate of completion within timescales remains below target consistently.
	• Infection control trajectories are reset from April, with C.difficile, e.coli, and Pseudomonas are over the month 3 trajectory.
	• VTE data remains below the 95% target overall and at 14 hours from admission.
	• From the available revised NOF framework, the benchmarking data shows lower overall performance.
		• For the conditions for which SHMI is calculated by NHS Digital – NLAG is identified as having a having a higher-than-expected SHMI for:
		  • Septicaemia
		• Patient complaint rate of completion within timescales remains below target consistently.
		• Infection control trajectories are reset from April, with C.difficile, e-coli, MRSA and Klebsiella are over the month 3 trajectory.
		• The latest position at 14 hours from admission is below target for VTE risk assessment, although this is achieved at >95% target at 24 hours.
		• From the available revised NOF framework, the benchmarking data shows lower overall performance.

SPC GUIDE

A guide to understanding Statistical Process Control (SPC) charts, variation and assurance icons

Statistical Process Control (SPC) charts help us understand how processes perform over time, distinguishing between normal and special cause variation. These charts follow best practice principles aligned with the **Making Data Count** (MDC) approach. Further details of Making Data Count principles can be found as follows:

https://www.england.nhs.uk/publication/making-data-count/

WHAT YOU'LL SEE

SPC Chart

Each point represents a data value over time. The chart helps you understand how the process is performing, highlighting whether variation is expected (*common cause*) or unusual (*special cause*).
Blue dots indicate improvement (special cause variation); **Amber dots** indicate concern (special cause variation); **Grey dots** indicate expected variation (common cause).

Variation Icons

These summarise the type of variation at a glance.
Blue indicates improvement; **Amber** indicates concerning variation that may require action; **Grey** indicates no significant change (common cause variation).

Assurance Icons

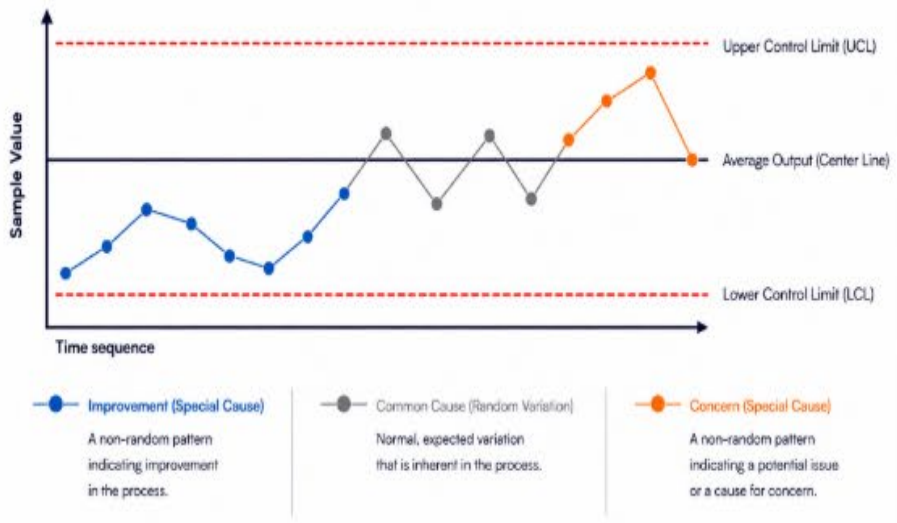
These indicate how reliably the target is being met.
Blue indicates target is consistently achieved; **Amber** indicates target is not consistently achieved; **Grey** indicates target is inconsistently achieved due to random variation.

Triple-A Status

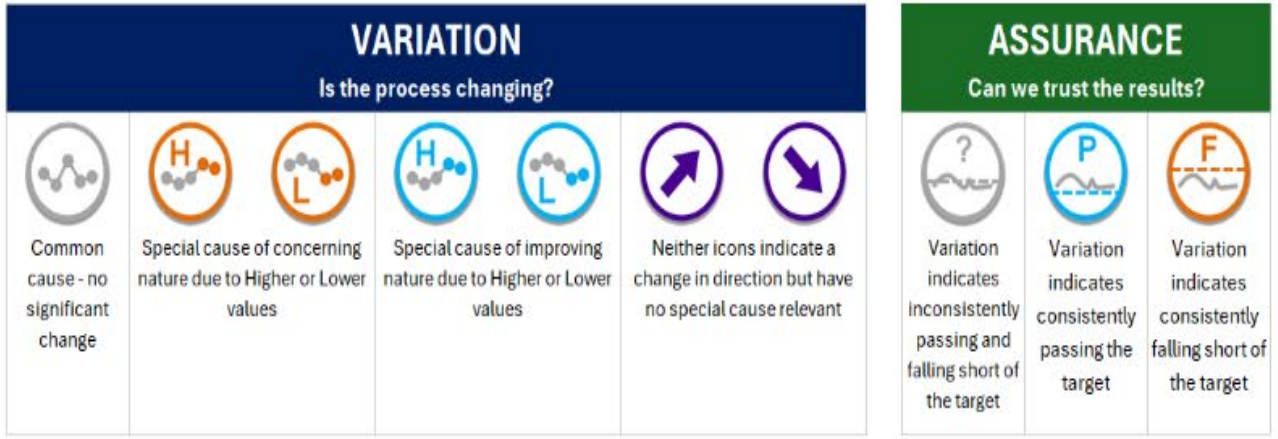
Combines variation and assurance to give an overall rating:
Assure, **Advise**, or **Alert**.

Variation	Plan / Assurance	AAA Status
Improving	Meeting	Assure
Normal	Meeting	Assure
Improving	Missing	Advise
Concerning	Meeting	Advise
Concerning	Missing	Alert
Normal	Missing	Alert

SPC Chart



Variation and Assurance Icons



NHS Outcomes framework 2026/27 (Publicview latest data)

Hull University Teaching Hospitals

NOF 2026/27 | NOF BETA | Headlines | Board | Peers | Reports

Default | Filters | Jul 26

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer - Patients treated within 62 of referral	May 26	75.00%	49.43%			7
Cancer - Patients treated within 62 of referral QTD	Q1 26/27	75.00%	51.10%			4
Cancer - Urgent referrals diagnosis within 4 weeks	May 26	80.0%	70.6%			11
Cancer - Urgent referrals diagnosis within 4 weeks QTD	Q1 26/27	80.0%	70.9%			15
Community Services - Patients waiting less than 18 weeks	Jan 25	-	0.00%			0
Community Services - Patients waiting over 52 weeks	Jan 25	-	0.00%			100
Data Quality Maturity Index (DQMI)	Feb 26	90.0	95.0			78
Diagnostics - 6 Week Standard	May 26	5.00%	38.62%			14
ED - Attendances managed within 4 hours	Jun 26	78.00%	58.60%			9
ED - Attendances managed within 4 hours QTD	Q1 26/27	78.00%	61.63%			9
ED - Attendances over 12 hours in department	May 26	-	9.1%			55
ED - Attendances over 12 hours in department QTD	Q1 26/27	-	7.5%			65
Finance - Combined finance score	Q4 25/26	-	4			100
Finance - Planned surplus/deficit	Q4 25/26	0.0%	-1.4%			38
Finance - Variance year-to-date to financial plan	Q4 25/26	0.00%	-2.13%			14
Frontline healthcare workers to receive a flu vaccination	Q4 25/26	-	51.0%			62
Number of MRSA bacteraemia cases	May 26	0	2			73
Patients cared for in corridors - ED	Jun 26	-	882			27
Patients cared for in corridors - ED QTD	Q1 26/27	-	1,478			31
Productivity - Implied productivity level	Mar 26	-	-1.0%			17
Proportion of C-Difficile infections against threshold	May 26	1.00	1.95			2
Proportion of E-Coli bacteraemia against threshold	May 26	1.00	1.04			77
RTT - Patients waiting 18 weeks or less	May 26	-	57.25%			5
RTT - Patients waiting over 52 weeks	May 26	1.00%	3.64%			4
RTT - Planned v actual 18 week performance	Q4 25/26	0.0%	-5.5%			7
Sickness Absence Rate	Mar 26	-	4.13%			92
Sickness Absence Rate QTD	Q4 25/26	-	4.54%			88
Staff Survey - Advocacy sub-score	2024	-	6.10			9
Staff Survey - Engagement Theme Score	2024	-	6.47			9
Staff Survey - Raising Concerns sub-score	2024	-	6.09			12
Summary Hospital Mortality Indicator	Feb 26	-	1.04			36

Northern Lincolnshire and Goole

NOF 2026/27 | NOF BETA | Headlines | Board | Peers | Reports

Default | Filters | Jul 26

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer - Patients treated within 62 of referral	May 26	75.00%	64.03%			21
Cancer - Patients treated within 62 of referral QTD	Q1 26/27	75.00%	64.56%			22
Cancer - Urgent referrals diagnosis within 4 weeks	May 26	80.0%	58.5%			2
Cancer - Urgent referrals diagnosis within 4 weeks QTD	Q1 26/27	80.0%	60.8%			2
Community - Urgent response 2 hours performance	May 26	70.00%	97.26%			90
Community - Urgent response 2 hours performance QTD	Q1 26/27	70.00%	97.88%			96
Community Services - Patients waiting less than 18 weeks	May 26	-	83.14%			57
Community Services - Patients waiting over 52 weeks	May 26	-	0.37%			55
Data Quality Maturity Index (DQMI)	Feb 26	90.0	91.3			43
Diagnostics - 6 Week Standard	May 26	5.00%	34.41%			18
ED - Attendances managed within 4 hours	Jun 26	78.00%	69.17%			32
ED - Attendances managed within 4 hours QTD	Q1 26/27	78.00%	69.54%			29
ED - Attendances over 12 hours in department	May 26	-	15.0%			15
ED - Attendances over 12 hours in department QTD	Q1 26/27	-	15.4%			12
Finance - Combined finance score	Q4 25/26	-	4			100
Finance - Planned surplus/deficit	Q4 25/26	0.0%	-2.4%			24
Finance - Variance year-to-date to financial plan	Q4 25/26	0.00%	-2.25%			13
Frontline healthcare workers to receive a flu vaccination	Q4 25/26	-	51.1%			64
Number of MRSA bacteraemia cases	May 26	0	4			45
Patients cared for in corridors - ED	Jun 26	-	684			37
Patients cared for in corridors - ED QTD	Q1 26/27	-	1,146			40
Productivity - Implied productivity level	Mar 26	-	1.3%			34
Proportion of C-Difficile infections against threshold	May 26	1.00	1.89			3
Proportion of E-Coli bacteraemia against threshold	May 26	1.00	1.63			8
RTT - Patients waiting 18 weeks or less	May 26	-	62.01%			23
RTT - Patients waiting over 52 weeks	May 26	1.00%	2.50%			12
RTT - Planned v actual 18 week performance	Q4 25/26	0.0%	-3.7%			13
Sickness Absence Rate	Mar 26	-	4.75%			68
Sickness Absence Rate QTD	Q4 25/26	-	5.11%			65
Staff Survey - Advocacy sub-score	2024	-	5.98			4
Staff Survey - Engagement Theme Score	2024	-	6.43			8
Staff Survey - Raising Concerns sub-score	2024	-	6.06			10
Summary Hospital Mortality Indicator	Feb 26	-	0.98			56

Quality IPR dashboard (Safe)

Trust Scorecard | Care Group Scorecard | Specialty Scorecard | Assurance Scorecard | Balanced Scorecard | EasySPC Spotlight | Data Table | Metadata

Scorecard: Quality | Metric Group: Safe | Search

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
Clinical Harm Reviews - Cancer 104 day wait	Jun-26		0		
Clinical Harm Reviews - RTT 78 week wait	Jun-26		0		
Duty of Candour - Verbal apology	Sep-25	≥ 100.0%	60.4%		
Duty of Candour - Verbal apology within 10 working days	Sep-25	≥ 100.0%	54.1%		
Duty of Candour - Written apology	Sep-25	≥ 100.0%	100.0%		
Duty of Candour - Written apology within 10 working days	Sep-25	≥ 100.0%	100.0%		
Falls - Moderate and above (per 1,000 bed days)	Jun-26		0.10		
Falls - per 1,000 bed days	Jun-26		6.86		
Falls - Serious harm or death	Jun-26		2		
Falls - Serious harm or death (per 1,000 bed days)	Jun-26		0.06		
Falls - Total incidents	Jun-26		214		
Inpatient - Corridor Care on Wards	Jun-26		45.8		
Inpatient - Discharge Lounge Utilisation	Jun-26		15.0%		
Inpatient - Discharge to Assess (D2A) over 14 days	Jun-26		2.4%		
Inpatient - Discharges by 12pm (midday)	Jun-26		21.3%		
Inpatient - Discharges by 5pm	Jun-26		63.3%		
Inpatient - Long Stay Occupancy (21+ days)	Jun-26		194.3		
Medication Incidents	Jun-26		105		
Medication Incidents - Moderate harm	Jun-26		0		
Medication Incidents - per 1,000 bed days	Jun-26		3.37		
Medication Incidents - Serious harm	Jun-26		0		
Medication Incidents - Serious harm	Jun-26		0		
Mixed Sex Accommodation Breaches	May-26		2		
Never Events	Jun-26		1		
Never Events (per 1,000 bed days)	Sep-25		0.03		
Patient Incidents	Jun-26		1,992		
Patient Safety Incidents - % Harmful	Jun-26		1.8%		
Patient Safety Incidents - Fatal	Jun-26		3		
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	Jun-26		391		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Jun-26		1.15		
Patient Safety Incidents - Moderate harm	Jun-26		28		
Patient Safety Incidents - No harm	Jun-26		1,565		
Patient Safety Incidents - Severe harm	Jun-26		5		
Pressure Ulcers - Category 1	Jun-26		8		
Pressure Ulcers - Category 2	Jun-26		47		
Pressure Ulcers - Category 3	Jun-26		1		
Pressure Ulcers - Category 4	Jun-26		0		
Pressure Ulcers - Community acquired	Jun-26		376		
Pressure Ulcers - Device related	Jun-26		16		
Pressure Ulcers - Hospital acquired	Jun-26		116		
Pressure Ulcers - Hospital acquired (per 1,000 bed days)	Jun-26		3.72		
Pressure Ulcers - Hospital acquired moderate and above (p...	Jun-26		0.16		
Pressure Ulcers - Suspected deep tissue injury	Jun-26		29		
Pressure Ulcers - Unstageable	Jun-26		5		
VTE Risk Assessment	Jun-26	≥ 95.0%	92.7%		
VTE Risk Assessment 14 Hour Standard	May-26	≥ 95.0%	92.0%		

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
Clinical Harm Reviews - Cancer 104 day wait	Jun-26		0		
Clinical Harm Reviews - RTT 78 week wait	Jun-26		0		
Falls - Moderate and above (per 1,000 bed days)	Jun-26		0.15		
Falls - per 1,000 bed days	Jun-26		6.07		
Falls - Serious harm or death	Jun-26		2		
Falls - Serious harm or death (per 1,000 bed days)	Jun-26		0.10		
Falls - Total incidents	Jun-26		122		
Inpatient - Corridor Care on Wards	Jun-26		3.6		
Inpatient - Discharge Lounge Utilisation	Jun-26		17.8%		
Inpatient - Discharge to Assess (D2A) over 14 days	Jun-26		2.1%		
Inpatient - Discharges by 12pm (midday)	Jun-26		27.3%		
Inpatient - Discharges by 5pm	Jun-26		73.9%		
Inpatient - Long Stay Occupancy (21+ days)	Jun-26		88.7		
Medication Incidents	Jun-26		76		
Medication Incidents - Moderate harm	Jun-26		1		
Medication Incidents - per 1,000 bed days	Jun-26		3.78		
Medication Incidents - Serious harm	Jun-26		0		
Mixed Sex Accommodation Breaches	May-26		4		
Never Events	Jun-26		0		
Never Events (per 1,000 bed days)	May-26		0.00		
Patient Incidents	Jun-26		1,703		
Patient Safety Incidents - % Harmful	Jun-26		2.8%		
Patient Safety Incidents - Fatal	Jun-26		1		
Patient Safety Incidents - Investigation rate (per 1,000 bed ...	Jun-26		0.00		
Patient Safety Incidents - Investigations (PSIIs)	Apr-26		0		
Patient Safety Incidents - Low harm	Jun-26		437		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Jun-26		2.34		
Patient Safety Incidents - Moderate harm	Jun-26		44		
Patient Safety Incidents - No harm	Jun-26		1,219		
Patient Safety Incidents - Severe harm	Jun-26		2		
Pressure Ulcers - Category 1	Jun-26		13		
Pressure Ulcers - Category 2	Jun-26		131		
Pressure Ulcers - Category 3	Jun-26		8		
Pressure Ulcers - Category 4	Jun-26		1		
Pressure Ulcers - Community acquired	Jun-26		398		
Pressure Ulcers - Device related	Jun-26		17		
Pressure Ulcers - Hospital acquired	Jun-26		245		
Pressure Ulcers - Hospital acquired (per 1,000 bed days)	Jun-26		12.18		
Pressure Ulcers - Hospital acquired moderate and above (p...	Jun-26		1.34		
Pressure Ulcers - Suspected deep tissue injury	Jun-26		46		
Pressure Ulcers - Unstageable	Jun-26		19		
VTE Risk Assessment	Jun-26	≥ 95.0%	96.7%		
VTE Risk Assessment 14 Hour Standard	May-26	≥ 95.0%	94.8%		

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)	Jun-26		2.4%		
Mortality - HSMR	Mar-26	≤ 100.0	98.9		
Mortality - SHMI	Feb-26	≤ 1.0	1.038		
Mortality - Still Births (per 1,000 births)	Jun-26		0.000		

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)	Jun-26		1.9%		
Mortality - HSMR	Mar-26	≤ 100.0	84.8		
Mortality - SHMI	Feb-26	≤ 1.0	0.977		
Mortality - Still Births (per 1,000 births)	Jun-26		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	Jun-26	≥ 85.0%	42.4%		
Complaints - 60 day compliance	Jun-26	≥ 85.0%	57.6%		
Complaints - Average response time	Jun-26	≤ 40.0	60.6		
Complaints - Received	Jun-26		29		
Complaints - Received (per 1,000 bed days)	Jun-26		0.93		
Complaints - Reopened	Jun-26		0		
Friends & Family - A&E Score	May-26	≥ 85.0%	66.7%		
Friends & Family - Antenatal Score	May-26	≥ 95.0%	100.0%		
Friends & Family - Birth Score	May-26	≥ 95.0%	100.0%		
Friends & Family - Inpatient Score	May-26	≥ 95.0%	89.0%		
Friends & Family - Outpatient Score	May-26	≥ 95.0%	96.2%		
Friends & Family - Postnatal Score	May-26	≥ 95.0%	100.0%		
PALS - Complaints	Jun-26	≤ 1	159		
PALS - Complaints compliance within 5 working days	Jun-26		33.0%		
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	Jun-26	≥ 85.0%	38.9%		
Complaints - 60 day compliance	Jun-26	≥ 85.0%	72.2%		
Complaints - Average response time	Jun-26	≤ 40.0	42.4		
Complaints - Received	Jun-26		26		
Complaints - Received (per 1,000 bed days)	Jun-26		1.29		
Complaints - Reopened	Jun-26		0		
Friends & Family - A&E Score	May-26	≥ 85.0%	74.3%		
Friends & Family - Antenatal Score	May-26	≥ 95.0%	66.7%		
Friends & Family - Birth Score	May-26	≥ 95.0%	100.0%		
Friends & Family - Community Score	May-26	≥ 95.0%	99.3%		
Friends & Family - Inpatient Score	May-26	≥ 95.0%	98.4%		
Friends & Family - Outpatient Score	May-26	≥ 95.0%	96.3%		
Friends & Family - Postnatal Community Score	May-26	≥ 95.0%	100.0%		
Friends & Family - Postnatal Score	May-26	≥ 95.0%	100.0%		
PALS - Complaints	Jun-26	≤ 1	248		
PALS - Complaints compliance within 5 working days	Jun-26		54.0%		

Quality IPR dashboard (Infection Prevention)

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
CQC Safe Inspection Score	Jun-26		1.0		
Infections - C.Difficile	May-26		10		
Infections - C.Difficile (Cumulative)	May-26		26		
Infections - C.Difficile (per 1,000 bed days)	May-26		0.33		
Infections - E.Coli	May-26		17		
Infections - E.Coli (Cumulative)	May-26		40		
Infections - E.Coli (per 1,000 bed days)	May-26		0.56		
Infections - Klebsiella	May-26		5		
Infections - Klebsiella (Cumulative)	May-26		11		
Infections - Klebsiella bacteraemia (per 1,000 bed days)	May-26		0.16		
Infections - MRSA	May-26		0		
Infections - MRSA (Cumulative)	May-26		0		
Infections - MRSA (per 1,000 bed days)	May-26		0.00		
Infections - MSSA	May-26		3		
Infections - MSSA (Cumulative)	May-26		14		
Infections - MSSA (per 1,000 bed days)	May-26		0.10		
Infections - Pseudomonas aeruginosa	May-26		3		
Infections - Pseudomonas aeruginosa (Cumulative)	May-26		5		
Infections - Pseudomonas aeruginosa bacteraemia (per 1,0...	May-26		0.10		

Northern Lincolnshire and Goole NHS Foundation Trust

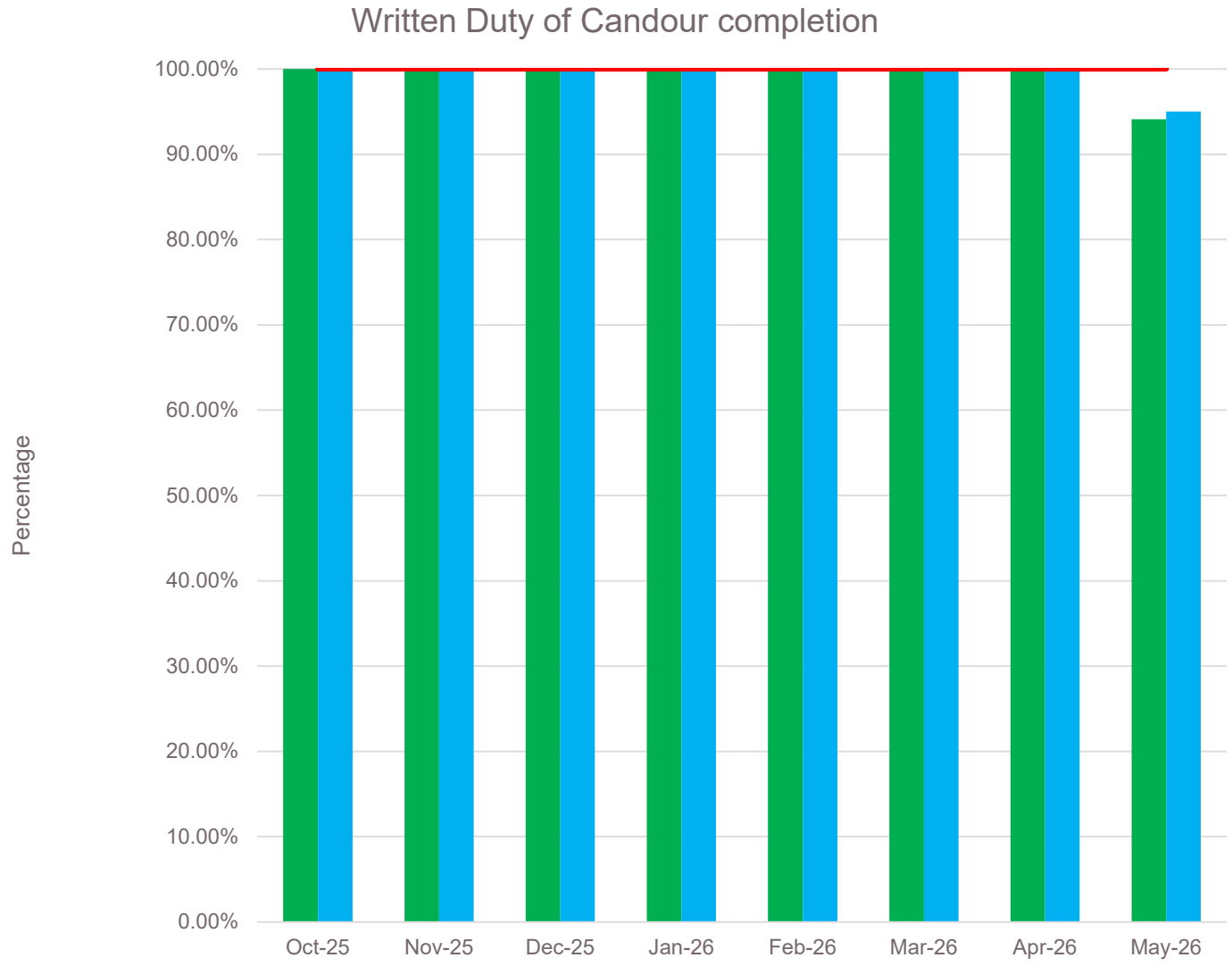
Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
CQC Safe Inspection Score	Jun-26		2.0		
Infections - C.Difficile	May-26		3		
Infections - C.Difficile (Cumulative)	May-26		7		
Infections - C.Difficile (per 1,000 bed days)	May-26		0.14		
Infections - E.Coli	May-26		25		
Infections - E.Coli (Cumulative)	May-26		46		
Infections - E.Coli (per 1,000 bed days)	May-26		1.20		
Infections - Klebsiella	May-26		5		
Infections - Klebsiella (Cumulative)	May-26		12		
Infections - Klebsiella bacteraemia (per 1,000 bed days)	May-26		0.24		
Infections - MRSA	May-26		3		
Infections - MRSA (Cumulative)	May-26		4		
Infections - MRSA (per 1,000 bed days)	May-26		0.14		
Infections - MSSA	May-26		10		
Infections - MSSA (Cumulative)	May-26		13		
Infections - MSSA (per 1,000 bed days)	May-26		0.48		
Infections - Pseudomonas aeruginosa	May-26		4		
Infections - Pseudomonas aeruginosa (Cumulative)	May-26		4		
Infections - Pseudomonas aeruginosa bacteraemia (per 1,0...	May-26		0.19		

Duty of Candour

HUTH

NLAG



	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
HUTH % completed	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.12%
NLAG % completed	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	95.00%
Target	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

There is a 10-working day target for completing written DoC and an improvement plan to achieve completion and improve timeliness. Additional measures of oversight have been introduced to improve timeliness across the group and resolve historical casework.

HUTH

- The chart illustrates that there is 100% completion for the periods shown except for 2 cases in May 2026.

Group Actions being taken to improve:

- Ulysses closure requirement ensures DoC section of the manager forms is completed.
- Dashboard on Ulysses provides real-time data.
- Care Group weekly performance reporting through the weekly monitoring report and ADQG reminders to all care groups through group safety meetings.
- Bi-weekly meetings with Group Chief Patient Safety Officer:
    - Commitment to focus on 10 working day target for newly reported incidents
    - Sharing of good practice.

NLAG

- The chart illustrates 100% compliance for written DoC across the months shown except for 2 cases in May 2026.

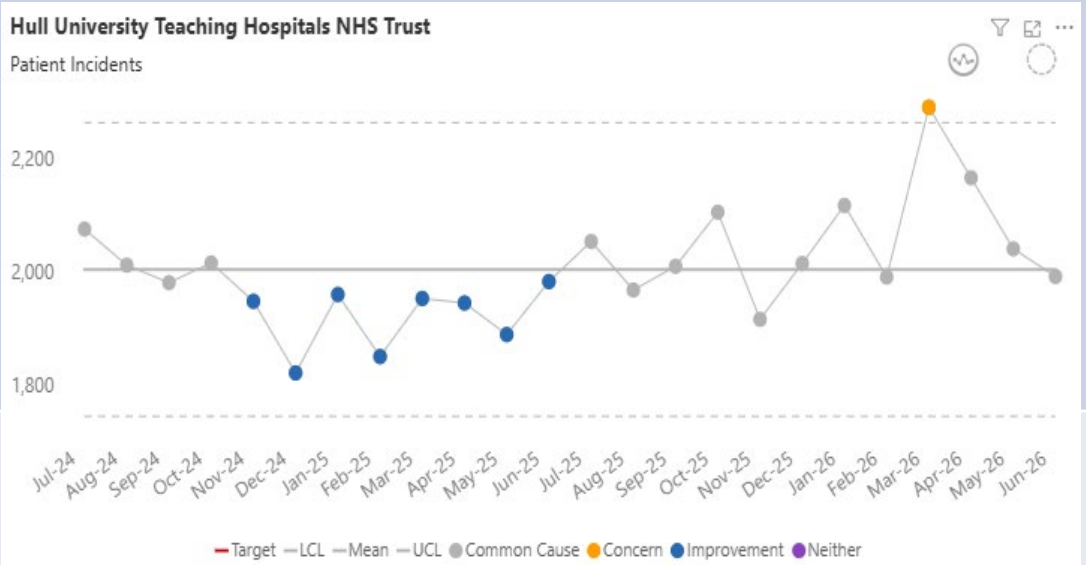
Never Events

HUTH	• There have been 5 Never Events in HUTH in the rolling 12 months up to the end of June 2026, with the last identified in June 2026 relating to a hernia operation undertaken on the wrong site. An immediate response meeting was held on 10/7/2026 • The latest published data for 2025/26 shows that HUTH has the joint 12th highest number of Never Events from all NHS providers in England in 2025/26.
NLAG	• There have been 4 Never Events in NLAG in the rolling 12 months up to the end of June 2026, with the last case identified in December 2025. • The latest published data for 2025/26 shows that NLAG has the joint 12th highest number of Never Events from all NHS providers in England in 2025/26.

	There have been no never events identified for patients recent episodes of care provided since December 2025 at NLAG.
	
	Group wide actions
	• There is an action plan in place inclusive of:
	  • ongoing audit of compliance including record keeping and observation for theatre environments, incorporating observation of Team Brief and debrief. Documentation of checklist completion. Observation of NAtSSIPS2 steps with theatre safety checklists.
	  • Feedback to staff
	  • TACC training sessions
	  • Simulation training
	  • Implementation support training in NLAG, following introduction of revised checklists in December 2025.
	  • Learning from Audit findings being shared with teams.
	  • A simulation of the Wrong Site Surgery in June is being undertaken.
	• Assurance:
	  • HRI Audit compliance shows overall observed practice for individual patient safety checks is >98% at HRI and Castle Hill.
	  • Documentatory record audits demonstrated opportunities to improve patient checklist completion and ward/transit based checking steps.

Patient Safety Incident (PSI) reporting

HUTH



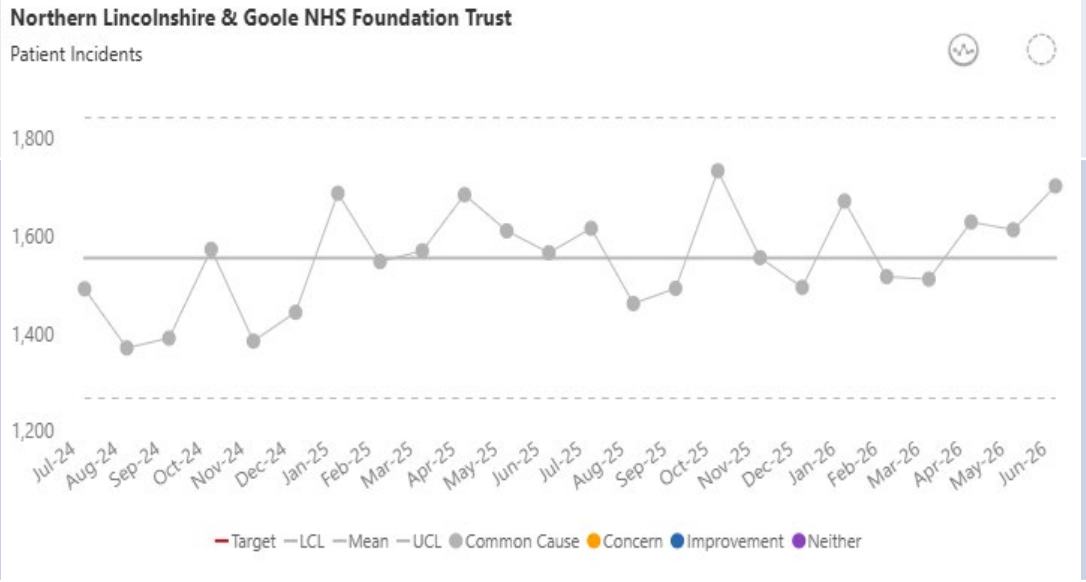
Key themes

- HUTH has Quartile 3 rates of Patient Safety Incident rates of reporting, with proportionally lower harm levels than the national data from LFPSE.
- Proportional rates of reporting harm show higher no harm and low harm reporting than the national benchmark from LFPSE.
- The data shows common cause variation after an increase in March 2026.

NLAG

Key themes

- NLAG has Quartile 4 rates of Patient Safety Incident rates of reporting, with proportionally lower harm levels than the national data from LFPSE.
- Proportional rates of reporting harm show higher no harm and low harm reporting than the national benchmark from LFPSE.
- The data shows common cause variation.

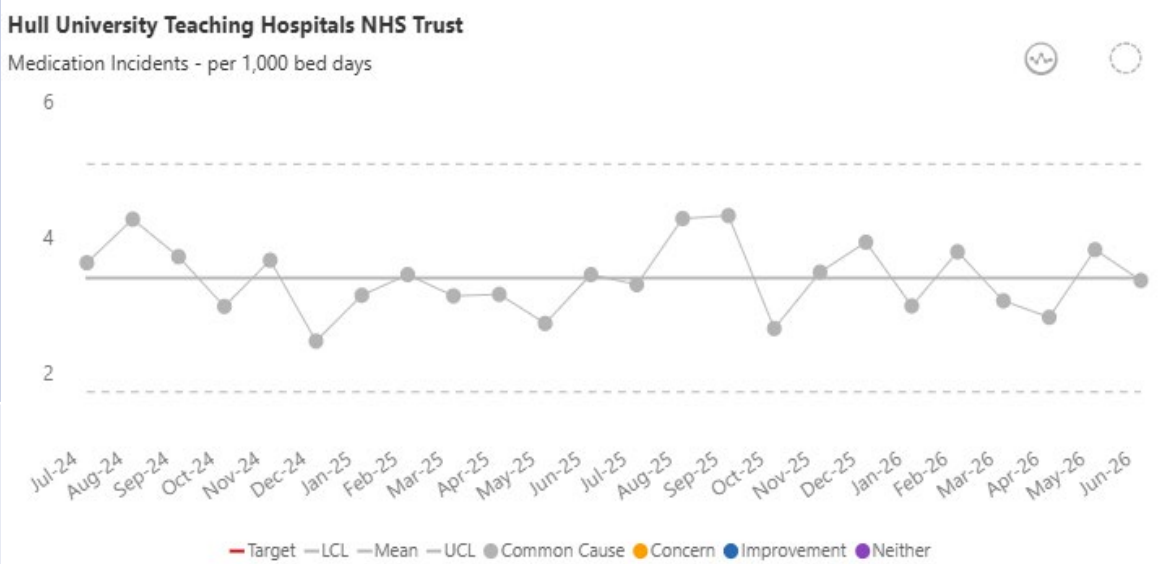


Controls, Oversight and Assurance

- Daily Safety Huddles – Monday to Friday include focus on incidents that have been reported on the previous day raising moderate and greater harm patient safety issues for early intervention
- The Care Group teams undertake a review of their incidents on a weekly basis, with urgent clinical reviews leading to reporting at the group wide weekly meeting.
- Learning Response Panel meets each week, where decisions are made for commissioning PSII and other learning responses and sharing immediate learning..
- Alternate weekly PSIRF Oversight meetings monitor activity and review completed learning responses, consider wider learning benefits to other teams and services.
- Monthly oversight is then provided by the Patient Safety and Learning Group, which reports to the Quality and Safety Committees-in-Common

Patient Safety Incident (PSI) – Medication incidents per 1000 bed days

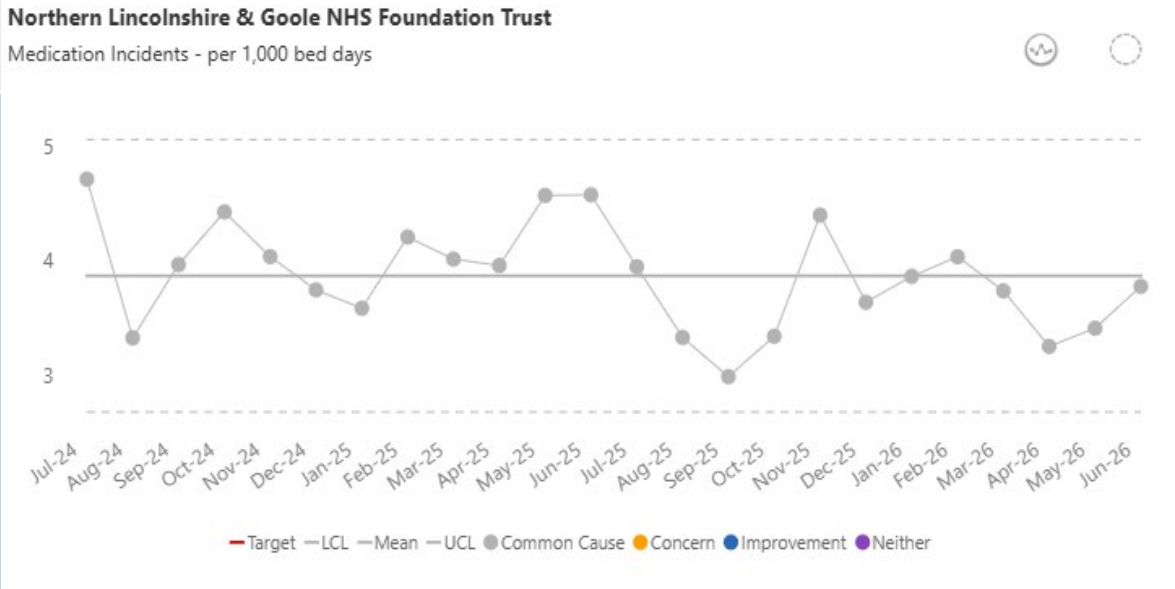
HUTH



Key themes

- Common cause variation seen on the chart illustrating no change to reporting patterns.
- There are no Fatal or Severe harm incidents for the recent period

NLAG



Key themes

- Common cause variation seen on the chart illustrating no change to reporting patterns.
- There are no Fatal or Severe harm incidents for the recent period

Controls, Oversight and Assurance
The Safer Medication Group review of incidents and learning points, policy and prescription form oversight. The Safer Medication Group reports to the Patient Safety Learning Group and Annual reporting to the Quality and Safety Committees-in-Common.

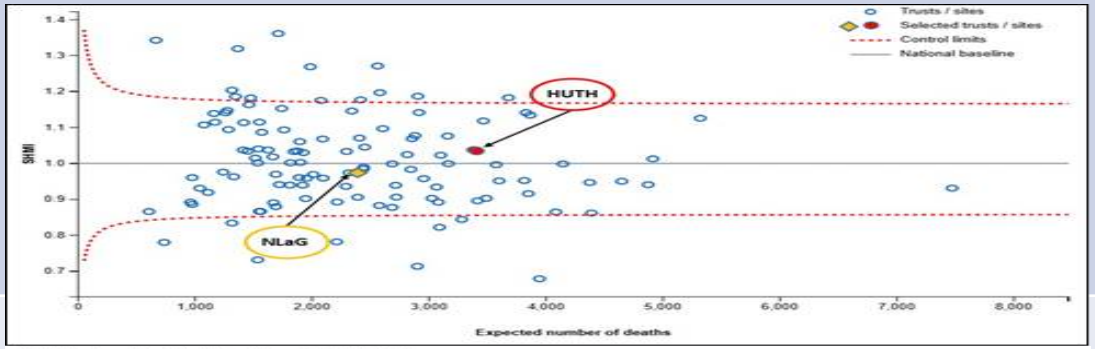
Improvement activities:
- Quality Priority workstreams on Insulin Safety are in place for 2026/27.
- Infection control quality priorities include oversight of IV/Oral switch of antibiotics.

Patient Safety Alerts

HUTH	**Overdue – 1 alert:** • Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls. Closure report and evidence collation has 2 actions that lack evidence for: Action 4 - subcontracted maintenance process oversight. Escalation for resolution with Estates and Clinical Engineering. • A contract for a managed service is being explored with oversight arrangements, as an adjustment to the existing contract which should address Action 4.
Group	**Current open Alerts and in time:** • NatPSA/2025/006/NHSPS - Harm from incorrect recording of a penicillin allergy as a penicillamine allergy, due by 20 November 2026. • The first internal meeting took place on 27 March. The group will continue to meet monthly to discuss progress. **Completed Alerts: None**
NLAG	**Overdue:** • None to report.

Mortality - SHMI

Benchmark

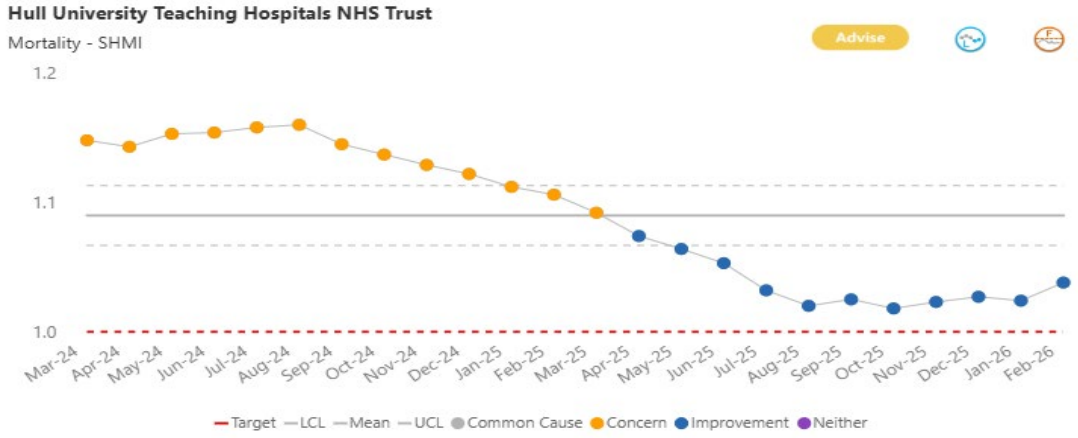


SHMI values include the episode of care and 30 days following discharge survival and deaths risk ratings..

The latest SHMI values for each site are:

- Castle Hill – 1.0152; 'as expected' (previously 0.9858 and 'as expected')
- Hull – 1.0476; 'as expected' (previously 1.0407 and 'as expected')
- Grimsby – 0.9224; 'as expected' (previously 0.9021 and 'as expected')
- Scunthorpe – 1.0382; 'as expected' (previously 1.0542 and 'as expected')
- Goole – insufficient relevant activity for SHMI to be calculated

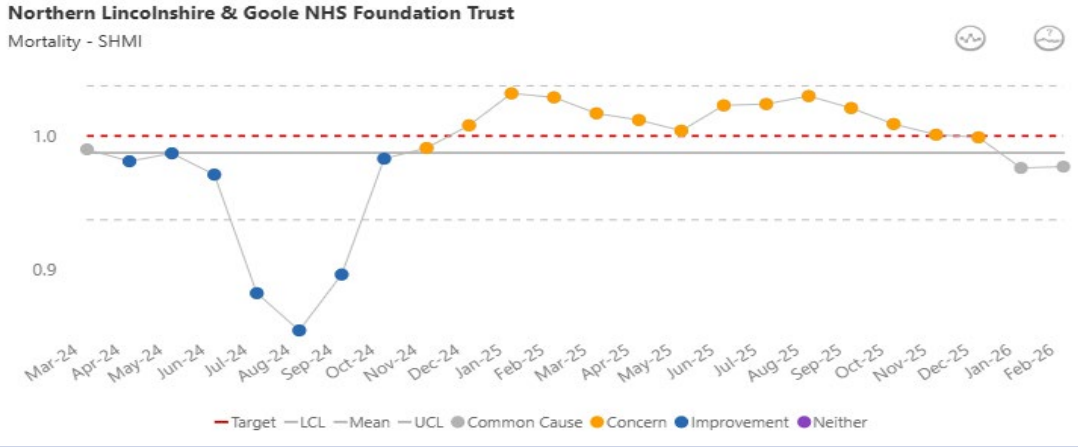
HUTH



Key themes

- HUTH is identified as having a 'as expected' SHMI, with an overall SHMI of 1.0376. This is higher than last month's value of 1.0242.For the conditions for which SHMI is calculated by NHS Digital –
- HUTH is identified as having a higher than expected SHMI for:
  - Septicaemia
  - Gastrointestinal hemorrhage
- Advise alert due to improvement trend.

NLAG



Key themes

- NLaG is identified as having a 'as expected' SHMI, with an overall SHMI of 0.9767. This is higher than last month's value of 0.9756.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

Controls, Oversight and Assurance

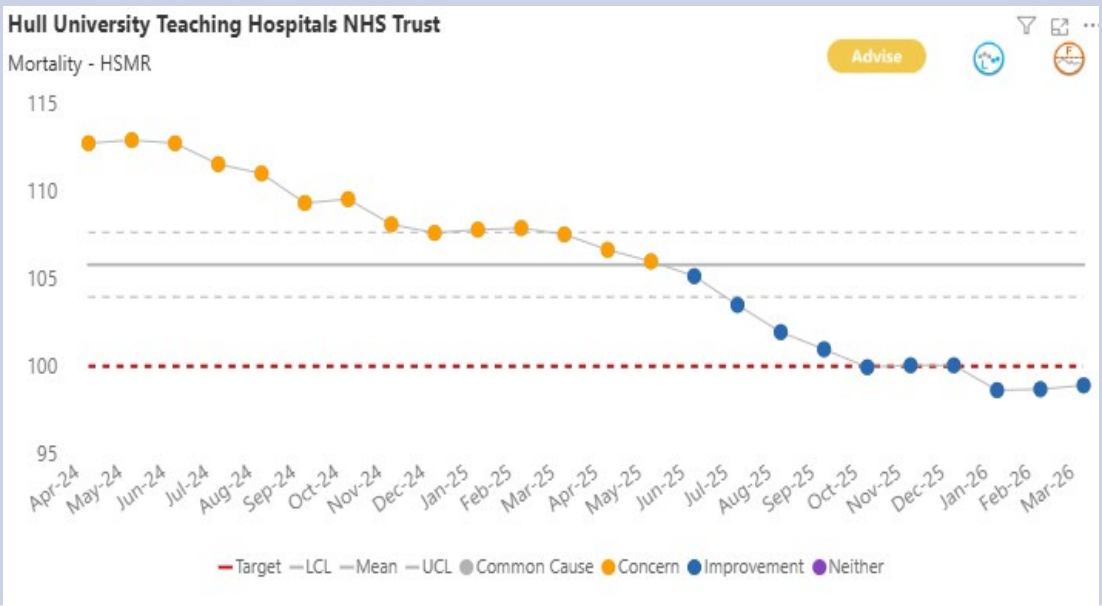
- Mortality Improvement Group (MIG) meets monthly and has a workplan to report on workstreams investigating and reviewing areas for improvement identified through analysis, to investigate causes of concern in the data and triangulated qualitative and quantitative sources.
- Care Groups report their mortality and morbidity activities to MIG
- MIG reports to the Patient Safety and Learning Group and Quarterly Learning from deaths reports are also reported to the Quality and Safety Committee.

Actions being taken to improve across the Group:

- Septicaemia is a Quality Priority for the group and remains an area of focus through the Mortality Improvement Group.

Mortality - HSMR

HUTH

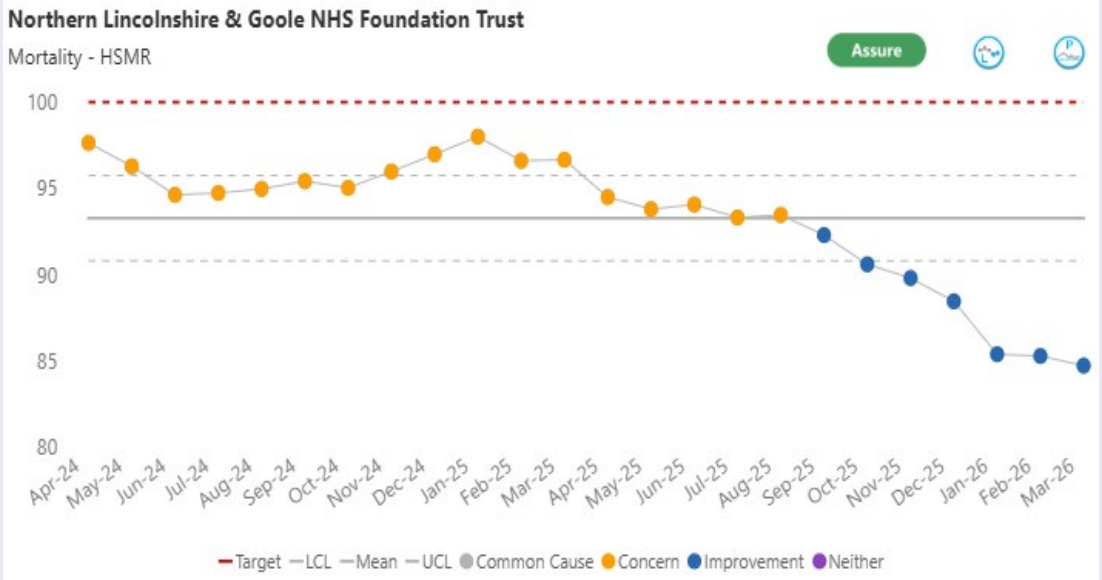


HSMR is a risk adjusted mortality index for a basket of 56 diagnosis groups. The risk adjusted tool uses 100 as the national baseline, focusing on the inpatient episode, and therefore the inpatient risk of death.

Key themes

- The HSMR is improving and the downward trend tracks more recent data than SHMI, with a ratio of 98.9.
- Advise alert due to improvement trend.

NLAG



Key themes

- There has been a statistically significant improvement with successive reduction in the HSMR over several months, now remains under 100 for 24 months, and at 84.8. This figure is the lowest level on record.
- Assure alert due to improvement and continued trajectory being sustained.

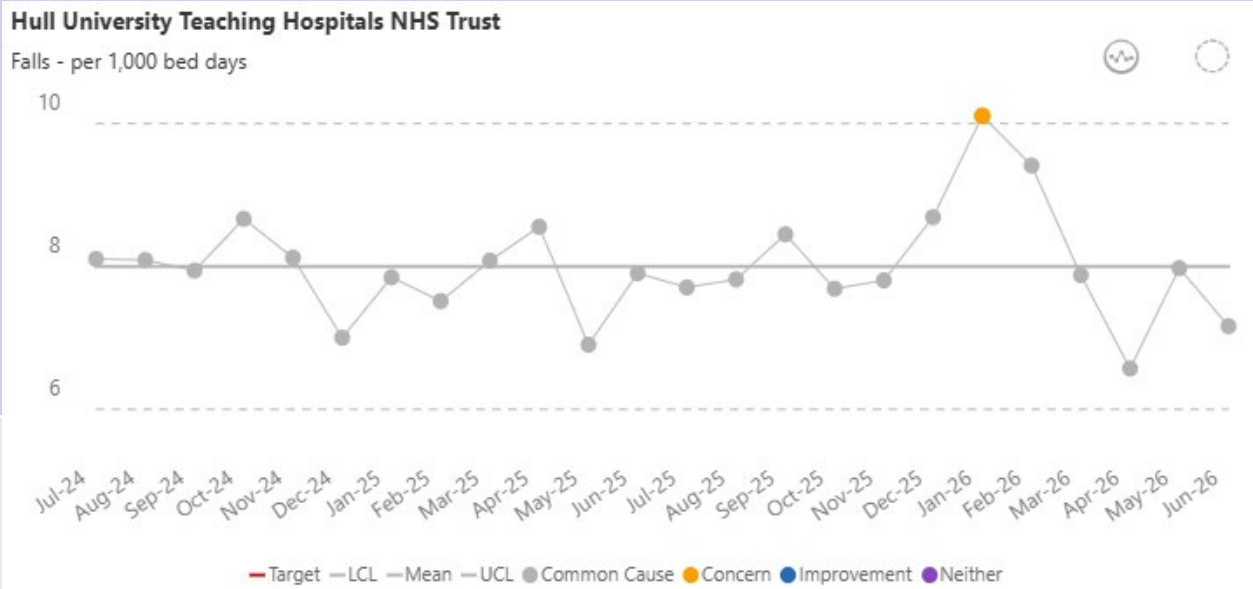
Actions are included in the same way for the SHMI description, and HSMR is used as part of the analysis of the mortality data, recognising a different methodology and risk adjustment is applied.

Controls, Oversight and Assurance

The same process are in place for MIG as set out in the SHMI section of this report.

Falls

HUTH

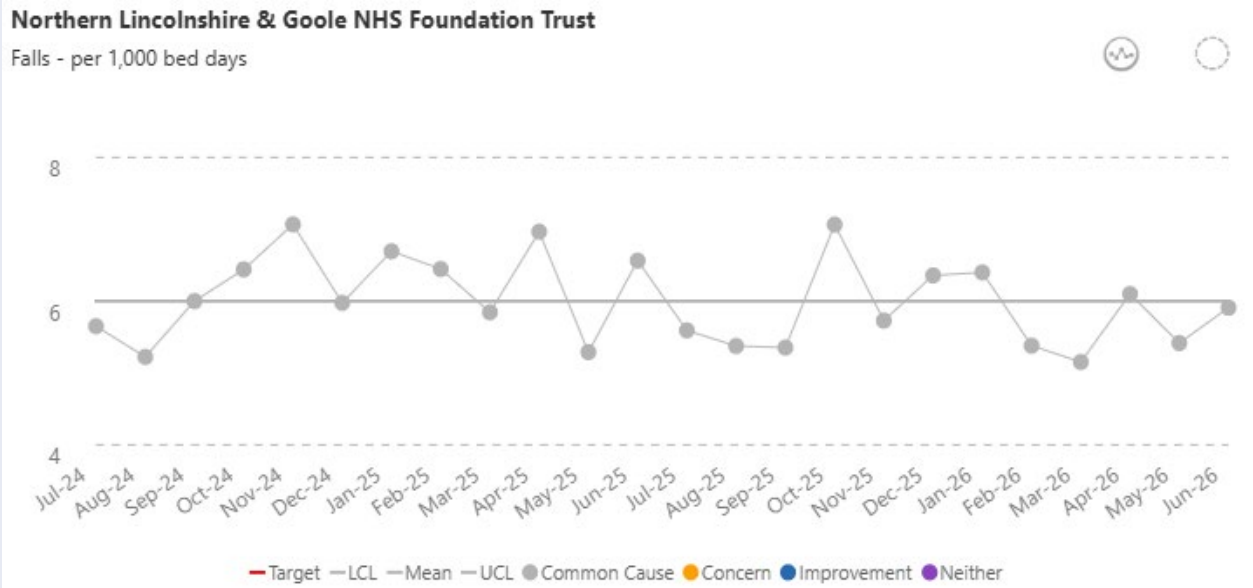


Key themes

HUTH – The Falls Improvement Programme has been successful in driving a reduction in the number of falls across the Trust, through the appointment of key leads, focus on risk assessments and environment and learning from incidents.

There is an increased rate of falls per 1000 bed days in January 2026 with a return to common cause variation.

NLAG



Key themes

NLAG Falls rate data shows common cause variation.

Controls, Oversight and Assurance

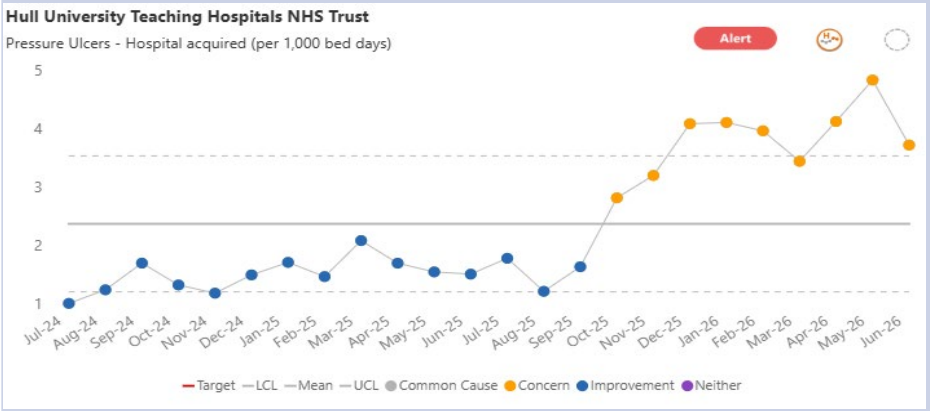
- Falls are reported as part of the daily safety huddle, flagging repeated fall patients, and significant injuries.
- Falls team review all repeated fall cases and potentially significant injuries
- All significant injuries following a fall are reviewed with a Swarm Huddle which is then reported to weekly falls group.
- Weekly review of all falls incidents and Swarm huddle reports.
- Escalation of concerns, including fatal outcomes are reported to the Weekly Learning Response Panel.
- Reduction of patient falls is part of the patient deconditioning Quality Priority.

Actions being taken to improve across the Group:

- Consideration of falls impact on workstreams for:
    - reducing patient deconditioning from prolonged hospital stays
    - improving Enhanced Therapeutic Observation and Care.

Pressure Ulcers

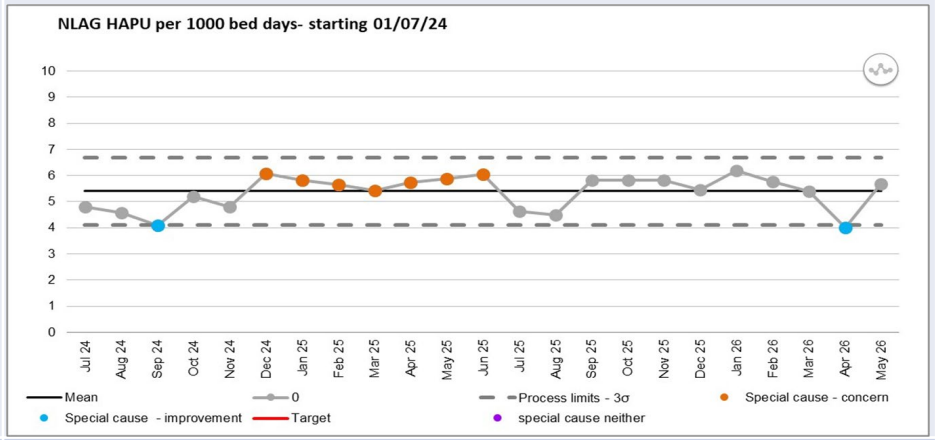
HUTH



Key themes

- There is an increase in the rate of hospital acquired pressure ulcers from October 2025 to March 2026 and has been attributed to hospital acquired moisture lesions that were not included in the Datix dataset, prior to the change to Ulysses in October 2025.
- Further analysis is being taken to interrogate the data and rebase the data moving forward.
- Data has not been refreshed with May 2026 data by the information team at the time of reporting

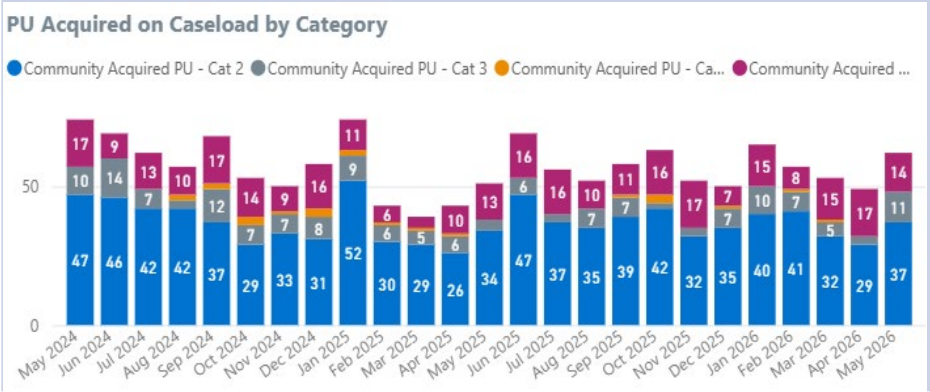
NLAG



Key themes

- The chart shows the NLAG hospital rate with common cause variation following a decrease in April.
- North Lincolnshire Community nursing team data is provided also.

NL Community



Controls, Oversight and Assurance

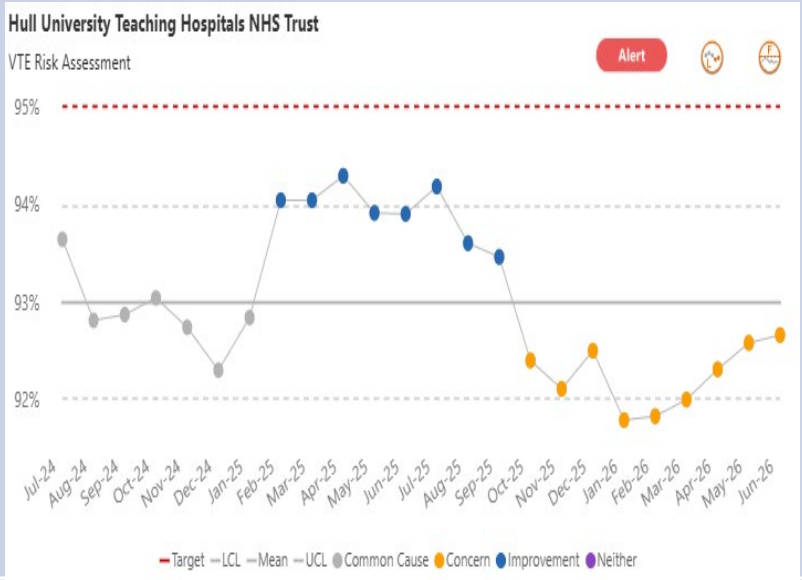
- Groupwide Pressure Ulcer Group has been established
- Weekly Pressure Ulcer Incident review process.

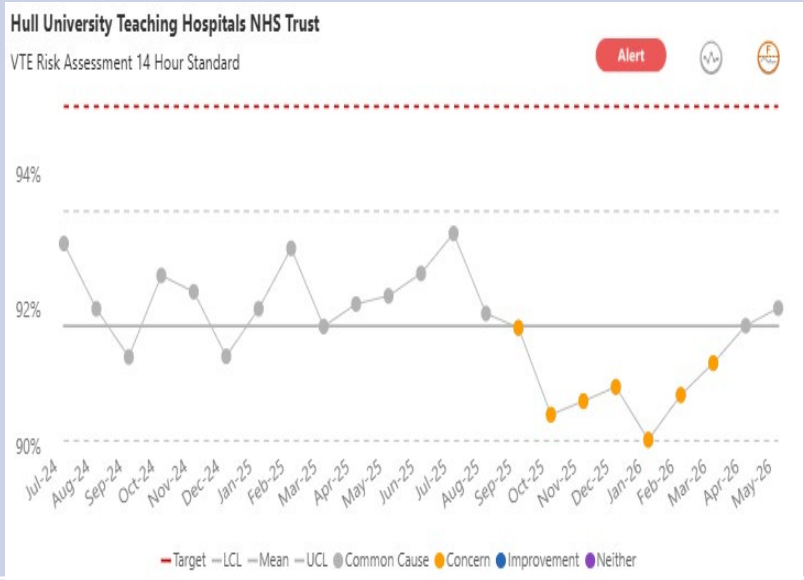
Actions being taken to improve across the Group:

- Contributes to the metrics for measurement of patient deconditioning.

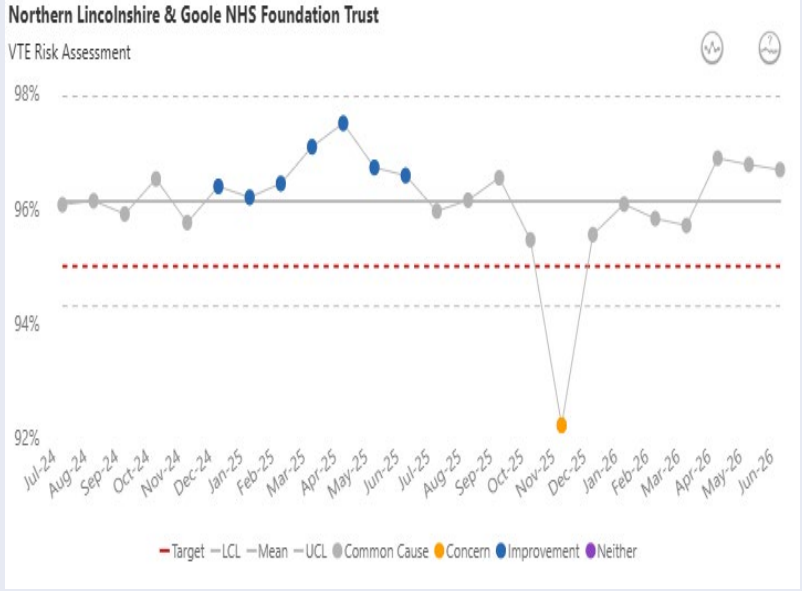
VTE Risk assessment rate

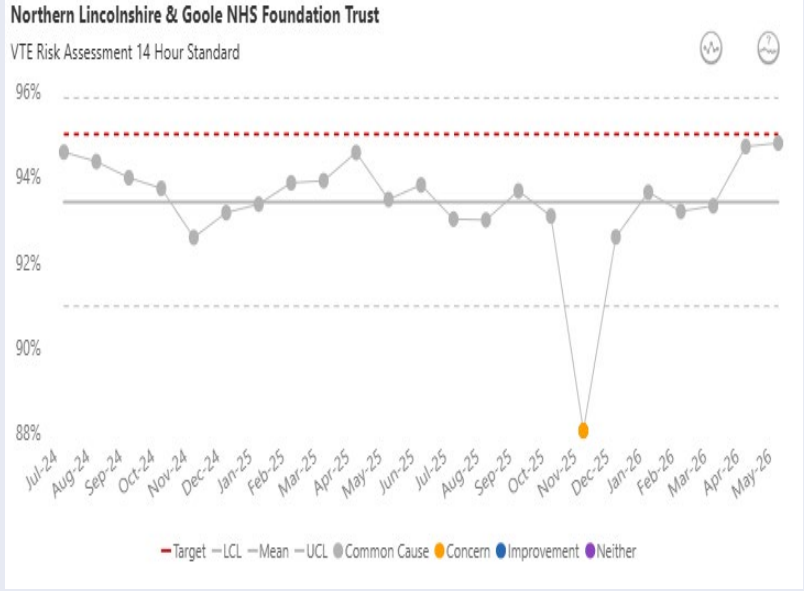
HUTH





NLAG





Key themes

- VTE risk assessment compliance has been measured historically, which is the chart to the left, is within one day of admission.
- HUTH data demonstrate that the 95% target is not achieved for these measures, with a deterioration since October 2025. This series of reduced compliance has triggered an alert on the SPC charts.
- NLAG has completion.achieving >95% compliance at 24 hours, but not at 14 hours, with 94.8%.

Controls, Oversight and Assurance

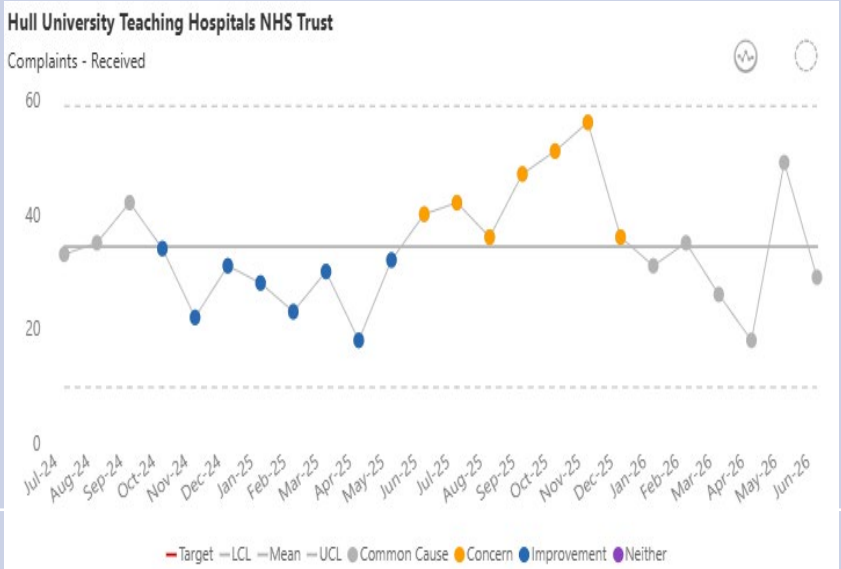
Rates of VTE harm are reviewed to determine if associated with risk assessment on admission with no evidence of harm being identified. On discharge and restarting treatment following surgery, there are some examples of harm identified through WLRP.

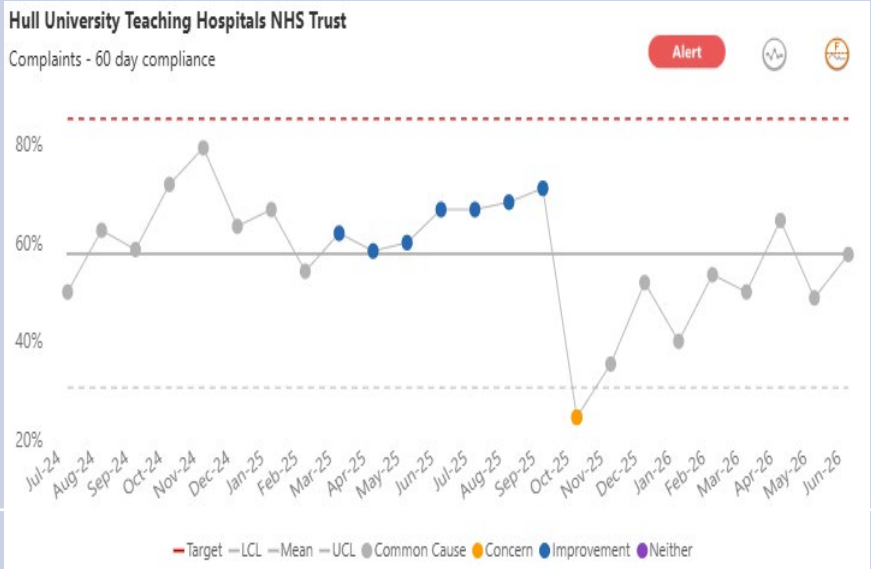
Actions being taken to improve:

- Care Group data is available to provide focus on the relevant teams to address their performance and will be used in the Performance Review meetings and at the Patient Safety and Learning Group as part of Care Group Highlight reports.
- A review has been undertaken for initial risk assessment for VTE and there is no evidence of causation for harm.
- Each care group has been asked to take forward recovery plans.
- The Thrombosis Committee reviews cohorts of specialties for exclusion from the dataset, e.g. short stay clinical services.

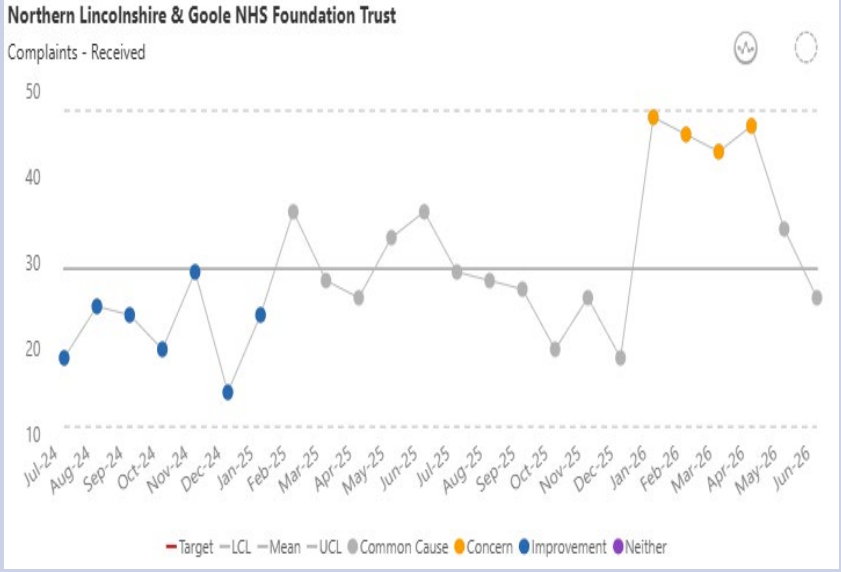
Patient Experience: Complaints – received and compliance with KPIs

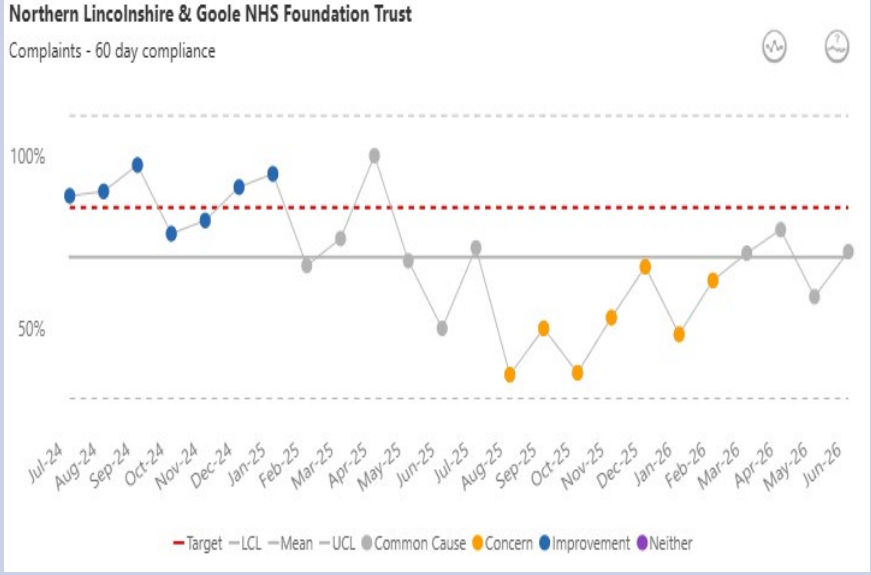
HUTH





NLAG





Key themes

- HUTH complaints have returned to common cause variation, following a moderate increase, Acute and Emergency Medicine is still receiving more complaints than other care groups.
- Previously there has been a reduced rate from November 2024 –August 2025 at HUTH.
- Compliance with timescales remains below the 85% target at 57.6% in June

Actions to improve:

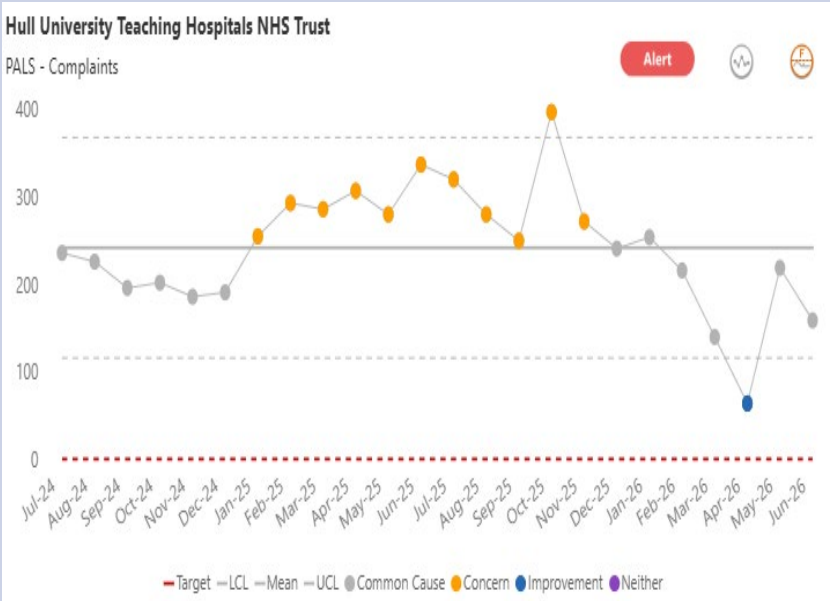
- A dedicated action plan focus being undertaken on
    - Patient Experience a user of service,
    - Operational process Complaints/ Pals
    - HR/Staffing (loss of 2.9 WTE complaint facilitators)
    - IT/Telephony
- Central team NLAG investigation and response model being introduced
- Reporting of Care Group performance
- Weekly meetings with Care Group and Central team case handlers.
- Care Group Performance Meeting with Site Nurse Director
- QI programme in development established , with Care Group accountability for their improvement plans

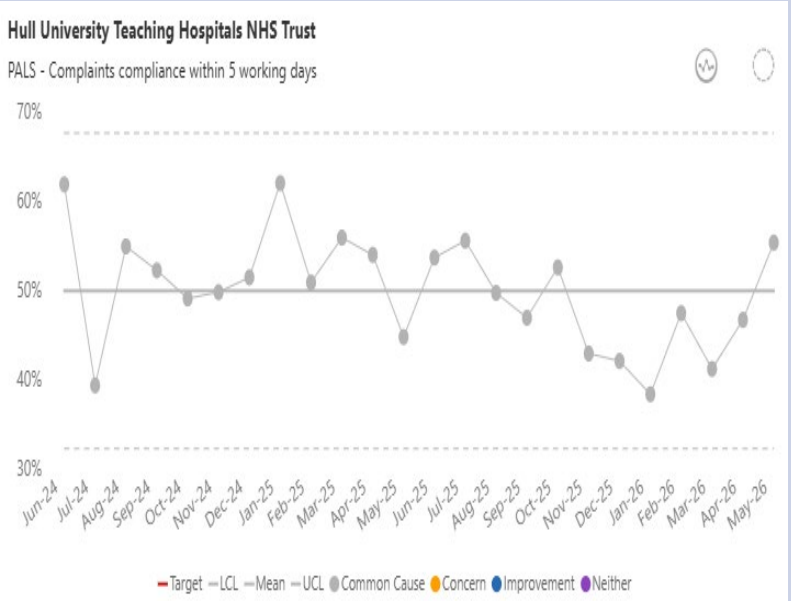
Key themes

- The rate of complaints has started to show a decrease during Q4 2026 and at 72.2% in June.
- Ongoing work, with processes is taking place to achieve 60-day KPI to support.
- Working with PALs is ongoing to prevent PALs escalation to complaints

PALS – received and response times

HUTH

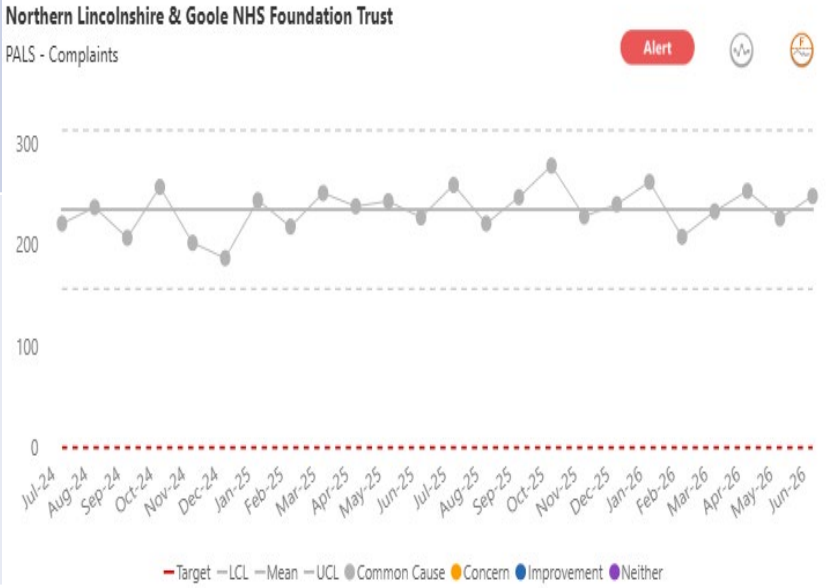


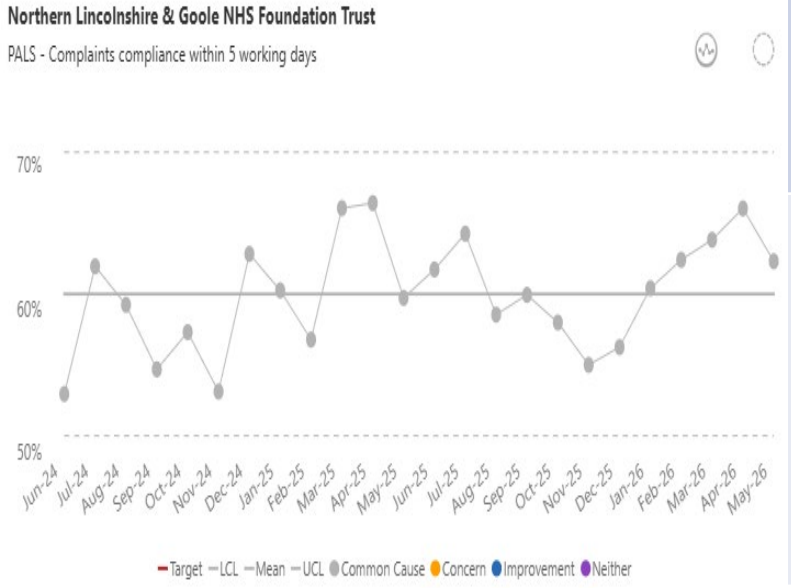


Key themes

- PALS received for HUTH is variable in respect of logging of casework, triggering an alert.
- The Patient Experience Quarterly report provides further details.
- HUTH have challenges of completion of PALS concerns within 5 days (KPI 60%).
- There are challenges in achieving the 5day response KPI, due to:
  - Delay in IT / Telephony work expected date was 8/2025
  - Recruitment into posts and agreement via recruitment Panel
  - Aligning processes for PALs
- HUTH PALS Recovery program in progress to improve include:
  - Process mapping exercise with external support.
  - Process revisions learning from process mapping.
  - Temporary staff support being provided.

NLAG



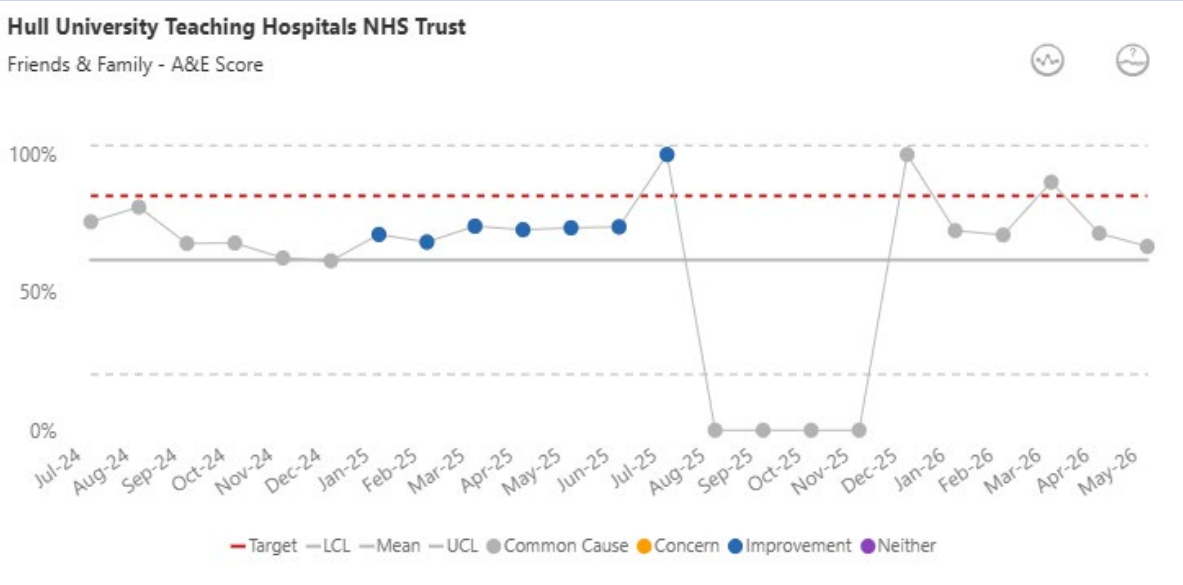


Key themes

- NLAG PALs have remained consistent with common cause variation.
- With no improvement seen, an Alert trigger is shown.
- NLAG have returned to achieving >60%

Patient Experience – Friends and Family Test A&E

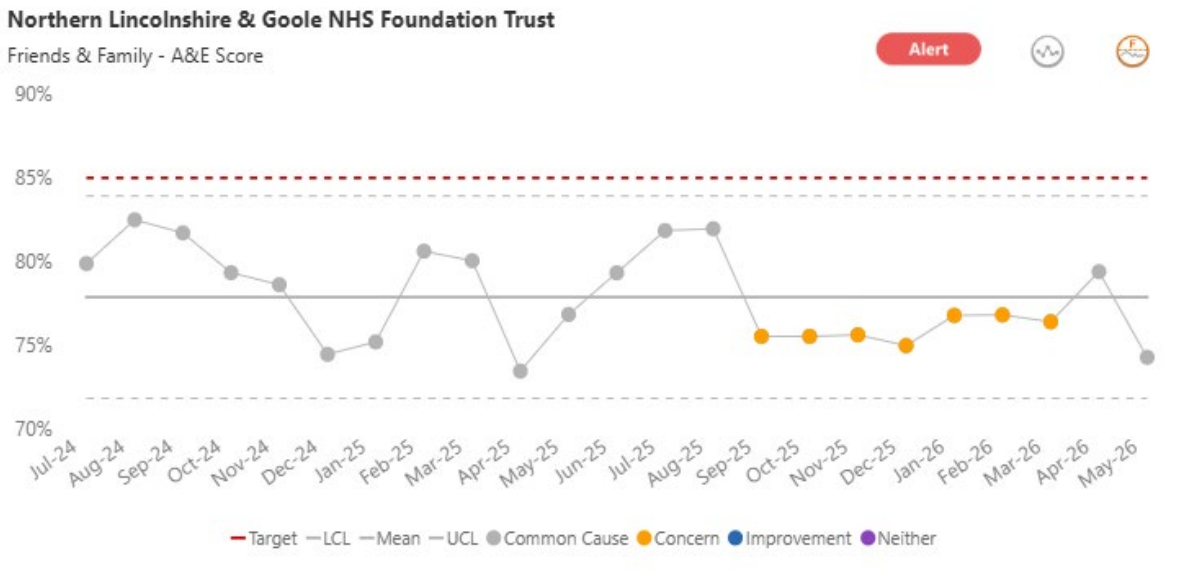
HUTH



Key themes

- A new system for collection of FFT for HUTH has been successfully implemented.
- No FFT data has been collected for 4 months from August to November 2025. Smaller samples obtained for January 2026 and July 2025 are the likely caused for the high scores of 100%. NHS England aware and being updated with resolution plan.
- Common cause variation is found for the last 6 data points.

NLAG



Key themes

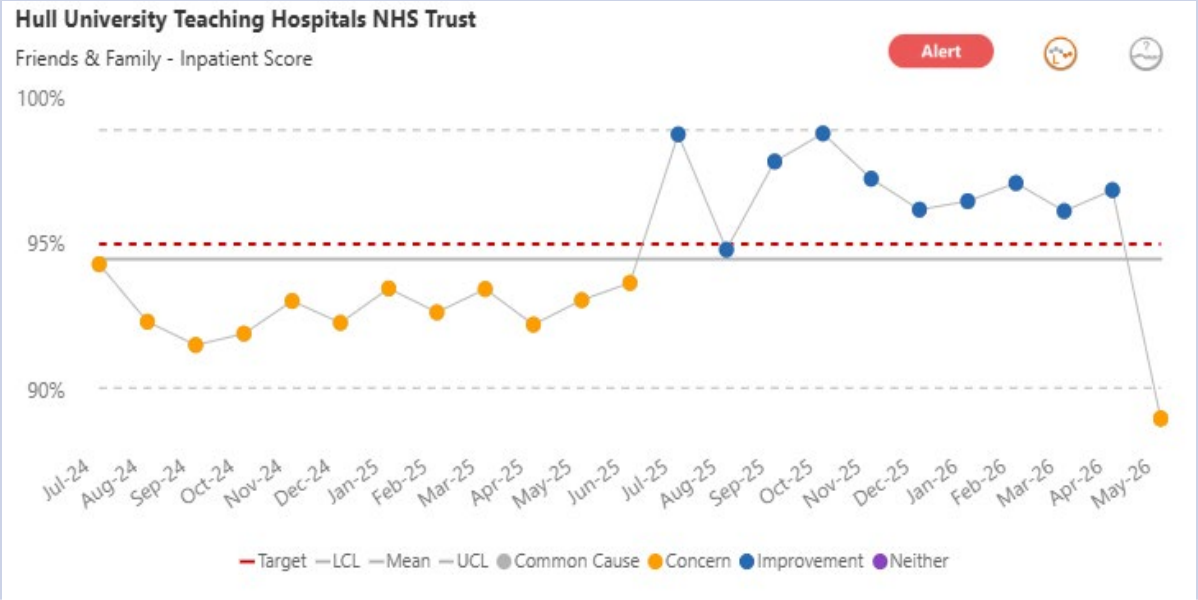
- There is a trend of reduced scores below the mean triggered.
- Remains below the target and has caused an Alert trigger.

Actions being taken to improve across the Group:

- Performance data available in the Care Group
- Initiatives to improve timely ambulance handover delays
- Initiatives to support patients despite crowding in the EDs.

Patient Experience – Friends and Family Test Inpatient and daycase

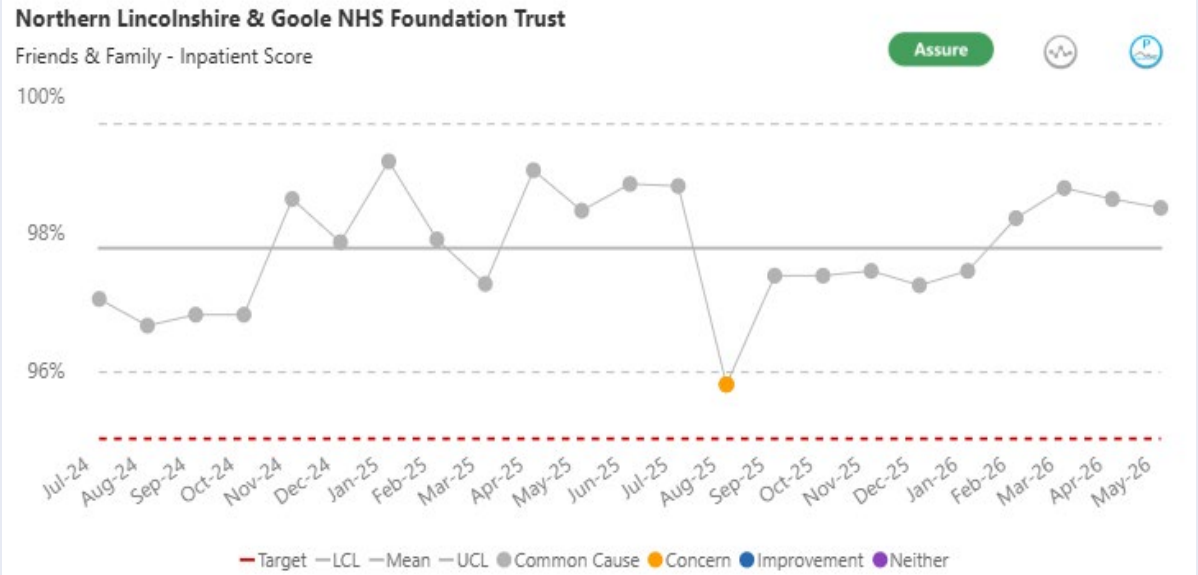
HUTH



Key themes

- A new system for collection of FFT for HUTH has been successfully implemented.
- There is a deterioration in May 2026.
- The Alert trigger is due to the reduction seen in May.
- June 2026 data is held locally and not in the BI report, but has shown an increase in responses to 1177 from 304 in May. This may improve the reliability of the data and score when processed.

NLAG

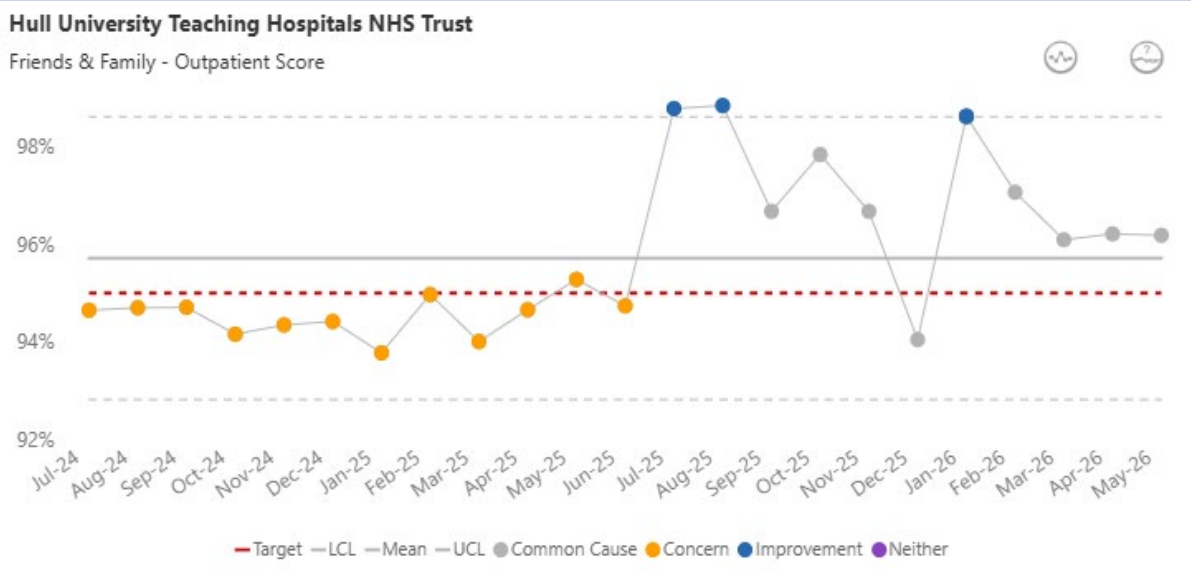


Key themes

- Consistency in achievement of the 95% target.
- Common cause variation is evident
- The Assure trigger is due to the consistent performance over the target.

Patient Experience – Friends and Family Test Outpatient

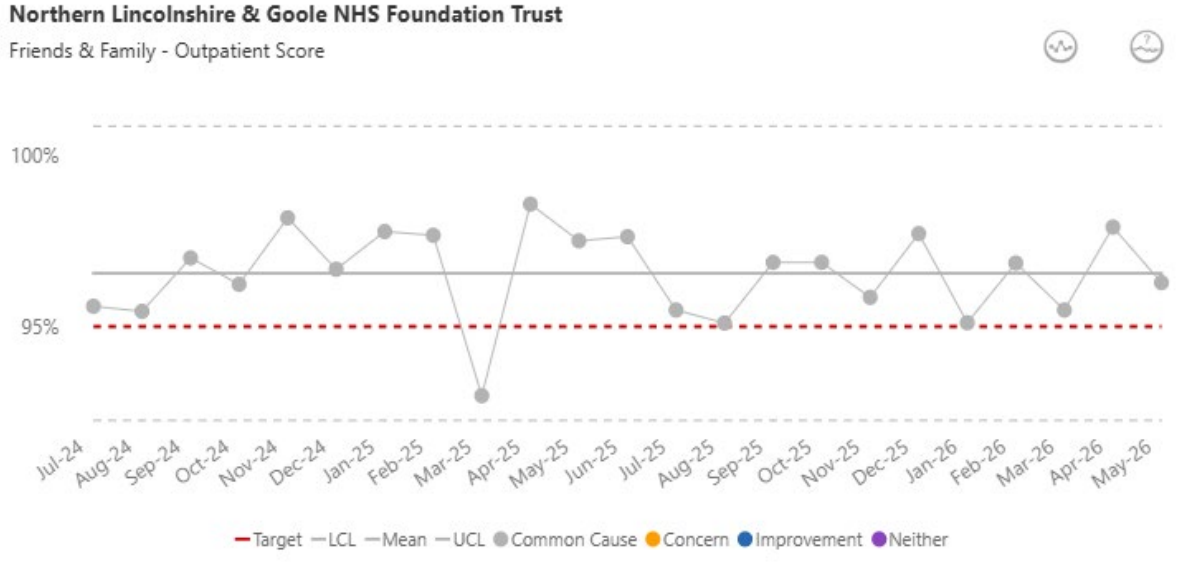
HUTH



Key themes

- A new system for collection of FFT for HUTH has been successfully implemented.
- Common cause variation evident, with achievement of >95% target since January 2026.

NLAG

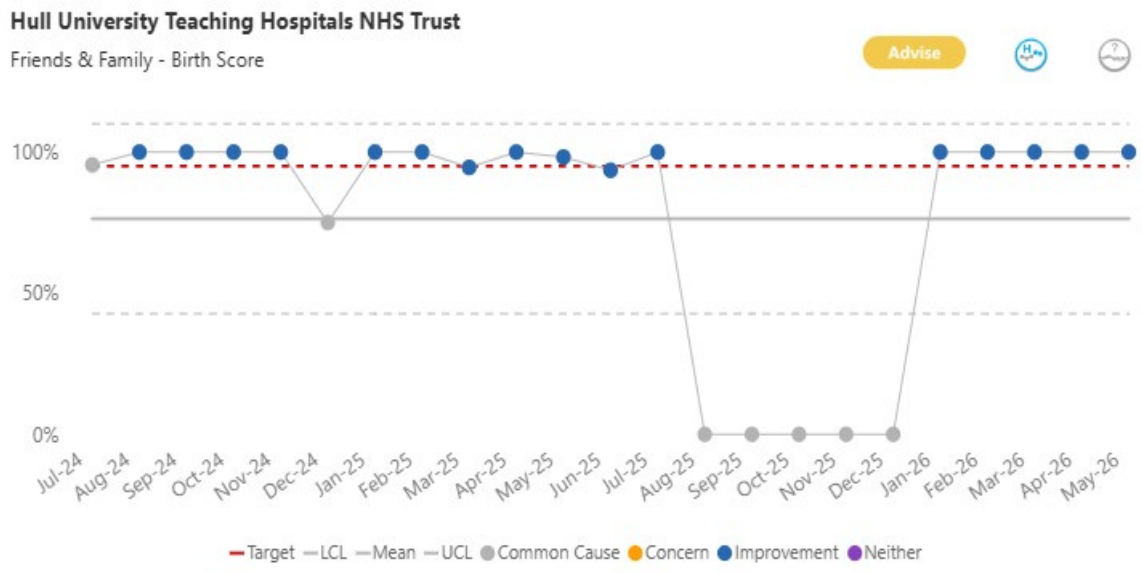


Key themes

- Previously sustained achievement over the target of 95%.
- Common cause variation demonstrated.

Patient Experience – Friends and Family Test Maternity (Birth)

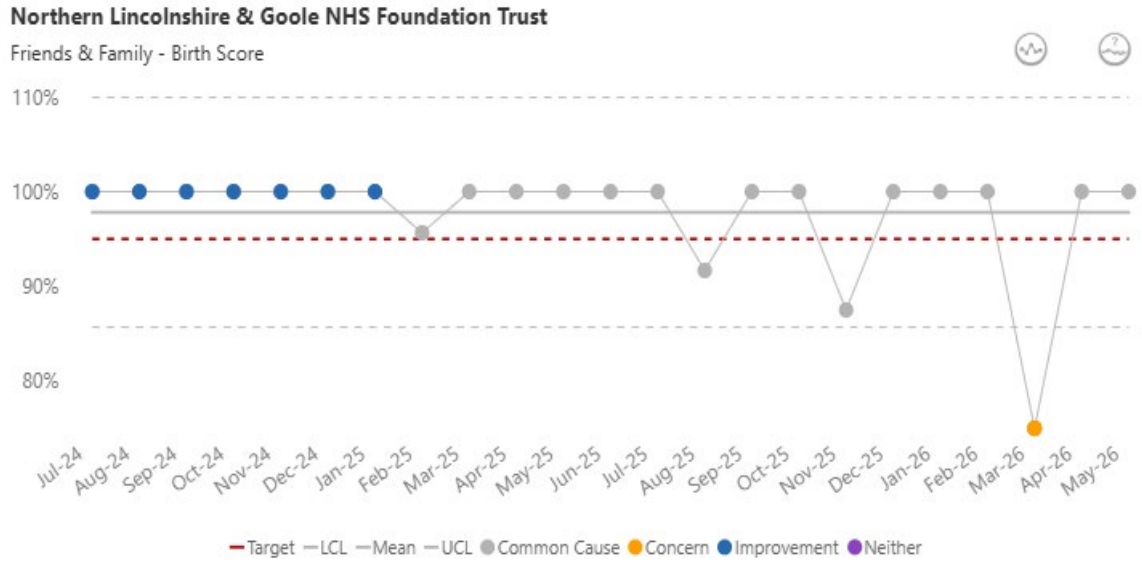
HUTH



Key themes

- Some positive results following the data collection changes implemented from January 2026.
- A new system for collection of FFT for HUTH has been successfully implemented.
- The Advise trigger is due to the return to achieving the target following the period of no reporting.

NLAG

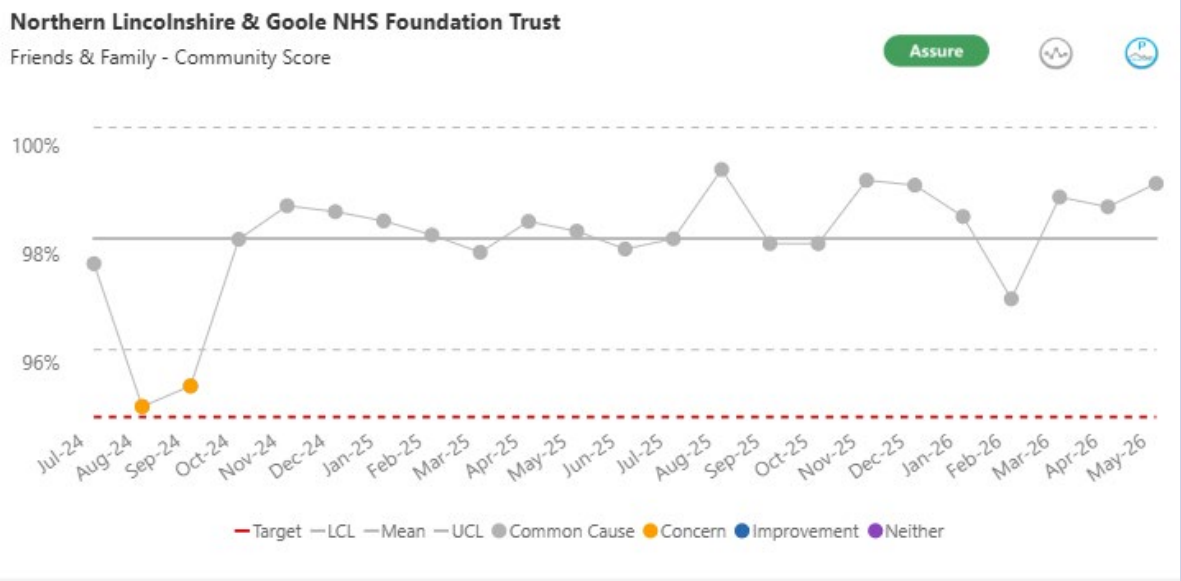


Key themes

- There is a reduced score shown for March 2026. Further analysis is being undertaken.

Patient Experience – Friends and Family Test Community (NLAG only)

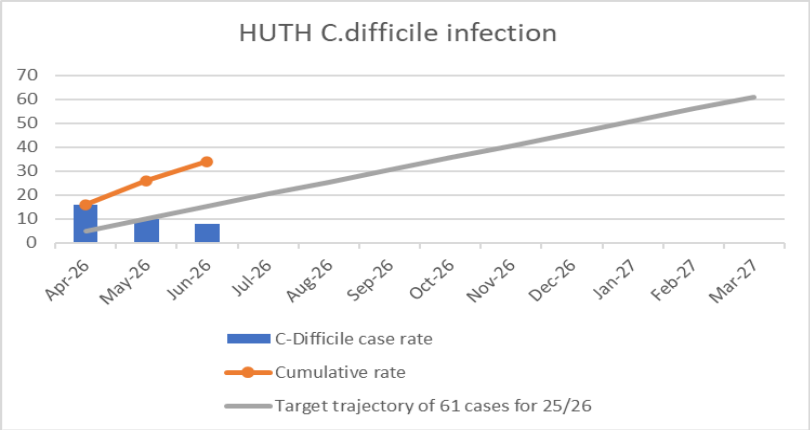
NLAG

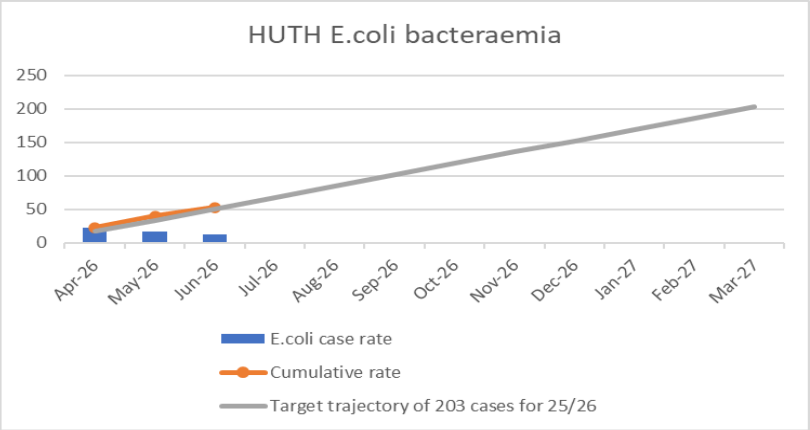


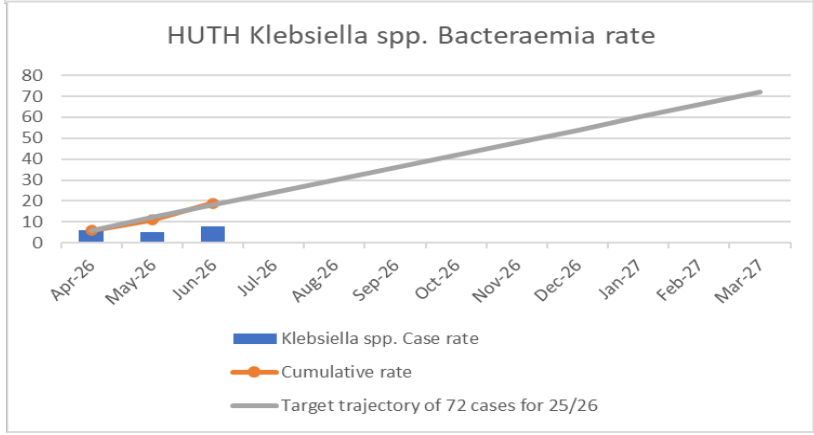
Key themes

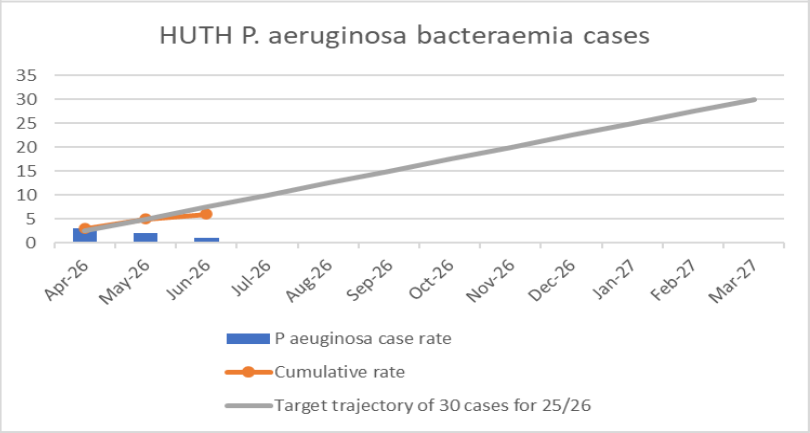
- Common cause variation continues.
- Trust is consistently achieving the 95% target with a mean of 98%.
- The chart has an Assure flag, as there is consistent achievement of this target.

Infection Control - HUTH









The latest data is refreshed when validated and approved from 15th of the month, so this charting shows the June 2026 position.

- MRSA has zero cases in the last month
- The other organisms are over trajectory.

National Outcomes Framework

Publicview data from the latest available period: May 2026 is provided.

- C.Difficle – The ratio is currently higher than the NOF May 2026 data and so not expected to change the NOF banding in the near future.
- E.Coli – The ratio is slight lower and may remain in Quartile 2.
- MRSA – The rolling 12 month rate is the same so NOF May 2026 data is likely to remain the same.

Improvement plans

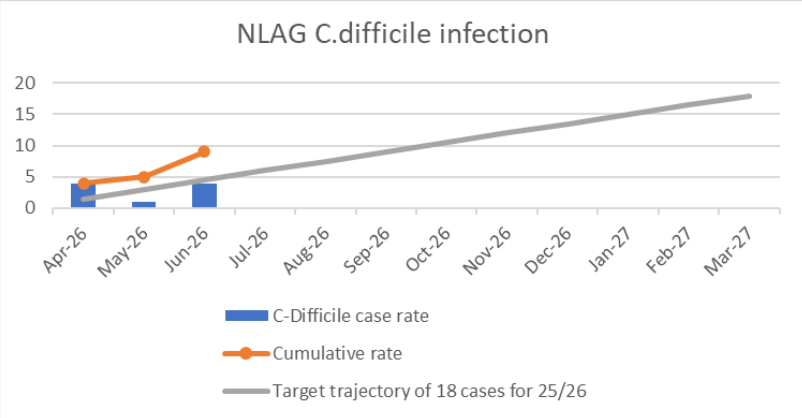
- The Quality Priorities for 2026/27 include the infection control KPI's that are part of the Safe section of the National Outcomes Framework. Which is shown using Publicview data from the latest available period: May 2026.

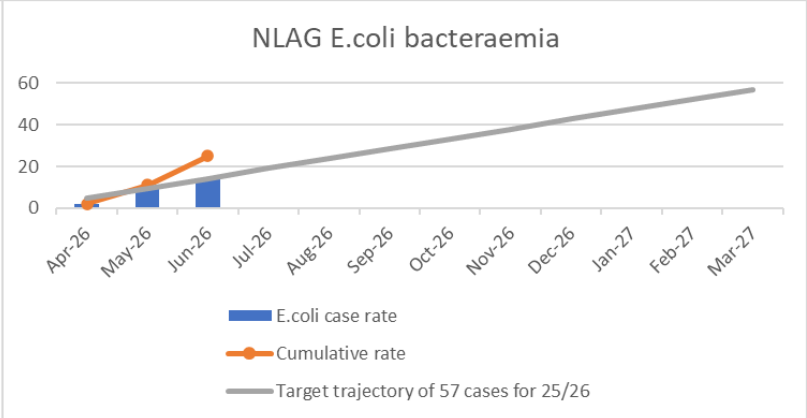
- SPC charts for trend monitoring are shown on the following charts.

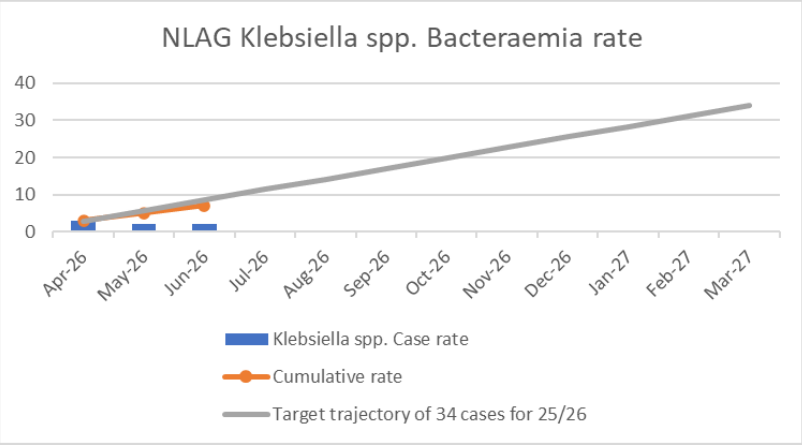
HUTH	2025/26 Target	M3	YTD rate	12 month rolling rate	Current ratio	NOF rolling 12-month cases /target ratio	NOF score & band
C. Difficile	61	8	34	121	1.98	1.95	3.92
E. Coli	203	13	53	200	0.99	1.04	2.07
P. Aeruginosa	30	1	6	31	1.03	NA	NA
Klebsiella spp.	72	8	19	84	1.17	NA	NA
MRSA bacteraemia	0	0	0	2	NA	2	2.25
MSSA bacteraemia	No target	5	19	91	NA	NA	NA

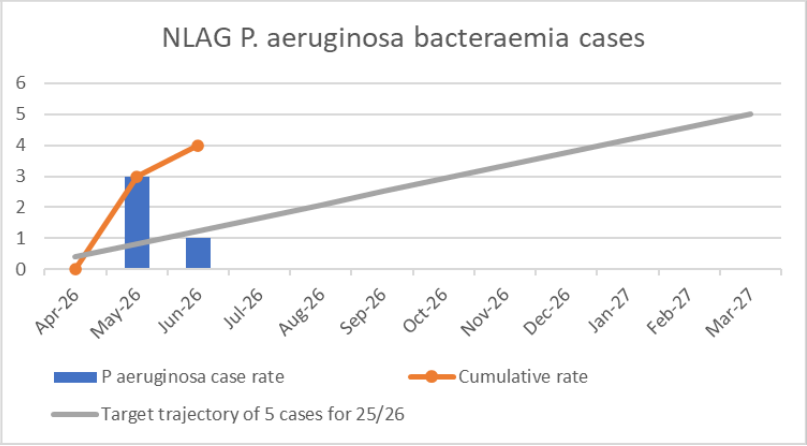
Key	In year Trajectory performance	NOF quartile ranking of Trusts
	Over the annual target	Quartile 4 (worst)
	Over the trajectory	Quartile 3
	-	Quartile 2
	Below the trajectory	Quartile 1 (best)

Infection Control - NLAG









The latest data is refreshed when validated and approved from 15th of the month, so this charting shows the June 2026 position.

- MRSA BSI for one case in June against a Zero target.
- Pseudomonas has zero cases in the last month
- E.Coli is slightly over trajectory, along with C.difficile and P. Aeruginosa.
- Klebsiella is under trajectory.

National Outcomes Framework

Publicview data from the latest available period: May 2026 is provided.

- C.Difficle – The ratio is the same as the NOF May 2026 data and is not expected to change the NOF banding in the near future.
- E.Coli – The current ratio is higher than NOF May 2026, so likely to remain in Quartile 4.
- MRSA – The rolling 12 month rate is 2 higher than the May 2026 data so may increase the NOF score and band.

Improvement plans

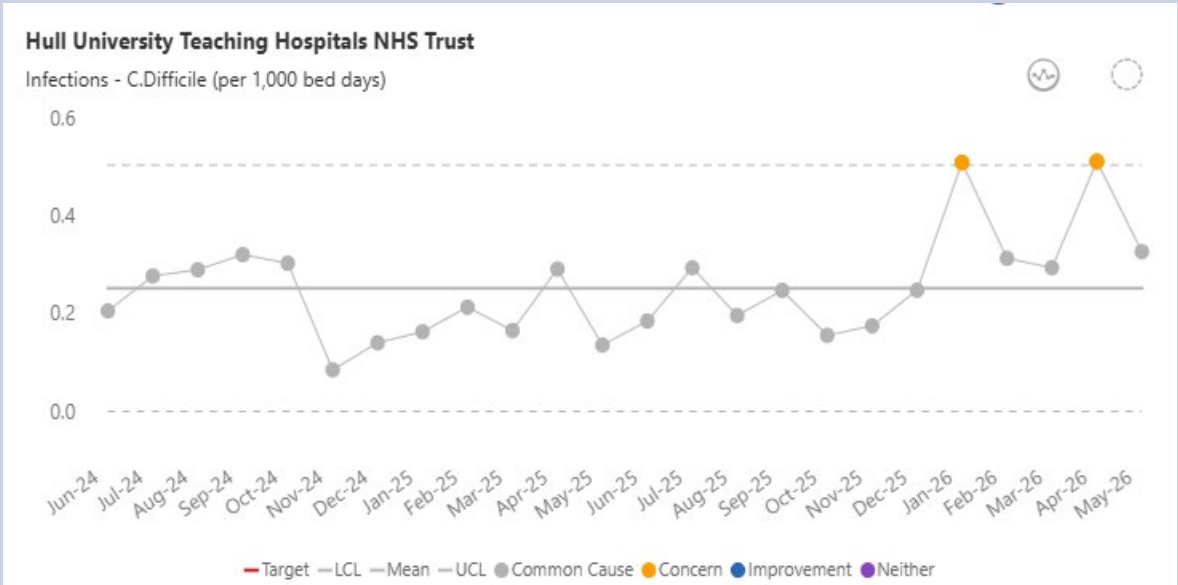
- The Quality Priorities for 2026/27 include the infection control KPI's that are part of the Safe section of the National Outcomes Framework. Which is shown using Publicview data from the latest available period: May 2026.
- SPC charts for trend monitoring are shown on the following charts.

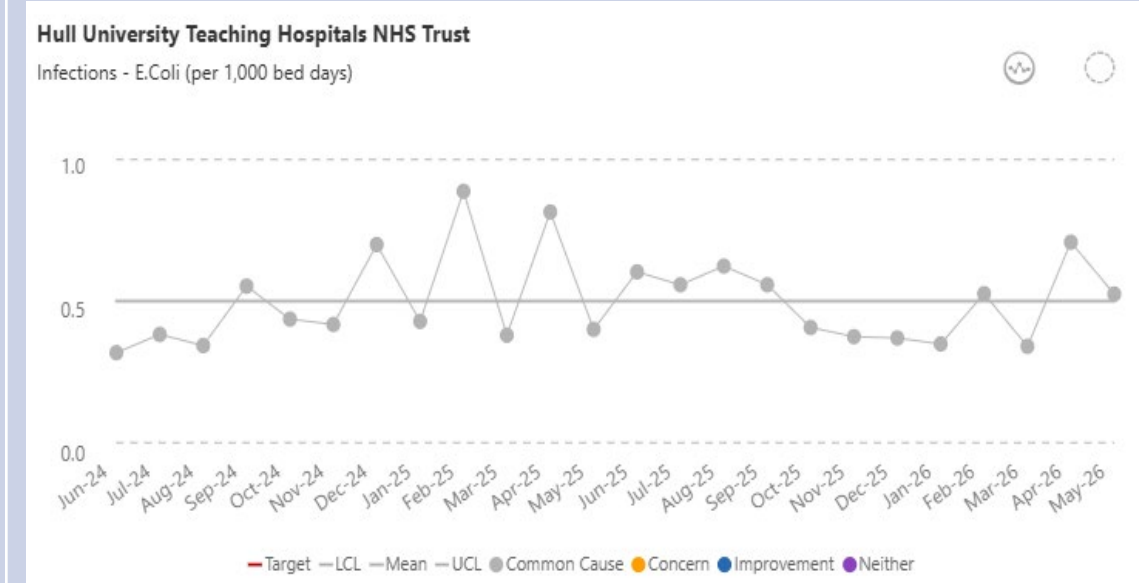
NLAG	2025/26 Target	M3	YTD rate	12 month rolling rate	Current ratio	NOF rolling 12-month cases /target ratio	NOF score & band
C. Difficile	18	4	9	34	1.89	1.89	3.90
E. Coli	57	14	25	96	1.68	1.63	3.81
P. Aeruginosa	5	1	4	20	4.00	NA	NA
Klebsiella spp.	34	2	7	39	1.15	NA	NA
MRSA bacteraemia	0	1	1	6	NA	4	2.92
MSSA bacteraemia	No target	1	7	21	NA	NA	NA

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

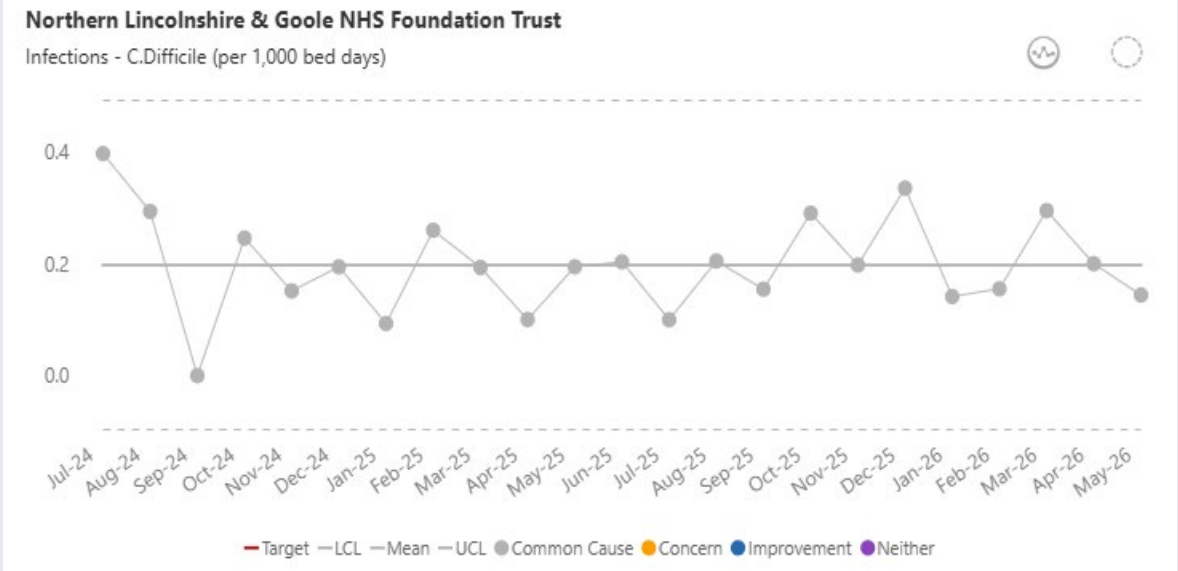
Infection control rates per 1000 bed days – C-difficile and E.Coli bateraemia

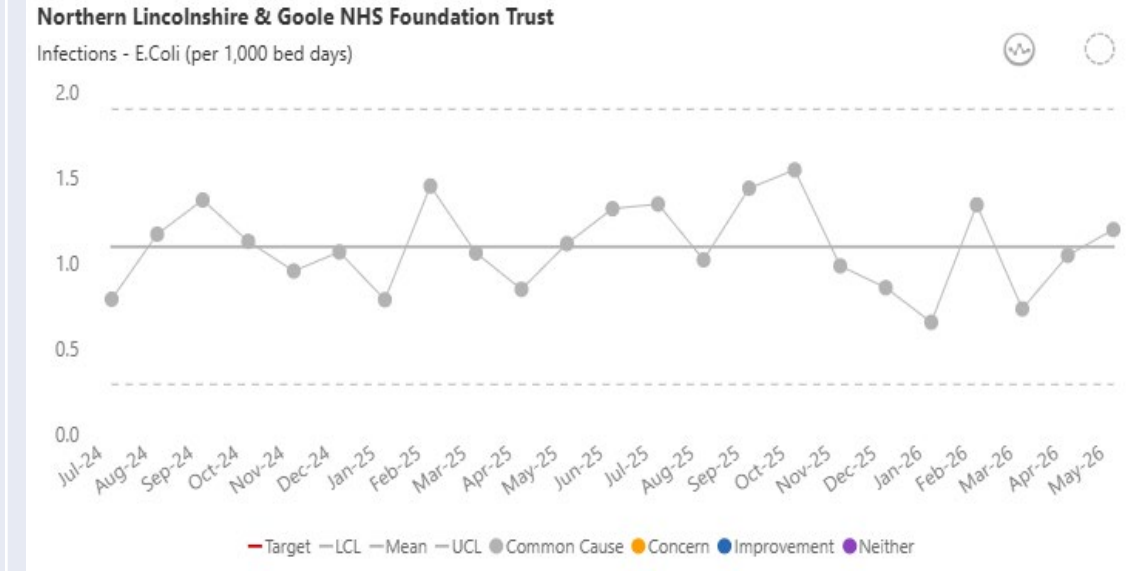
HUTH





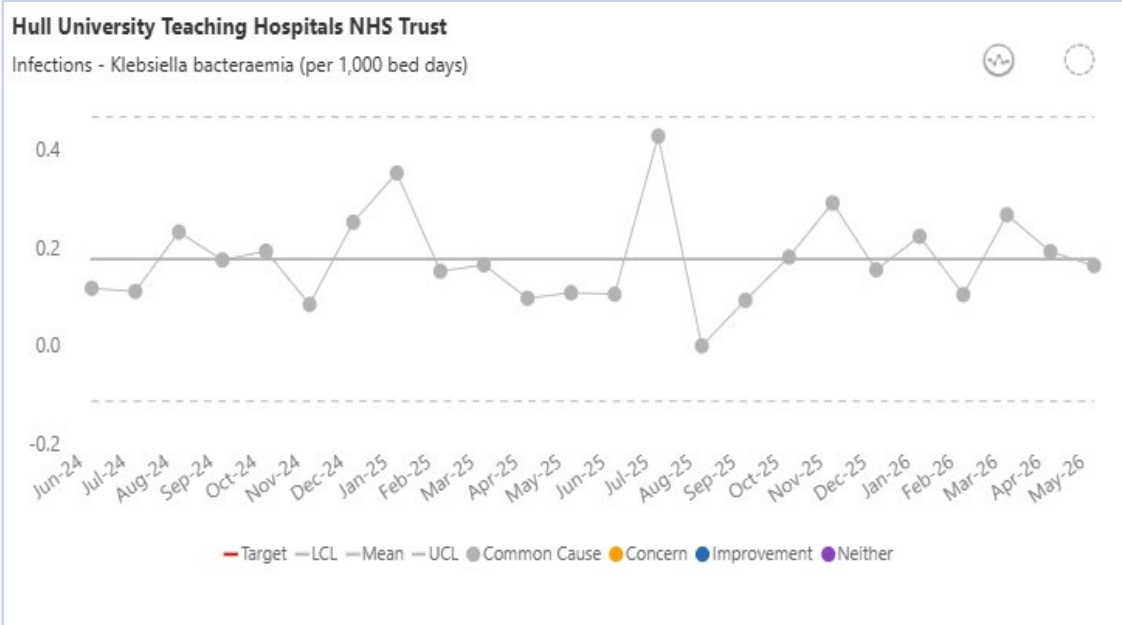
NLAG

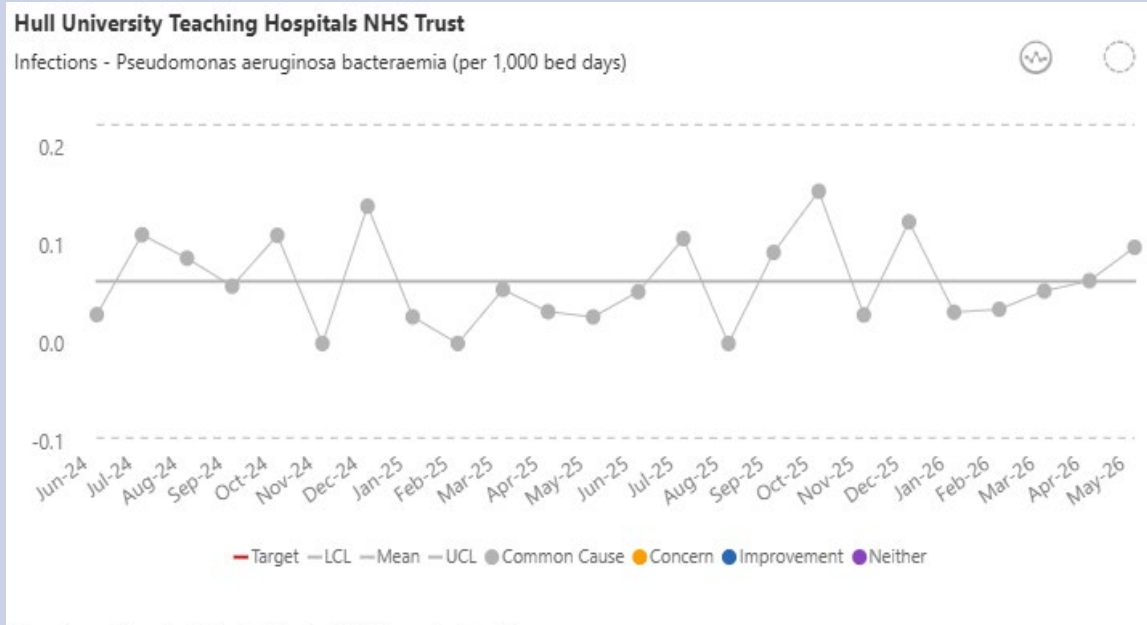




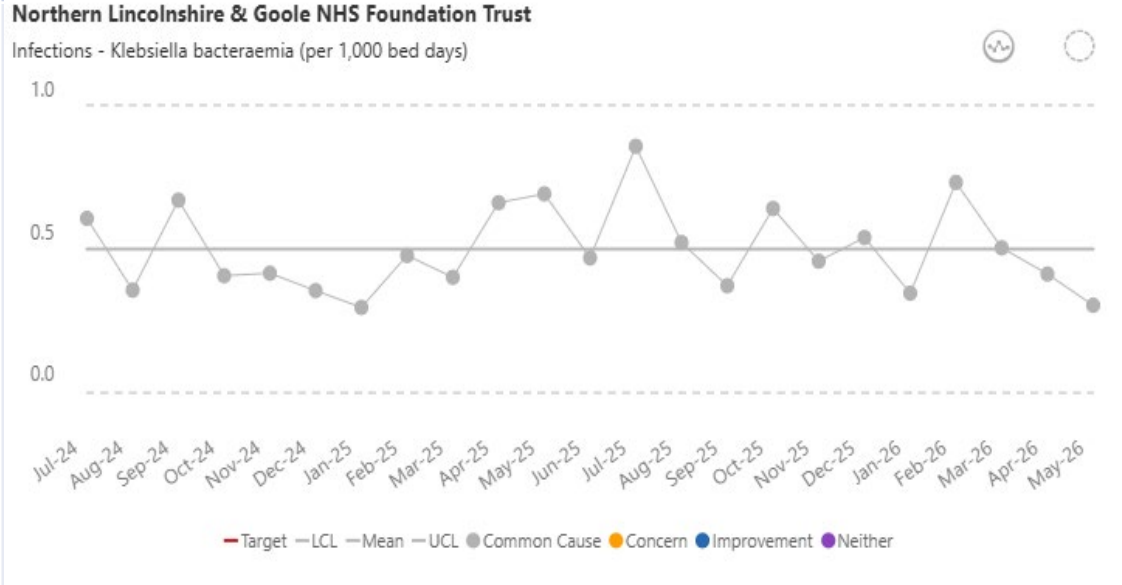
Infection control rates per 1000 bed days – Klebsiella and Pseudomonas aeruginosa bacteraemia

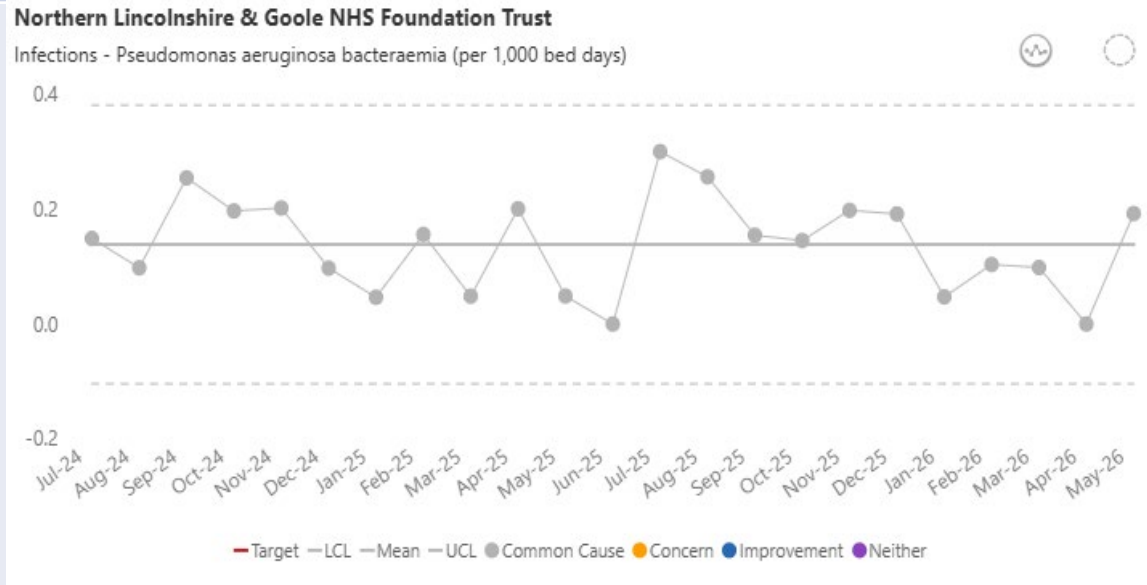
HUTH





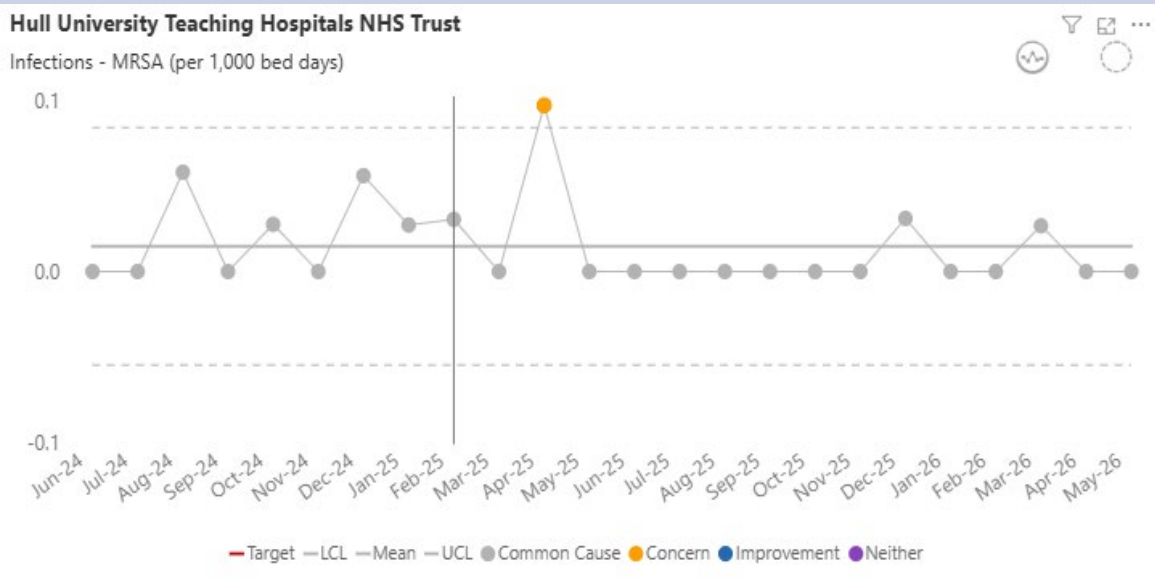
NLAG

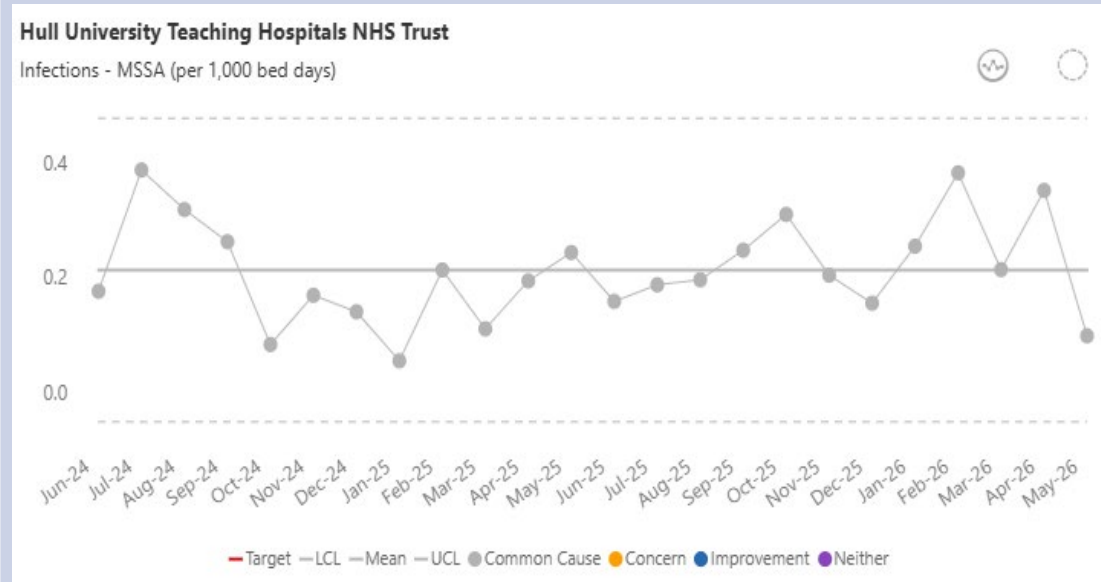




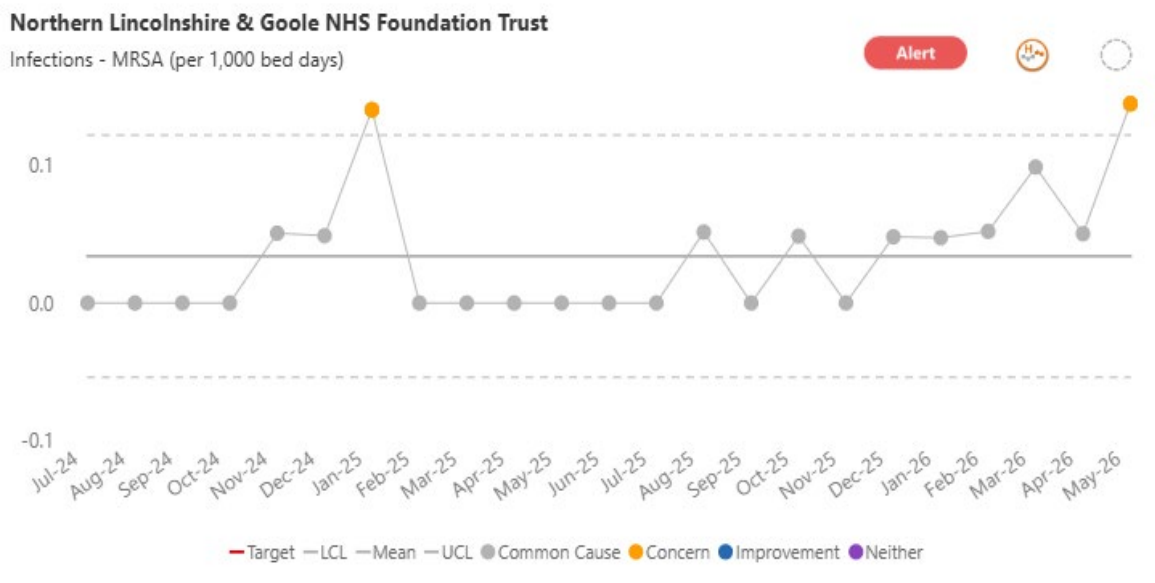
Infection control rates per 1000 bed days – MRSA and MSSA bateraemia

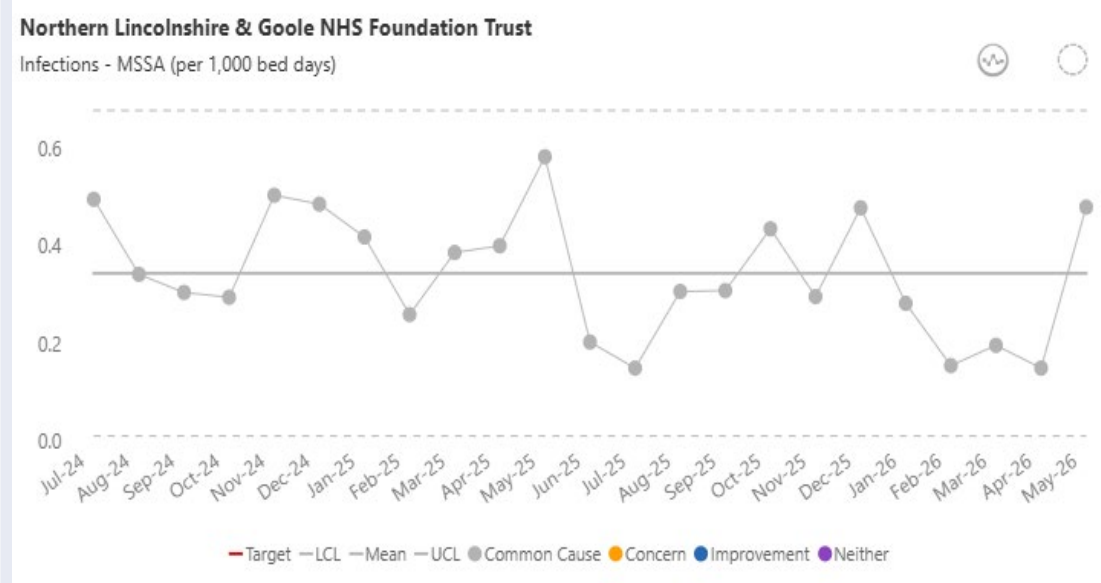
HUTH





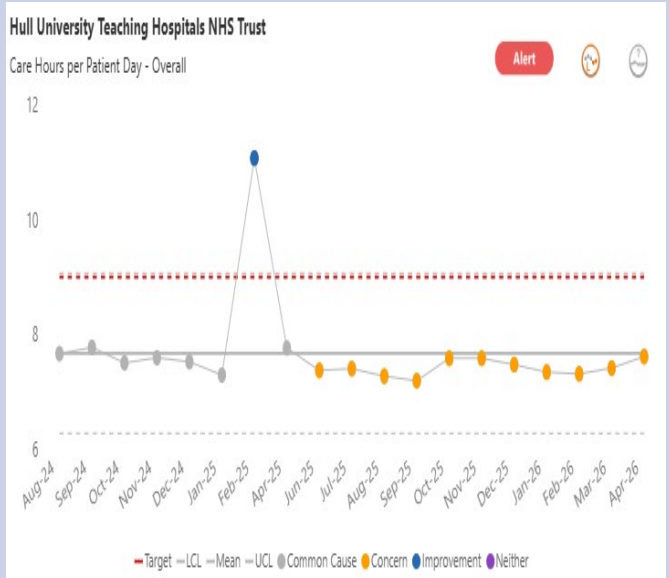
NLAG

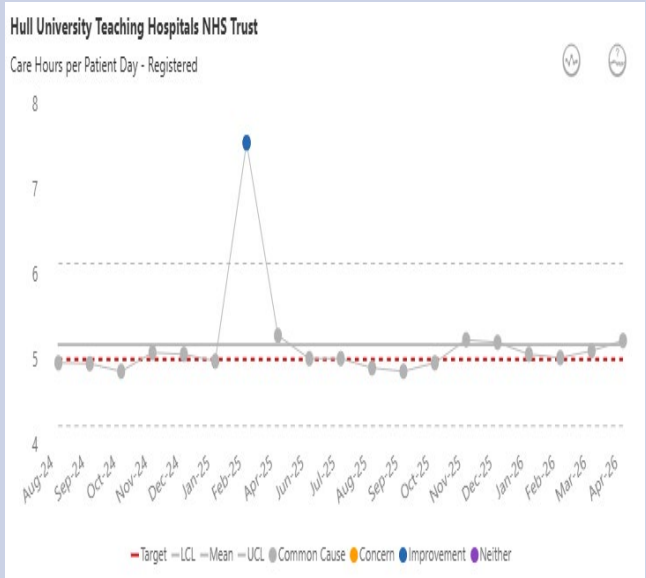


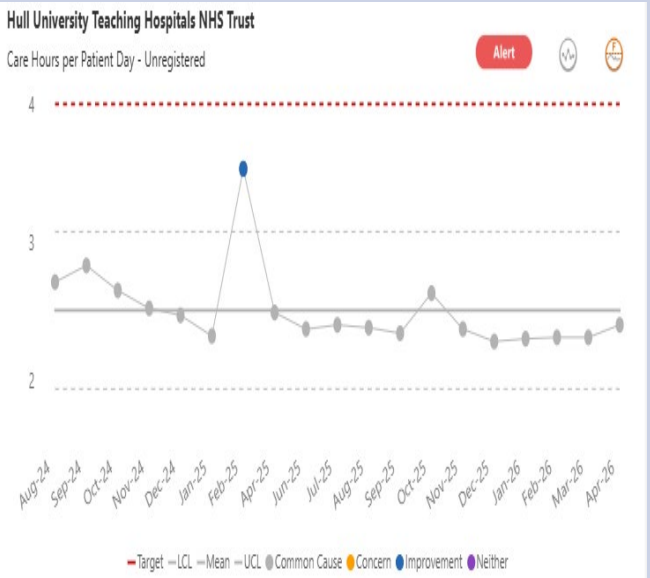


Care Hours per Patient Day

HUTH

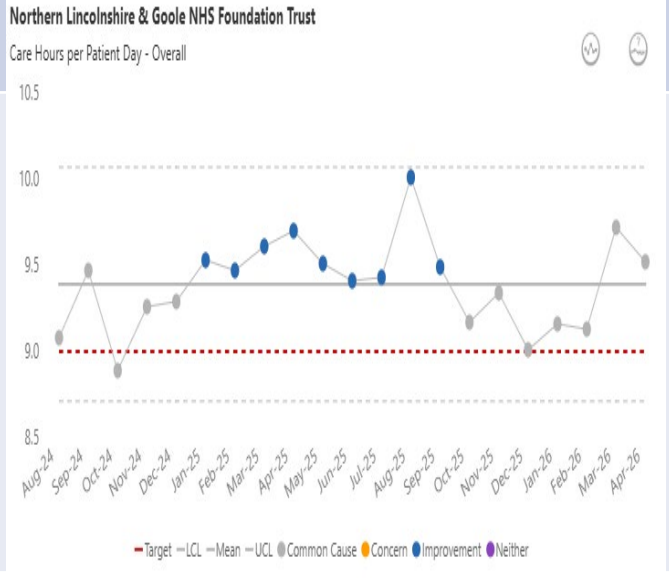


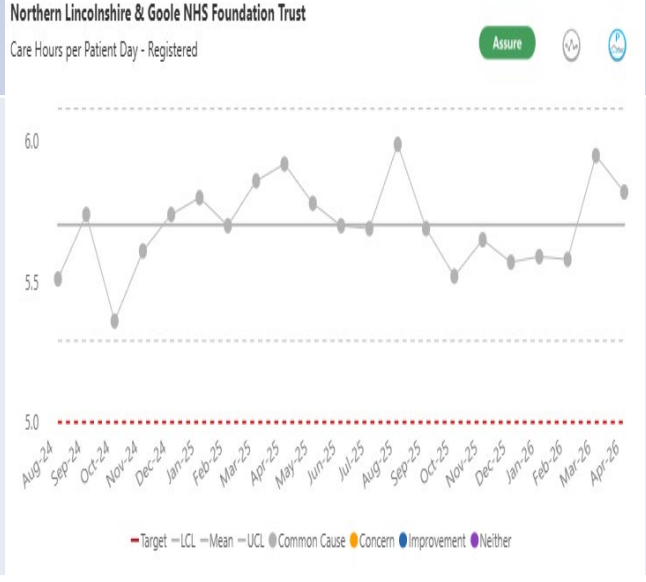


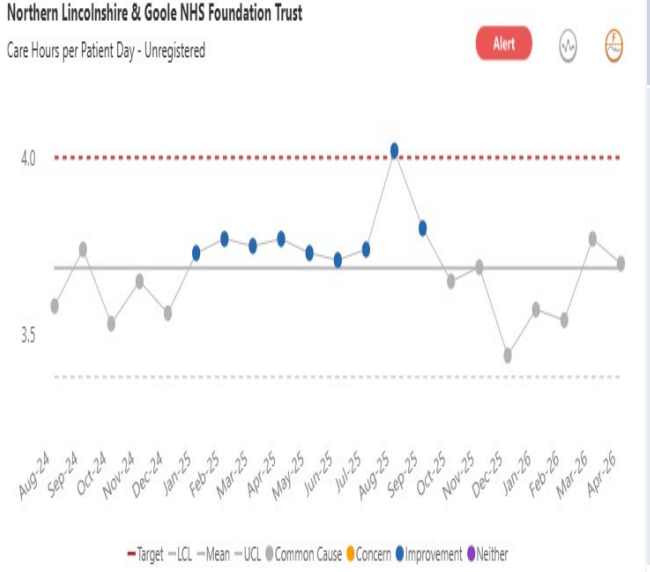


- This metric has been introduced to the Quality IPR.
- The alert for HUTH is associated with CHPPD being below the mean for seven consecutive data points and variability om the data in the unregistered chart.

NLAG







- The latest data shows NLAG in quartile 3, above mean.
- The Assure label is associated with consistency for Registered staffing.
- The Alert label for unregistered is due to the deterioration seen in the previously higher than average rates.

Glossary

NHS
Humber Health
Partnership

- C.difficile – clostridium difficile is a type of bacteria that can cause bowel infection
- CCS – Clinical Classification Software
- CHH – Castle Hill Hospital
- COPD – Chronic Obstructive Pulmonary Disease
- CQC – Care Quality Commission
- CT – Computerised Tomography scan, using x-ray techniques to build detailed images.
- CVP – Central Venous Pressure lines are used to monitor haemodynamic status in critically unwell patients and can also be used to provide medicines into the large veins returning blood to the heart.
- DPOW – Diana Princess of Wales Hospital, Grimsby
- E.coli – Escherichia coli are a group of bacteria that are found in the gut of nearly all people, and can cause infections if gets into new areas, such as wounds, urinary catheter sites and can cause blood stream infections.
- ED/ A&E – Emergency Department
- FFT – Friends and Family Test
- GDH – Goole District Hospital
- HHP – Humber Health Partnership
- HSMR – Hospital Standardised Mortality Ratio, a measure to assess the in-hospital death rate
- HRI – Hull Royal Infirmary
- HUTH – Hull University Teaching Hospitals NHST
- ICB – Integrated Care Board
- IPC – Infection prevention and control
- Klebsiella – Klebsiella Pneumoniae are normally harmless bacteria that are found in the gut and can cause infections in the blood stream and pneumonia.
- LFPSE – Learning from Patient Safety Events is a national database that provider organisations automatically submit patient safety incidents to from their incident reporting systems.
- MRSA – Methicillin-resistant Staphylococcus aureus, which is resistant to the normal treatments for staphylococcus infections and can be difficult to treat in wound and blood stream infections.
- Never Event/NE – Considered to be wholly preventable due to safety measures available from national safety notices and defined by the Never Event List provided by NHS England.
- NLAG – Northern Lincolnshire and Goole NHSFT
- NPSA – National Patient Safety Alert
- NRFIT – An injection connection device to specifically reduce risk of error for spine and other anaesthetic blocks.
- PALS – Patient Advice and Liaison Service
- PIR – Post Infection Review
- Pressure Ulcer/PU – Tissue damage from pressure from prolonged pressure from sitting, laying or devices causing ulceration.
- PSI – Patient Safety Incident
- PSII – Patient Safety Incident Investigation, a detailed investigation as part of the response to an incident where there may be significant learning.
- RAG – Red, Amber, Green colour coded ranking, worst to best,
- RCEM – Royal College of Emergency Medicine
- SGH – Scunthorpe General Hospital
- SHMI – Summary Hospital-level Mortality Indicator, a measure to assess the in-hospital and for 30 days following discharge death rate.
- VTE – Venous thromboembolism, linked with risk assessment and prophylaxis.

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)213

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	10 September 2026
Director Lead	Keith Haynes, Interim Board Secretary
Contact Officer/Author	Keith Haynes, Interim Board Secretary
Title of the Report	Trust Boards-in-Common & Committees Meeting Cycle
Executive Summary	The attached schedule provides the planned dates and times of Trust Boards and Committees-in-Common meetings for the period between January 2026 and December 2026.
Background Information and/or Supporting Document(s) (if applicable)	This is a routine report in the agreed format.
Prior Approval Process	None
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

MEETING SCHEDULE - 2026 - V22

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

	Quarter 4 (25/26)			Quarter 1 (26/27)			Quarter 2 (26/27)			Quarter 3 (26/27)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Trust Board												
Public & Private (including Board Development) (Thursdays - Public - 10.00 am - 5.00 pm)		12.02.26 **Boardroom, DPOW**	12.03.26 **Boardroom, DPOW**	09.04.26 **Boardroom, DPOW**	14.05.26 **Boardroom, HRI**	11.06.26 **Boardroom, HRI**	09.07.26 **Boardroom, DPOW**		10.09.26 **Boardroom, HRI**	08.10.26 **Boardroom, HRI**	12.11.26 **Boardroom, DPOW**	10.12.26 **Boardroom, DPOW**
HUTH Annual General Meeting & NLaG Council Of Governors Annual Members Meeting (Virtual Meeting)										14.10.26 (2.30 pm - 5.00 pm)		
Committees in Common												
Performance, Estates & Finance (Tuesdays - 9.00 am - 12.30 pm)	06.01.26 **Virtual Meeting**	03.02.26 **Virtual meeting**	03.03.26 **Virtual Meeting**		05.05.26 **Virtual Meeting**	02.06.26 **Virtual Meeting**	07.07.26 **Virtual Meeting**	04.08.26 **Virtual Meeting**	01.09.26 **Virtual Meeting**	29.09.26 **(please note falls in September)** **Virtual Meeting**	03.11.26 **Virtual Meeting**	01.12.26 **Virtual Meeting**
Strategic Programmes & Partnerships (Thursdays - 9.00 am - 12.00 pm with exceptions as stated)						30.06.26 **Virtual Meeting**			17.09.26 **Virutal Meeting**			15.12.26 (Tuesday - 1.30 pm - 4.30 pm) **Virtual Meeting**
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)		26.02.26 **Virtual Meeting** (1.00 pm - 4.00 pm)	26.03.26 **Virtual Meeting**	30.04.26 **Virtual Meeting**	28.05.26 **Virtual Meeting**	25.06.26 **Virtual Meeting**	23.07.26 **Virtual Meeting**		24.09.26 **Virtual Meeting**	29.10.26 **Virtual Meeting**	26.11.26 **Virtual Meeting**	17.12.26 **Virtual Meeting**
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)					26.05.26 **Cancelled**			05.08.26			19.11.26	
Workforce, Education & Culture (Wednesdays - 9.00 am - 12.30 pm)	28.01.26 **Virtual Meeting**		25.03.26 **Virtual Meeting**		27.05.26 **Virtual Meeting**		22.07.26 **Virtual Meeting**		23.09.26 **Virtual Meeting**		25.11.26 **Virtual Meeting**	
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	22.01.26 **Virtual Meeting**			23.04.26 (subject to NHSE Submission Deadline **Virtual Meeting**		18.06.26 HUTH & NLaG **Annual Accounts** 1.30 pm - 4.30 pm **Virtual Meeting**	30.07.26 **Virtual Meeting**			15.10.26 (1.00 pm - 4.30 pm) **Virtual Meeting**		
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	15.01.26			01.04.26			08.07.26 **Boardroom, DPOW**			07.10.26		
HUTH (9.00 am - 12.00 pm)		05.02.26			06.05.26			06.08.26			20.11.26	
Executive Team Meetings												
Group Cabinet Meeting	06.01.26 13.01.26 20.01.26 27.01.26	03.02.26 10.02.26 17.02.26 24.02.26	03.03.26 10.03.26 17.03.26 24.03.26 31.03.26	07.04.26 14.04.26 21.04.26 28.04.26	07.05.26 27.05.26	03.06.26 09.06.26 17.06.26 25.06.26	07.07.26 21.07.26	04.08.26 18.08.26	01.09.26 15.09.26 29.09.26	13.10.26 27.10.26	10.11.26 24.11.26	08.12.26 22.12.26
SLT (Tuesdays - 2.00 pm - 5.00 pm)					05.05.26 19.05.26	02.06.26 16.06.26 30.06.26	14.07.26 28.07.26	11.08.26 25.08.26	08.09.26 22.09.26	06.10.26 20.10.26	03.11.26 17.11.26	01.12.26 15.12.26
Financial Planning & Improvement Board (Mondays - 2.00 pm - 4.00 pm)	12.01.26 26.01.26	09.02.26 23.02.26	09.03.26 23.03.26	13.04.26 27.04.26	11.05.26	08.06.26 22.06.26	13.07.26 27.07.26	10.08.26 24.08.26	14.09.26 28.09.26	12.10.26 26.10.26	09.11.26 23.11.26	14.12.26
Governors												
Council of Governors (2.00 pm - 5.00 pm, with exceptions as stated)	08.01.26	25.02.26 (2.30 pm - 5.00 pm) **(ARM - NED & Governor only Meeting)**		15.04.26			16.07.26	20.08.26 **(NED only Meeting - 4.00 pm - 5.30 pm)**			04.11.26	
Member & Public Engagement & Assurance Group (MPEAG) (Tuesdays - 5.30 pm - 7.00 pm)			03.03.26			02.06.26			22.09.26		24.11.26	
Appointments & Remuneration Committee (Thursdays - 3.00 pm - 4.30 pm)		19.02.26			28.05.26				24.09.26			
NED & CEO Meetings												
NED & CEO Meetings (Wednesdays - 10.30 am - 12.30 pm - exceptions ast stated)	14.01.26 (2.00 pm - 4.00 pm)		18.03.26	21.04.26 (11.30 am - 1.30 pm)	20.05.26	17.06.26	15.07.26	19.08.26	16.09.26	14.10.26 (10.00 am - 12.00 pm)	18.11.26	08.12.26 (2.00 pm - 4.00 pm)
Union Meetings												
JNCC - NLAG (Mondays - 2.30 pm - 4.30 pm)	19.01.26	16.02.26	16.03.26	20.04.26	18.05.26	15.06.26	20.07.26	17.08.26	14.09.26	19.10.26	16.11.26	14.12.26
JNCC - HUTH (Thursdays - 10.45 am - 12.45 pm)	08.01.26		05.03.26		07.05.26		02.07.26		03.09.26		05.11.26	
Consultant Meetings												
JLNC - NLAG (Tuesdays - 12.30 pm - 2.00 pm)	20.01.26	17.02.26	17.03.26	21.04.26	19.05.26	16.06.26	21.07.26	18.08.26	15.09.26	20.10.26	17.11.26	15.12.26
LNC - HUTH (Wednesdays - 10.00 am - 1.00 pm)	14.01.26		18.03.26		20.05.26		15.07.26		16.09.26		18.11.26	
Performance Meetings												
Specialist Medicine				27.04.26 (10.00 am - 11.30 am)		04.06.26 (1.30 pm - 3.00 pm)						
Cardiovascular				29.04.26 (2.00 pm - 3.30 pm)		08.06.26 (10.00 am - 11.30 am)						
Cancer Network				29.04.26 (3.30 pm - 5.00 pm)		15.06.26 (10.00 am - 11.30 am)						
Specialist Surgery					08.05.26 (9.00 am - 10.30 am)	16.06.26 (10.00 am - 11.30 am)						
Pathology Network					08.05.26 (2.00 pm - 3.30 pm)	18.06.26 (1.30 pm - 3.00 pm)						
Head & Neck					13.05.26 (1.30 pm - 3.00 pm)							
Specialist Cancer & Support Services						03.06.26 (2.30 pm - 4.00 pm)						
CFT					18.05.26 (10.00 am - 11.30 am)							
AEM North & Major Trauma Network					19.05.26 (10.00 am - 12.00 pm)							
Digestive Diseases					28.05.26 (1.30 pm - 3.00 pm)							
AEM South					28.05.26 (3.30 pm - 5.00 pm)							
Family Services						01.06.26 (10.00 am - 11.30 am)						
Neurosciences						03.06.26 (10.00 am - 11.30 am)						
TACC						10.06.26 (2.00 pm - 3.30 pm)						
Community & Frailty						22.06.26 (2.00 pm - 3.30 pm)						

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)214

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**10 September 2026**
Director Lead	Keith Haynes, Interim Board Secretary
Contact Officer / Author	Alison Hurley, Group Deputy Director of Assurance
Title of Report	**Council of Governors and Trust Board Engagement Policy (DCP231)**
Executive Summary	The Engagement Policy outlines the mechanisms by which Governors and the Trust Board will interact and communicate with each other. This will support ongoing interaction and engagement, and takes into account the statutory role of Governors and their duty to hold Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. The policy has been reviewed and minor updates have been addressed as per the usual Document Control cycle. Trust Board members are asked to note the updated document for information.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Minor updates approved by the author.
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

Northern Lincolnshire and Goole NHS Foundation Trust

COUNCIL OF GOVERNORS & TRUST BOARD ENGAGEMENT POLICY

Document control use only	
Reference	DCP231
Directorate / Care Group	Directorate of Corporate Assurance
Version	2.2
Result of last review	Minor changes
Issue date	

Author / Owner Use Only	
Group or Trust specific document	NLaG
Date approved by owner (for minor changes only outside committee)	23 April 2026
Date approved	29 July 2026
Approving body	Council of Governors / Trust Board
Next full review date	29 July 2029
Lead Director	David Sharif, Group Director of Assurance
Document type	Policy
Author / Contact	Alison Hurley, Group Deputy Director of Assurance
Key words	Council of Governors, Trust Board, engagement policy

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1.0 PURPOSE

This policy:

- outlines the mechanisms by which Governors and Executive and Non-Executive Directors (the Directors) will interact and communicate with each other to support ongoing interaction and engagement, and takes into account the role of Governors, set out in the:
  - National Health Service (NHS) Act 2006
  - Health & Social Care Act 2012
  - Health and Care Act 2022 (the Act)
  - Addendum (2022) to 'Your statutory duties – a reference guide for NHS foundation trust governors'
  - NHS Code of Governance for Provider Trusts 2023 (Appendix B, Section 1.2).
- This includes the duty to hold Non-Executive Directors individually and collectively to account for the performance of the Board of Directors (detailed as the Trust Board).
- describes the methods by which Governors are able to engage with the Trust Board in order to support each other with ongoing interaction and engagement, ensure compliance with the Regulatory Framework and specifically provide for those circumstances where the Council of Governors has concerns about:
  - the performance of the Trust Board.
  - compliance with the Trust's Provider Licence (as granted by the Act); or
  - other matters related to the overall wellbeing of the NHS Foundation Trust.

2.0 AREA

2.1 Holding to Account definition

2.1.1 The Health and Social Care Act 2012 specified the duty of the Council of Governors is to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board. The definition of this is open to interpretation, but broadly speaking this duty requires Governors to question Non-Executive Directors about how they have set the Trust's proposed strategy and forward plan and measured its performance against them, so that they are satisfied that the Board has acted to take the interests of members and of the public appropriately in to account and ensure that the Trust is not at risk of breaching its Licence. In performing this duty, Governors should keep in mind that the Trust Board manages the Trust and continues to bear ultimate responsibility for the Trust's strategic planning and performance and must promote the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

2.1.2 The Health and Care Act 2022 additionally requires Governors to also hold Non-Executive Directors, individually and collectively, to account for the Trust's contribution to the delivery of the objectives for the local Integrated Care System (ICS), being Humber and North Yorkshire ICS.

2.1.3 The process of engagement between the Council of Governors and Trust Board is clearly one which is already ongoing and routine, however, this policy, agreed between the Trust Board and the Council of Governors, aims to outline existing and additional mechanisms which have been agreed and which will be used by the Trust to ensure communication between the Council of Governors and the Trust Board and ensure that Governors are able to discharge the above duties effectively, harmoniously and recognising the different and complimentary roles of each body.

2.1.4 In support of the duty to hold to account, the Council of Governors also has the statutory power to require one or more of the Directors to attend a Governors' meeting for the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and for deciding whether to propose a vote on the Trust's or Directors' performance). Whilst it is recognised that this power will rarely be exercised, should this power be invoked, it must be reported in the report and accounts. The aim of this policy is to have agreed levels of engagement which will eliminate or at least minimise the need of Governors to ever invoke this statutory power.

2.2 Raising Concerns/Resolution of Disputes

2.2.1 Where material concerns exist regarding the performance of the Trust Board, compliance with the Trust's Licence or matters relating to the general well-being of the Trust, this policy should be followed. This policy is not to be invoked for minor issues raised by an individual Governor. A concern, in the meaning of this policy, must be directly related to:

- the performance of the Trust Board.
- compliance with the Trust's Licence.
- the welfare of the Foundation Trust.

2.2.2 The procedure for a situation in which the Council of Governors as a whole is in dispute with the Trust Board is covered in section 42.0 of the Trust Constitution. It is noted that the Chair shall convene a joint meeting of the two bodies to consider the issue in dispute. The Chair has the authority to make a decision on behalf of the Trust, which will communicated in writing, to all members of both the Trust Board of Directors and the Council of Governors.

2.2.3 Governors should acknowledge the overall responsibility of the Trust Board for running the Trust and should not try to use the powers of the Council, or the provisions of this policy, to impede the Board in fulfilling its duty.

3.0 DUTIES IN RELATION TO COMMUNICATION AND ENGAGEMENT

3.1 Throughout this document the Vice Trust Chair will deputise for the Trust Chair if and as required.

3.2 Trust Chair/Vice Chair

The Trust Chair/Vice Chair:

- acts as the principal link between the Council of Governors and the Trust Board and will therefore, have the main role in dealing with any issues raised by Governors, and will involve the Chief Executive and/or the Chief Financial Officer and other Directors as necessary.
- ensures that the Trust Board and Council of Governors work together effectively and enjoy constructive working relationships (including the resolution of any disagreements).
- ensures good information from and between the Trust Board, Committees, Council of Governors and members and between the Senior Management and Non-Executive Directors, members of the Council of Governors and Senior Management.
- ensures that the Council of Governors and Trust Board receive accurate, timely and clear information that is appropriate for their respective duties.
- constructs the agendas for both the Trust Board and Council of Governors (with the input of others as appropriate).
- encourages the participation of the Trust Board in the induction, orientation and training of Governors as required.

3.3 Chief Executive

The Trust Chief Executive:

- ensures the provision of information and support to the Trust Board and Council of Governors and ensures that Trust Board's decisions are implemented.
- facilitates and supports effective joint working between the Trust Board and Council of Governors.
- supports the Trust Chair in their task of facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive members of the Trust Board, elected and appointed members of the Council of Governors and between the Trust Board and Council of Governors.
- with the Trust Chair, ensures that the Council of Governors and Trust Board receive accurate, timely and clear information that is appropriate for their respective duties.
- with the Trust Chair, constructs the agendas for both the Trust Board and Council of Governors (with the input of others as appropriate).

- supports the Trust Board to request the Trust Chair to seek the views of the Council of Governors on such matters as the Trust Board may from time to time determine.

3.4 Senior Independent Director

The Senior Independent Director:

- can act as an alternative source of advice to Governors from the Trust Chair.
- shall be available to Governors if they have concerns which contact through the normal channels of the Trust Chair, Chief Executive and Chief Financial Officer has failed to resolve any issues which have been raised or for which such contact is inappropriate.

3.5 Governors

- Individual Governors have a responsibility to act in accordance with this policy, to raise concerns (as defined in this policy), and to assure themselves that issues have been resolved. In addition, the Council of Governors as a body has a duty to inform NHS England if the Trust is at risk of breaching the terms of its Licence.
- The Lead Governor shall make themself available to provide informal advice to any Governor who may seek it in advance of a concern being raised with the Director of Assurance or the Trust Chair.

3.6 Director of Assurance

As Trust Secretary for the Trust, the Director of Assurance shall:

- be a further point of contact for any Governor or group of Governors who wish to raise a concern covered by this policy, and where possible, resolve the matter informally and/or advise as to whether it is appropriate to the take the concerns to the Chair; and
- arrange informal meetings between Governors and Directors (including the Trust Chair and the Chief Executive) outside of formal Council of Governor meetings to answer questions and confirm decisions taken by the Trust Board (where appropriate) where requested to do so by the Trust Chair.

4.0 ACTIONS

4.1 Holding to Account

4.1.1 The relationship between the Council of Governors and Trust Board is critical and there are a number of ways an open and constructive relationship can be achieved between the two. Non-Executive Directors and Governors should have the opportunity to meet at regular intervals and Governors should feel comfortable asking questions regarding the management of the Trust. Executive Directors should keep Governors appropriately informed, particularly about key Board decisions and how they affect the Trust and the wider community via their reports to Board committees and the subsequent Committee Highlight Report to the Council of Governors and Trust Board meetings. Governors are also invited to attend Trust Board meetings and have access to the associated documentation.

4.1.2 Governors will hold the Trust Chair and other Non-Executive Directors to account partly through effectively undertaking the specific statutory duties summarised here:

- Governors are responsible for appointing the Chair and other Non-Executive Directors and may also remove them in the event of unsatisfactory performance.

- Governors have the right to receive the annual report and accounts of the Trust and can use these as the basis for their questioning of Non-Executive Directors.

- Governors have the power to appoint or remove the external auditor.

- Directors must take account of Governors' views when setting the operational and financial plan for the Trust, giving Governors the opportunity to feed in the views of Trust members and the public and to question the Non-Executive Directors if these views do not appear to be reflected in the strategy. Where Directors put a proposal in the forward plan for an activity outside of the principal purpose of the Trust, the Governors must decide whether carrying on the activity, to any significant extent, interferes with the Trust's principal purpose, and must notify the Directors of its determination. However, Governors should understand there may be valid reasons why member views cannot always be acted upon. Governors and Non-Executive Directors should have enough time to discuss these matters so Governors can be satisfied with the reasons behind the Board decisions.

- Governors have the power of approval on any proposal by the Trust Board to increase non-NHS income by 5% a year or more. They therefore need to be satisfied with the reasons behind any such proposals.

- Governors also have the power to approve amendments to the Trust's Constitution, approve 'significant transactions' and approve any mergers, acquisitions, separation or dissolution and will need to be satisfied with the reasons behind any proposals (as per Section 45 of the Trust Constitution).

4.1.3 It is clear that there are already a number of well-defined mechanisms in existence within the Trust for Governors to receive or seek information from and hold the Board and the Directors and Non-Executive Directors to account including:

- receiving the agenda and minutes of Board meetings and requesting any specific papers. Governors are also invited to attend Trust Board meetings and have the opportunity to ask questions as public members on the contents of the Board minutes and decisions at Council of Governor meetings.

- receiving the annual report and accounts and asking questions on their content.

- receiving the annual Quality Account and asking questions its content.

- receiving in-year information updates e.g. finance, performance, quality and workforce and asking questions on their content.

- receiving performance appraisal information for the Trust Chair and other Non-Executive Directors, via the Appointments & Remuneration Committee, and using this to inform decisions on remuneration for the Trust Chair and the other Non-Executive Directors.

- the attendance of the Chief Executive, other Executive and Non-Executive Directors at Council of Governors meetings and using these opportunities to ask them questions.

- the attendance of the Non-Executive Directors at the annual review of performance of the Council of Governors.

- receiving information on internal consultations, developments and media releases.

- receiving information on issues or concerns likely to generate adverse media interest and providing Governors with the opportunity to raise questions or seek information or assurances.

- involvement of Governors in the Trust’s strategy and planning process through the holding of an annual planning / briefing session for Governors led by the Group Chief Financial Officer.

4.1.4 The following additional measures (some of which are mandatory under the Health & Care Act), are intended to support Governors in their role and to ensure that Governors are well briefed about the decisions which they may be required to make and the context in which the Trust Board is working. This includes the requirements of relevant external stakeholders including Commissioners, NHS England and the Care Quality Commission, have and are being introduced:

- engagement with Directors to share concerns or raise questions about performance, such as by way of joint meetings between the Council of Governors and Non-Executive Directors (which can be conducted within the Council of Governors) or separately and without the Trust Chair (and in private) if required.

- receiving information on proposed significant transactions, mergers, acquisitions, separations or dissolutions and questioning the Directors on these.

- receiving information on documents relating to non-NHS income, in particular any proposals to increase this by 5% a year or more and questioning the Directors on these.

- the holding of Governor briefing and training opportunities, not least in order to ensure that Governors are equipped with the skills and knowledge they require in order to fulfil their role.

- the attendance of the Chair of the Membership and Public Engagement & Assurance Groupat meetings to set the agenda for the Council of Governors.

- each Council of Governors meeting to include a briefing(s) for Governors from the Trust Chair~~,~~ Chief Executive or appropriate Executive Director or senior officer.

- the submission of a formal bi-monthly briefing from the public Trust Board to Governors on key decisions made following each Board meeting.

- the provision of an annual report to the Council of Governors from each Trust Board -committee Chair to include the outcome of the annual review of performance and in turn a report to the full Council of Governors.

- Governors have elected a Lead Governor (and a Deputy Led Governor to deputise when the Lead Governor is unavailable). This role has specific responsibilities in terms of Governor and Board engagement built into the role description for this position. Joint meetings regularly take place between the Chair, Lead Governor, Deputy Lead Governor and the Group Director of Assurance. Feedback from these meetings is provided to the Council of Governors.

4.1.5 Additional statutory means available to Governors for holding Non-Executive Directors to account (where serious concerns exist and in extreme circumstances):

- dialogue with NHS England via the lead Governor. **Note**: "The existence of a lead Governor does not, in itself, prevent any Governor making contact with NHS England directly if they feel it is necessary" but see also 4.3.3 below.

4.2 Raising Concerns

4.2.1 Governors should not raise concerns that are not supported by evidence. That evidence must satisfy the following criteria:

- any written statement must be from an identifiable person or persons who must sign the statement and indicate that they are willing to be interviewed about its contents.

- other documentation must originate from a bona fide organisation and the source must be clearly identifiable.

4.2.2 Newspaper or other media articles will not be accepted as prima facie evidence but may be accepted as supporting evidence.

4.2.3 Governors (operating as a group or on their own) may raise concerns in the following circumstances:

- the performance of the Trust Board.

- compliance with the Trust's Provider Licence; or

- other matters related to the overall wellbeing of the Trust.

4.2.4 Notwithstanding the central role of the Trust Chair in providing the link between the Council of Governors and the Trust Board, it is highly recommended that any Governor or group of Governors who have concerns covered by this policy should, in the first instance, consult the Director of Assurance for advice and guidance. They will seek to resolve the matter informally and will certainly be able to advise the Governor/s on the acceptability of the evidence offered and so whether it is appropriate to take their concerns to the Trust Chair. The advice of the Director of Assurance is not, however, binding upon the Governor/s and they retain at all times the right to raise the matter with the Trust Chair. For concerns which it would be inappropriate to raise with the Trust Chair, for example, regarding his or her own performance, the role of the Trust Chair as described in this section will be undertaken by the Senior Independent Director.

4.2.5 The Trust Chair (or Vice-Chair if the dispute involves the Chair) shall investigate all concerns brought to them by Governors, involving the Chief Executive and/or the Chief Financial Officer at their discretion. The Trust Chair will endeavour to resolve the dispute informally, through discussions within the Council of Governors following investigation which shall include a review of the evidence offered and discussions with Trust officers as appropriate.

4.2.6 As soon as practicable after the conclusion of the investigation the Trust Chair shall meet with the Governor/s to discuss the findings. This meeting has three possible outcomes:

- the Governor/s are satisfied that their concerns were unjustified and withdraw them unreservedly. In this case no further action is required.
- the Governor/s are satisfied that their concerns have been resolved during the course of the investigation. The Trust Chair shall write a report on the concerns and the actions taken and present this the Council of Governors.
- the matter is not resolved to the satisfaction of the Governor/s. The Trust Chair shall call a closed extraordinary meeting of the Council of Governors as soon as possible in accordance with the terms of the Trust Constitution to consider the matter further. That meeting may choose either to take no further action or, if two thirds of the Governors present agree, to invoke the escalation process described from section 4.3.1 onwards.

4.3 Escalating Concerns

4.3.1 At this stage of the process the Senior Independent Director takes over the lead role from the Trust Chair. Should the Senior Independent Director be unavailable or be prevented from participating because of a conflict of interest, then the Council of Governors may choose any other Non-Executive Director to fulfil the role.

4.3.2 The first duty of the Senior Independent Director is to establish the facts of the matter. This will be accomplished by reviewing the evidence offered by the petitioner/s, the process of the investigation and any documentation produced and also by meetings/interviews with the Governor/s and any Trust officers involved. In carrying out this process the Senior Independent Director shall seek the agreement of all interested parties and shall have the authority to commission whatever legal or other advice is required.

4.3.3 Once the facts are established to their satisfaction, the Senior Independent Director shall make a decision on the course of action to be followed in the best interests of the Trust and shall describe the reasons for that decision in a written report. The decision of the Senior Independent Director shall be binding upon the Trust. In the first instance, the Senior Independent Director shall present the decision and the report to the Governor/s and to interested parties within the organisation.

4.3.4 The Trust Chair shall then, at the request of the Senior Independent Director, call a closed extra-ordinary meeting of the Council of Governors as soon as possible in accordance with the terms of the Trust Constitution. The purpose of this meeting, and the sole item on the agenda, will be for the Senior Independent Director to present his or her report and decision and for the council to give its response. Three outcomes are possible:

- the Council accepts the decision of the Senior Independent Director. In this case no further action is necessary.

- the Council does not accept the decision of the Senior Independent Director but chooses not to escalate the matter further. No further action is prescribed by this policy, but the Council of Governors may choose to keep the matter under review at future meetings.

- the Council votes to refer a question for legal review. The seriousness of the latter cannot be overemphasised. If such a question or any other important issue or uncertainty arises, Governors should always seek to discuss it in the first instance with the Trust Chair or another Non-Executive Director. NHS England strongly encourages all FTs and Governors to try to resolve questions internally before posing a question for legal review only as a last resort. The Council of Governors should only consider referring a question for legal review in exceptional circumstances, where there is uncertainty within the Council about whether the Trust may have failed, or is failing, to act in accordance with the Trust's Constitution or with Chapter 5 of the 2006 Act, and this uncertainty cannot be resolved through repeated discussions with the Trust Chair or another Non-Executive Director.

  A Governor may only refer a question for legal review if more than half of the members of the Council of Governors voting approve the referral. Individual Governors may not bring a question for legal without the approval of the Council as a whole. It is noted that once a legal response is provided, the Trust will not necessarily be required to adhere to the legal advice provided.

5.0 MONITORING COMPLIANCE AND EFFECTIVENESS

This policy will be kept under review, compared with the provisions developed by other Foundation Trusts and revised in accordance with emerging best practice and national guidance.

6.0 ASSOCIATED DOCUMENTS AND REFERENCES

6.1 NHS Code of Governance for Provider Trusts 2023

6.2 Trust Constitution

6.3 Monitor Your statutory duties: a reference guide for NHS Foundation Trust Governors, Monitor, 2013

6.4 Addendum to 'Your statutory duties – a reference guide for NHS foundation trust governors' 2022

6.5 National Health Service (NHS) Act 2006

6.6 Health & Social Care Act 2012

6.7 Health and Care Act 2022 (the Act)

7.0 DEFINITIONS

Chair means the Trust Chair of the Trust appointed in accordance with the Constitution.

Chief Executive means the Chief Executive (and Accounting Officer) of the Trust appointed in accordance with the Constitution.

Constitution means the Constitution of the Trust.

Council of Governors means the Council of Governors of the Trust as constituted in accordance with the Constitution.

Director means a person appointed as a Director on the Board of Directors (whether executive or Non-Executive Director) in accordance with the Constitution.

Director of Assurance is the Company/Trust Secretary of the Trust.

Governor means a member of the Council of Governors, being either an elected or an appointed Governor.

Independent Regulator the independent regulator of Foundation Trusts known as is NHS England (NHSE), previously Monitor.

Lead Governor means one Governor appointed by the Council of Governors to communicate directly with NHS England in certain circumstances.

NHS England is the independent regulator of NHS Foundation Trusts and Trusts (and superseded Monitor).

Petitioner(s) is a Governor or Governors raising concerns under this policy.

Provider Licence means the Trust's provider licence granted by the Independent Regulator under section 87 of the NHS Act 2006.

Senior Independent Director means the Non-Executive Director appointed by the Trust Board to provide an alternative to the Trust Chair as source of advice to Governors.

Trust means the Northern Lincolnshire and Goole NHS Foundation Trust.

Trust Directors means the Board of Directors as constituted in accordance with the Constitution.

8.0 DISSEMINATION

8.1 This policy will be made available to Trust staff as a controlled document on the intranet/hub.

8.2 This policy will be distributed to all Governors as soon as possible after their election or appointment and whenever it is revised.

9.0 CONSULTATION

9.1 Council of Governors.

9.2 Trust Board.

10.0 EQUALITY ACT (2010)

10.1 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.

10.2 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.

10.3 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.

10.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably for any reason, including the “protected characteristics” as defined in the Equality Act 2010 (such as by reason of age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual Orientation). These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

NB. It is the responsibility of the document author / contact to carry out an Equality Impact Assessment (EIA) and if there is no impact identified, it is recommended to include the following statement: ‘As part of its development

this document and its impact on equality has been analysed and no detriment identified'.

11.0 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 document, please speak in the first instance to your line manager (if appropriate). The different ways to speak up and guidance on raising concerns are available in the Freedom to Speak Up in the NHS and Raising Concerns at Work policies. Staff can also contact the NLaG Freedom to Speak Up Guardian in confidence. Further details about how to raise concerns and the contact details of the Guardian is available on the intranet/Bridget: Freedom to Speak Up Guardians - Bridget.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)222

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**10 September 2026**
Director Lead	Murray Macdonald, Vice-Chair and Chair of Performance, Estates and Finance Committees-in-Common
Contact Officer / Author	Lauren Rowbottom, Personal Assistant
Title of Report	Minutes from the Performance, Estates and Finance Committees-in-Common held on 3 March 2026, 5 May 2026, 2 June 2026 and 7 July 2026.
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	The minutes attached are for information.
Prior Approval Process	Minutes from the Performance, Estates and Finance Committees-in-Common held on 5 May 2026, 2 June 2026, 7 July 2026 and 1 September 2026
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

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PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 3rd March 2026 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
Jane Hawkard	Non-Executive Director (HUTH)
Dr Kate Wood	Group Chief Medical Officer
Matt Powls	Interim Group Chief Delivery Officer
Philippa Russell	Deputy Group Chief Financial Officer (attending for Group Chief Financial Officer)

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Julie Beilby	Non-Executive Director (NLaG)
Tom Myers	Group Director of Estates
Ryan Sutton	Associate Director of Quality Improvement (attending for Group Director of Transformation)
Chris Fry	Associate Director of Performance & Insight (attending for Group Director of Performance)
Hayley Briggs	Interim Operations Director for TACC (item 4.2.1)
Ashy Shanker	Operations Director for Cancer Network (item 4.3)
Laura Milburn	Assistant Director of Operational Transformation (item 4.4)
Brian Shipley	Deputy Director of Finance (item 4.6.3)
James Maclean	Chief of Service for Pathology Network (item 4.6.3)

Observers

Ian Reekie	Lead Public Governor (NLaG)
Lauren Rowbottom	Personal Assistant
Sam Peate	Group Chief Delivery Officer

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. Apologies for absence were noted for Emma Sayner, Group Chief Financial Officer, Ivan McConnell, Group Director of Transformation, and Adam Creeggan, Group Director of Performance.

Dr Kate Wood shared that she would need to leave the meeting at 11:30 hours to attend another commitment.

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 03 February 2026, the Private minutes from 03 February 2026, and the minutes from the Extra-ordinary meeting held on 28 January 2026.

The minutes of the meeting held on 03 February 2026, the Private minutes from 03 February 2026, and the minutes from the Extra-ordinary meeting held on 28 January 2026 were accepted as a true and accurate record.

1.5 Matters Arising

Jane Hawkard noted a discussion at the previous meeting regarding concerns that were raised to the CQC around the release of the electronic doors in ED.
Tom Myers confirmed that the locking procedures within ED were investigated and it was determined that there were no challenges with them. The Group had informed the CQC, and a process was implemented to test the locking procedure regularly.

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 an update on third-party properties.	The collation of data for third-party properties was underway and the Group were awaiting further

			financial information to formulate the overall financial position. A policy was being worked through to determine how to manage those properties on the North Bank, which would be shared at the next meeting. **Carry forward.**
4.2	Performance Recovery Trajectories and Underlying Delivery Plans: including a focus on Elective and Cancer (Group Performance Report)	Matt Powls to gain further context around the reasons for cancellations due to no theatre time and whether 642 planning had a beneficial effect on cancelled operations. An update would be shared with the CiC in due course.	The revised 6-4-2 process on the North Bank demonstrated a reduction in dropped sessions rate, an increase in booked utilisation and a reduction in COTD due to no theatre time. It was unclear which had greater capacity on COTD rates and the impact would be clear by the end of 2025/26. **Carry forward.**
4.3	24/7 Working in ED	Matt Powls to circulate Industrial Action performance data to the CiC.	Work was underway by the Performance team and the data would be circulated to the CiC in due course. **Carry forward.**
4.3.1	24/7 Working in ED	Matt Powls to circulate an update outside of this meeting regarding the impact and value that opening UTC on a 24/7 basis would have on the Faster Diagnosis Standard in relation to ED performance.	If the Group achieved 95% UTC performance on the HUTH site it would improve performance from 77% to 79.4%. **Action closed.**

2. MATTERS REFERRED

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

None to note.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF) including Risks

David Sharif took the report as read and explained that it detailed the 2 strategic risks under the PEF CiC, which were performance and the public purse, both with a recommended risk score of 20. He emphasised that the BAF did not yet reflect

the recommendations from work undertaken by The Value Circle. A Boards-in-Common development session was scheduled to discuss the BAF and was expected to introduce additional risks which would be outlined in future BAF reports.

Gill Ponder queried whether the proposed public purse risk score increase of 16 to 20 was due to the year-end outturn re-forecast or whether the Group expected a risk of 20 as they entered 2026/27.
Philippa Russell confirmed that it related to the in-year position deficit, a significant deficit going into 2026/27, and the £50 million unidentified Cost Improvement Programme (CIP) in 2026/27 which was a significant risk.

Gill Ponder referred to page 5 of the paper which stated that the patient access risk would reduce to 13 by April 2026, and she queried whether this was accurate.

Action: Matt Powls and Sam Peate to review the progress on the patient access risk, and circulate an update to the CiC prior to the next meeting.

Gill Ponder noted that page 7 of the report mentioned a statement about inert behaviour towards addressing system solutions by the Integrated Care Board (ICB) however there did not appear to be any actions in place that intended to address this.

Ryan Sutton joined the meeting at 09:24 hours.

Gill Ponder mentioned that the risk trajectory within the public purse assumed that the risk would reduce to 12 by October 2026 and required further review.

Action: Philippa Russell to review the risk trajectory within the public purse and confirm whether the risk was expected to reduce to 12 by October 2026.

Dr Kate Wood suggested that BAF deep dive reviews would strengthen the CiCs assurance by clarifying how BAF trajectories were constructed, advising that the CiC would gain more understanding if they were able to show the operational trajectories that underpin the BAF trajectory.

The Committees-in-Common approved the increase in the risk score of 20.

3.2 Review of Relevant Internal & External Audit Report(s), Recommendation(s) & Assurances as appropriate

None to note.

3.3 Review of Relevant External Report(s), Recommendation(s) & Assurances as appropriate

None to note.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Group Finance Report: Month 10

Philippa Russell updated that the year-to-date financial position had worsened in comparison to month-9 however, this was as expected. There was a £8.5 million in-month deficit with a £11 million adverse variance to plan, which was a slight improvement in comparison to the month-9 forecast trajectory and was primarily due to the timing of expenditure rather than significant improvement. Some improvement was seen in the Care Group position however, several Care Groups continued to overspend significantly. CIP delivery remained significantly below plan. The forecast position was currently £93 million with a £37 million adverse variance to plan. There was an element of risk to delivery in the forecast and the Group assumed a level of Care Group recovery. £3 million additional allocations were received from the Integrated Care System (ICS) and there were further opportunities of system support however, system support was likely to impact on reduced allocations for 2026/27 if the forecasted delivery was not seen. The Group had submitted an application for revenue Cash support and were awaiting a response. The Group were required to apply for Cash support funding for 2026/27 and a paper was being developed which would be presented at the Boards-in-Common to request approval of the required Revenue Support Public Dividend Capital for the year ahead. Concerns were raised regarding Capital spend at NLaG due to the £50 million of outstanding Capital resource to be delivered by the end of 2025/26. Capital spend at HUTH had improved slightly. Same Day Emergency Care (SDEC) was identified as the most significant risk at HUTH, due to the Memorandum of Understanding (MOU) being issued while the Group were still in the process of awarding SDEC contracts.

Jane Hawkard noted the risk of £3 million to deliver the financial position and wondered whether the Group were confident that they would deliver what they said they would due to the additional allocation.
Philippa Russell clarified that while the Group expected to achieve their target in 2025/26, there was still a gap and whilst mitigations were in place through system support, there was a risk of a £6 million impact on the 2026/27 delivery.

Philippa Russell confirmed that the Group would do everything possible to get Capital spend over the line, highlighting that there was a risk around the scale of it and a potential audit risk should the Group accrue more Capital expenditure than previously accrued.

Action: Philippa Russell to confirm the exact Capital expenditure that the Group expects to accrue and update the CiC.

Gill Ponder acknowledged that the grip and control measures that were put in place were insufficient and wondered what mitigations would be enacted.
Philippa Russell confirmed that the grip and control measures that were in place were working to some extent. There was acknowledgement around the high-costs that the Group were incurring however, the Group had not yet developed a credible plan to address the underlying deficit which was reflected in the CIP delivery for

2025/26 and the lack of plans for 2026/27 delivery. The most significant challenge was the CIP delivery.

Julie Beilby emphasised that the Group needed to strengthen their grip and control measures prior to 01 April 2026.

Jane Hawkard suggested that once the PEF workplan is finalised, the CiC may need to prioritise deep dive reviews into key areas of concern, particularly CIP plans, Elective Care Pathways (ECPs), and Agency spending. To ensure greater emphasis on the CIP. Noting that those areas would not improve on their own. Gill Ponder agreed that it would be helpful to have a deep dive on the CIP however, she questioned when that might be useful.

Julie Beilby shared that the workforce plan had not been fully triangulated with the CIP and the financial planning and emphasised the importance of it being fully triangulated moving forward.

Gill Ponder noted that there was an automatic correlation between people thinking that the only way to improve access for patients was to spend more money, which was incorrect and the Group needed to break the embedded culture that the only way to drive improvement was to spend.

Philippa Russell mentioned that the Group being in OPEL-4 had resulted in a significant amount of financial planning and recovery meetings being cancelled, which had impacted their ability to work up efficiencies.

The Committees-in-Common agreed limited assurance, noting that they had confidence in the delivery of the revised plan however, concerns were raised regarding the method in delivering the plan. System support would impact 2026/27 and that risk was currently expected to be £6 million. Work was underway to deliver the 2025/26 plan with the current preferred method of savings. Month 10 had not shown the level of expected improvements. Cash support was required for 2026/27 however, it had not yet been approved for 2025/26.

4.1.1 Update on Transformation Programme

Ryan Sutton updated that there was a current focus on tracking the 100 schemes from 2025/26 that were yet to reach benefits realisation, with the aim of improving the position. There were 12 outstanding schemes awaiting costing. Several schemes had not delivered the benefits that were expected. An opportunity plan was developed to achieve the £98.1 million target for 2026/27 however, the Group had experienced challenges with operationalising that plan. Financial Planning Improvement Board (FPIB) meetings would take place weekly throughout March 2026 with the aim of developing a credible delivery plan by 31 March 2026. Significant transformational opportunities were underway however, the Group expected that some of that work may take longer than 12 months to realise those benefits. Efforts were underway to identify service reconfiguration within the plan and what the financial benefits might be.

Jane Hawkard asked how much clinical involvement there would be in the weekly FPIB meetings.
Ryan Sutton explained that several task and finish groups were ongoing with involvement from operational teams and Chief of Service colleagues to finalise plans, which would then be consolidated into the overarching plan for check and challenge at FPIB.

Dr Kate Wood mentioned that clinician involvement within discussions and decision-making had enabled different discussions to take place, and work was underway to produce a plan that was realistic and achievable. She emphasised the importance of clinical involvement, focusing on achievable targets rather than aspirational ones, and ensuring that actions were linked to measurable impacts.

Jane Hawkard thanked the team for their hard work which had supported the Group to deliver almost £100 million in 2025/26.

The Committees-in-Common agreed limited assurance, noting that weekly meetings were in place to try and establish a credible plan to be signed off by 31 March 2026.

Chris Fry joined the meeting at 10:00 hours.

4.2 Group Performance Report: with a focus on Urgent and Elective Care

Chris Fry provided an update.

UEC
HUTH performance in January 2026 was 57.1% for all-types against a target of 73.3%, which was inclusive of on-site Urgent Treatment Centres (UTCs). Type-1 performance was 42.7% against a target of 62.8%. Type-3 performance at Hull Royal Infirmary (HRI) was 92.4% against a target of 95%. Type-1 attendance was slightly above plan and type-3 performance was below plan. Work was required around how to re-direct performance into UTCs. NLaG had a combined performance for January 2026 of 66.1% which was 11% below the trajectory. Type-1 performance was 41.7% which was 20% below the target. Type-3 performance remained above the target of 99%. Type-1 attendance was below plan and type-3 attendance was above plan.

Matt Powls acknowledged that the Group were currently running ‘Perfect Weeks’ and noted that HUTH were in Operational Pressures Escalation Level 2 (OPEL 2) on Friday 27 February 2026, which was a significant improvement, as the Group had not been in this position for several months. This was also achieved alongside the closure of Ward 130 and Ward H1.

RTT
Improvements had been seen in the amount of patients waiting 65-weeks at NLaG. In January 2026, there were 131 patients waiting 65-weeks at HUTH and 26 patients at NLaG. Work that was undertaken by the Care Groups was significant in improving the 65-week position. An increase was seen in the 52-week wait backlog across the Group. The focus on improving 65-week and 52-week performance had

impacted the grip and control on 18-week performance which had deteriorated across the Group in January 2026. Chris Fry highlighted that there was 1 reported 78-week breach in January 2026, and 3-4 were expected in February 2026 based on the latest available data. A root cause analysis would be undertaken to address those breaches and understand the cause.

Hayley Briggs joined the meeting at 10:15 hours.

Diagnostics
Diagnostic performance was significantly challenged and had seen a further deterioration. Performance at HUTH in January 2026 was 42.8% and performance at NLaG was 46.5%.

Cancer
62-day performance at HUTH was 53.7% and 66.1% at NLaG. Chris Fry highlighted that 62-day performance was a challenge nationally and explained that due to the position of the Group's backlogs, 28-day and 62-day performance would require negotiation between priorities over the coming months. In order to remove breaches in one area, the Group would need to allow for some breaches to occur in the other area, which was reflected in the Group trajectories for 2026/27.

Jane Hawkard asked how the Group would sustain the efforts that were applied during the Perfect Weeks once they had concluded.
Dr Kate Wood explained that the Group were taking a different approach and acknowledged that whilst undertaking 3 consecutive Perfect Weeks was ambitious, a difference was made. The Group expected that it would be challenging to keep the progress maintained whilst focusing on a particular site for the next 2 weeks.

Jane Hawkard emphasised that Executive colleagues must be held accountable for continued implementation and asked how that would be embedded.
Dr Kate Wood acknowledged that the ownership and accountability could not sit with an individual and that it was crucial that it was embedded throughout the Group. It was expected that the Perfect Weeks undertaken in February and March 2026 would serve as a platform for embedding revised working practices and sustaining change.

Gill Ponder mentioned that it was difficult to take assurance from the report that the Group would achieve 78% by the end of March 2026 however, the narrative appeared to indicate that this remained the forecast.
Matt Powls confirmed that it would be a challenge to achieve 78% by the end of March 2026.

The Committees-in-Common agreed limited assurance, noting that the 'Perfect Weeks' had shown considerable benefit however, the dial had not shifted on performance.

4.2.1 Theatre Performance Update

Hayley Briggs explained that the paper provided an update on current progress on the elective actions that were discussed previously at the meeting in January 2026.

She acknowledged that there was a long way to go regarding further improving theatre start and finish times and increasing pre-assessment capacity. Utilisation was slowly improving however, the Group had not seen the pace of change that was expected. Sessions that were not being utilised appropriately would be re-allocated to the Day Surgery Centre at Castle Hill Hospital (CHH), with 12 sessions scheduled to be re-allocated from April 2026, and the Group expected that this would improve session and capped utilisation.

Jane Hawkard noted that a theatre trajectory was included in the paper which was different in comparison to what was included in the Group Performance Report (GPR).

Action: Hayley Briggs and Chris Fry to work together to include the theatre trajectory metrics in the Group Performance Report.

Julie Beilby suggested that it would be helpful to understand who was accountable for which actions. Hayley Briggs explained that the actions were part of the Group improvement plan and the responsibility for those was Hayley Briggs, Richard Owen-Smith for the Care Group actions, and Dr Kate Wood was the Senior Responsible Officer (SRO) for the actions on the improvement plan.

Gill Ponder noted that the GPR narrative indicated HUTH was continuing to make 'unreasonable offers' to patients due to delays in providing admission dates, which was causing patient breaches. She highlighted that this seemed to be an administrative issue. Chris Fry agreed and confirmed that he would check the wording within the report. He mentioned that admin capacity was understaffed which provided a challenge for staff to keep up with the demand.

Jane Hawkard mentioned that the private sector at the Spire had transferred orthopaedics patients back to HUTH and wondered whether this had an impact on the Group performance.
Action: Chris Fry to review whether the transfer of orthopaedics patients from the Spire had caused an impact on the Groups performance.

Gill Ponder noted the capped utilisation of the day surgery centre and how it was pivotal to the Group improving performance. She wondered what the barriers were and what the Group were doing to remove those barriers.
Hayley Briggs explained that a deep dive was underway to understand what was required to improve performance in each Care Group.

Action: Hayley Briggs to present a further paper in 3 months' time detailing whether the plans and trajectories were delivered, and whether they had made the expected improvements in performance as a result.

The Committees-in-Common agreed limited assurance, noting that detailed work underway within theatres.

Ashy Shanker joined the meeting at 10:46 hours.
Laura Milburn joined the meeting at 10:55 hours.

4.3 Cancer Performance Update

Ashy Shanker updated that significant progress was made on the Faster Diagnosis Standard (FDS) which was currently 74.9%, and it has been over a year since the Group had achieved that position. A decline was seen in performance across the Group in December 2025 which was attributed to decreased activity levels over the Winter period. The impact on the top 3-5 cancer performance initiatives were not included in the paper due to several initiatives; the radiotherapy business case was approved and the phased implementation was underway with an expectation that it would come to fruition by Q3 in 2026/27. Work was underway with the planning team to review the trajectories for 2026/27. Histopathology turnaround times for Pathlinks at NLaG had reduced from 11 days to an average of 7.58 days. Scarborough, Hull, and York Pathology Service (SHYPS) turnaround times had reduced from 25 days to 15 days, and had been maintained over the last 2 weeks. Work was underway with the Lower GI team to submit bids through the Cancer Alliance, with the aim of strengthening the service and enhance its efficiency. The risks associated with the high levels of Cancer Alliance and other funding received in 2025/26 to support the tiering position would be mitigated.

Gill Ponder queried whether the Group had verified that had capacity shortages and whether they were utilising available capacity in the most effective way, or whether it was limited to specific areas and the underlying reason was due to something other than capacity in areas.
Ashy Shanker explained that unless a full pathway analysis of demand capacity was undertaken, the Group would not know whether it was due to a capacity gap, or efficiencies to be gained through service improvement. Waiting times for a first outpatient appointment would be monitored through the cancer delivery group and work was ongoing with a focus on ensuring that patients did not have to wait for the outcome of their diagnostics.

Jane Hawkard asked for further detail around the business cases that were underway. Ashy Shanker confirmed that the radiotherapy business case had been approved and was awaiting implementation, the gynaecology business case had been approved and was awaiting phased implementation, and work was underway around the business case for lower GI colonoscopy. A significant bid was submitted through the diagnostics opportunities and the Group were awaiting the outcome.

Jane Hawkard asked when the administration and vacancies challenges were first highlighted and why a technological solution had not been pursued.
Ashy Shanker referred to a restructure and consultation that took place 18 months' ago, noting that the historical admin challenges that followed were now resolved. Plans were in place for training and development and additional capacity was anticipated through the planning process which would allow implementation of those training plans. Work was underway to establish a digitisation programme in 2026/27 which included incorporating an improved version of the cancer system and harmonisation of the Patient Tracking List (PTL) to reduce duplication.

Action: Ashy Shanker to present a further paper in a few months' time detailing what performance improvements were expected due to the actions in place and when the Group would expect to see those.

An update to be provided at the next cancer deep dive, regarding a forward view on what the impact would be and when the impact was expected to delivered.

The Committees-in-Common agreed limited assurance, noting that performance was heading in the right direction due to the plans that were in place.

Ashy Shanker left the meeting at 11:14 hours.

4.4 Deep Dive: Diagnostics

Laura Milburn updated that the Group expected to end 2025/26 with an improved diagnostic waiting times and activity (DM01) performance position in comparison to the position 6 months' ago however, further improvement was required. Several performance recovery actions were outstanding and it was recommended that the Group prioritised implementation of those actions. 6 modalities were on target to achieve the 5% target or less, and 4 modalities were on target to achieve 20% or less by the end of 2025/26. The ICB had allocated £850k worth of Capital and £3.3 million revenue funding to the Group to support further improvement of the DM01 performance position, and work was underway to pull together a list of schemes. The funding would also support the digestive diseases business case that was underway which would further improve DM01 performance and lower GI FDS performance. The Group expected that the 2-week wait position would recover within 24 weeks of the business case being implemented. Aligned revenue bids were submitted against modalities with the most challenged performance which looked at improvement in DEXA performance, neurophysiology, CT at HUTH, and non-obstetric ultrasound, audiology, and MRI across the Group. If the schemes were approved, the services were expected to deliver 5% performance or less in 2026/27.

Jane Hawkard asked for assurance that the Group would maintain performance, having utilised additional funding and capacity to clear the backlog.
Laura Milburn confirmed that some schemes would provide sustainable improvements once the backlog had been cleared however, she noted that other modalities were likely to continue facing challenges unless an improvement was seen in recruitment.

Gill Ponder queried why performance had deteriorated despite the Group having additional capacity in the Community Diagnostic Centres (CDCs). She also wondered what mitigations could be put in place to resolve the lack of demand in the Grimsby CDCs.
Laura Milburn clarified that the guidance on appropriate use of CDCs had been misinterpreted, and work was underway to re-educate General Practitioners (GPs) to address this. The Group would ensure that all sites were appropriately offered to patients for diagnostic tests.

Julie Beilby made a reference to the paper which stated that patients ‘would not’ travel however, it was confirmed that patients ‘could not’ travel. She noted that the Group needed to look at equality statements differently.
Laura Milburn apologised for the language that was used in the paper and noted that it was a mixture of an inability and a preference not to travel. Equality Impact Assessments (EQIAs) were carried out as part of the ongoing service development work.

Action: Laura Milburn to amend the report to state that individual EQIAs were carried out.

Chris Fry and Dr Kate Wood left the meeting at 11:30 hours.

Julie Beilby noted the endoscopy deep-dive findings, which highlighted several actions to support performance recovery, and asked for indicative timescales for those actions. Laura Milburn confirmed that the Group were meeting with NHSE next week and following this, the recommendations would be implemented into a tracker where timescales would be assigned. This would be shared at a future meeting.

Jane Hawkard queried whether the Group expected to see an overarching performance improvement by the end of March 2026.

Action: Laura Milburn to share the expected performance position for March 2026 with the CiC.

A discussion took place around JAG accreditation.

Action: Laura Milburn to check the JAG accreditation status for each unit and circulate this outside of the meeting.

The Committees-in-Common agreed limited assurance, noting that high-quality plans were seen however, performance on diagnostics had deteriorated and the CiC had not had the chance to see the outcome and the impact. They raised concerns regarding the potential impact on sustaining improvement due to Laura Milburn’s secondment coming to an end.

Action: An update would be provided at the next Diagnostics Deep Dive around whether the plans were delivered and if they had the expected impact, and if not then what was being done about it.

Laura Milburn left the meeting at 11:38 hours.

4.5 Directorate of Estates, Facilities and Development Update: including HRI Tower Block Update

Tom Myers reported that 116 projects were in progress across 12 project managers, noting that the Group’s initial £40 million allocation for 2025/26 had grown to £89.4 million and had significantly increased the challenge of delivering

the programme. Efforts were underway to utilise the remaining funding, with orders being placed for kit and equipment on schemes experiencing minor delays.
There were no concerns raised from a Capital perspective. The Health, Safety and Environment (HSE) had recently undertaken an inspection at Scunthorpe General Hospital (SGH) and they confirmed that the site met all required standards. The cleaning harmonisation project was progressing, and the Group was currently mid-way through the tender process for renewing the OCS cleaning contract however, the impact of tele-tracking was a concern as it affected how cleaning was managed and would be considered as part of the procurement. Specifications around the security and car parking contracts had been agreed and the Group were preparing to go out to tender, with lots of interest received. Work was underway to develop plans around decontamination as the contract was due to end in January 2028, and a Group would be established to work on that area. Further work was required in relation to the Private Finance Initiative (PFI).

Julie Beilby shared that she was disappointed to read a Health Service Journal (HSJ) report that stated that NLaG were at the bottom of the worst acute trusts for cleanliness. Tom Myers explained that the results were based on a place assessment that was undertaken in one day, during which several issues were identified on the day and resolved immediately.

Julie Beilby wondered whether the lease arrangements with the council could include a provision allowing the Group to place homeless No Criteria to Reside (NCTR) patients in council-managed accommodation.

Action: Tom Myers to discuss with Lesley Potts the possibility of utilising council lease arrangements to accommodate homeless NCTR patients.

Gill Ponder noted that the Group had requested for Salix to defer the Capital Public Sector Decarbonisation Scheme (PSDS) phase 3C funding, acknowledging that a similar request was previously declined. She expressed concern that this presented a potential risk and asked whether a contingency plan was in place should Salix refuse again.
Tom Myers clarified that the request related specifically to a delay in delivery rather than funding. He confirmed that the Group expected to have drawn down the allocation from Salix by the end of 2025/26, with any delay affecting only the operational date of the electric boilers. Negotiations with Salix were ongoing and they were on board.

The Committees-in-Common agreed significant assurance, noting the ongoing work around the Tower Block at HRI. They highlighted the volume of projects underway and the potential risk that brings, particularly that the Group may not be able to spend the funding from Salix by the end of 2025/26.

4.6 Contract Approvals

4.6.1 Contract Approval: HRI Surgical SDEC Level 3

Tom Myers updated that the contract was valued at £3.2 million including VAT. Following a tender process, it was further assessed by DKP, external quantity surveyors who had recommended awarding the contract to Zenith Development.

Gill Ponder noted that delegated authority was agreed by the CiC at the previous meeting however, this was on the basis that 70% of the evaluation criteria would be weighted towards quality. She further noted that the paper made no reference to quality.

Action: Tom Myers to ensure that the quality elements for the HRI Surgical SDEC contract were fully included in the evaluation.

The Committees-in-Common gave retrospective approval for the contract, subject to the quality elements being fully included in the evaluation of the contract.

4.6.2 Contract Approval: Theatres 5 & 6 Refurbishment at Castle Hill Hospital

Tom Myers noted that the contract had been shared for completeness, highlighting that its £2.714 million value fell below the CiC approval threshold. Following a tender process, Andrew Johnson Construction Ltd were identified as offering the most financially advantageous bid, and their proven track record in successfully delivering theatre refurbishment works at HRI further strengthened their suitability for the contract.

Gill Ponder noted that the evaluation in the paper did reference quality.

David Sharif wondered whether there was value in Zenith Development carrying out both contracts. Tom Myers confirmed that it would not be efficient.

The Committees-in-Common noted the contract for information.

4.7 Emerging Issues

Nothing to raise.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

This was shared for information.

5.2 Planned Care Board Meeting Draft Minutes

This was shared for information.

5.3 Unplanned Care Board Meeting Minutes

This was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

The CiC thanked Matt Powls for his contribution to the meeting, noting that his willingness to take things away was appreciated.

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 05th May 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 06/01 Y 28/01	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 06/01 N 28/01		
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 06/01 Y 28/01	Y	D
Jane Hawkard	NED (HUTH)	Y	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09	D	Y	Y 06/01 N 28/01	Y	Y
Simon Parkes	NED (NLaG)	Y	Y	Y	Y	Y 05/08	N 02/09	Y 30/09	D	Y	N 06/01		

						N 07/08					N 28/01		
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 06/01 Y 28/01	Y	Y
Dr Kate Wood	Group Chief Medical Officer	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	D 30/09	Y	Y	Y 06/01 Y 28/01	Y	Y
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 06/01 D 28/01	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 06/01 N 28/01	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 06/01 Y 28/01	Y	Y
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 06/01 N 28/01	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 06/01 N 28/01	Y	Y
ADDITIONAL ATTENDEES													
Murray MacDonald	Interim Group Chair										Y 06/01 N 28/01	N	N

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 5th May 2026 at 09:00 to 12:30 hours via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Julie Beilby	Non-Executive Director (NLaG) – Joint Chair
Jane Hawkard	Non-Executive Director (HUTH) – Joint Chair
Sam Peate	Group Chief Delivery Officer
Emma Sayner	Group Chief Financial Officer

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Lauren Rowbottom	Personal Assistant (Minute Taker)
Philippa Russell	Deputy Group Chief Financial Officer
Tom Myers	Group Director of Estates
Chris Fry	Associate Director of Performance & Insight (attending for Group Director of Performance) (Item 4.3)
Edd James	Procurement Director

Observers

Wendy Lawtey	Public Governor (NLaG)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Jane Hawkard, welcomed those present to the meeting. Apologies for absence were noted for Kate Wood, Group Chief Medical Officer, Peter Sedman, Deputy Group Chief Medical Officer, Ivan McConnell, Group Director of Transformation, Ryan Sutton, Associate Director of Quality Improvement, Murray MacDonald (Vice Chair) and David Sharif, Group Director of Assurance.

1.2 Staff Charter and Values

Jane Hawkard 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 03 March 2026, and the minutes of the Effectiveness Outcome Discussion held on 12th January 2026.

The minutes of the meeting held on 03 February 2026, the Private minutes from 03 February 2026, and the minutes from the Extra-ordinary meeting held on 28 January 2026 were accepted as a true and accurate record.

Action: Lauren Rowbottom to ensure all the agreed actions from the Effectiveness Outcome Discussion are on the action tracker.

1.5 Matters Arising

No matters arising.

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 an update on third-party properties.	**Referred and completed under Quality Safety CiC.** **Tom Myers updated that the policy was under development, with standards for specific rooms still being defined, and the action was agreed to be closed on the tracker.**
4.2	Performance Recovery Trajectories and Underlying Delivery Plans: including a focus on Elective and Cancer (Group	Matt Powls to gain further context around the reasons for cancellations due to no theatre time and whether 642 planning had a beneficial effect	**Tom Myers updated that continuous progress was being made and the CiC closed the action.**

	Performance Report)	on cancelled operations. An update would be shared with the CiC in due course.	
4.3	24/7 Working in ED	Matt Powls to circulate Industrial Action performance data to the CiC.	**Karena Groom circulated data to CiC members on 30 April 2026.**
3.1	Board Assurance Framework (BAF) including Risks	Matt Powls and Sam Peate to review the progress on the patient access risk, and circulate an update to the CiC prior to the next meeting.	**Sam Peate and David Sharif met to discuss the BAF, which will be reviewed to ensure it is updated.** **Internal audit was set to take place around patient quality policy.** **Agreed to carry forward to June 2026.**
3.1.1	Board Assurance Framework (BAF) including Risks	Philippa Russell to review the risk trajectory within the public purse and confirm whether the risk was expected to reduce to 12 by October 2026.	**Philippa Russell discussed with Emma Sayner and agreed that the trajectory was probably too ambitious. Trajectory to be updated to reflect a reduction in risk from 20 to 16 by October 2026.** **Action can be closed.**
4.1	Group Finance Report: Month 10	Philippa Russell to confirm the exact Capital expenditure that the Group expects to accrue and update the CiC.	**Philippa confirmed this. Action can be closed.**
4.2.1	Theatre Performance Update	Hayley Briggs and Chris Fry to work together to include the theatre trajectory metrics in the Group Performance Report.	**Hayley reviewed the group IPR and the theatre trajectories, these are two separate items, and she did not feel the TACC specific actions and trajectories were required to be included in the IPR as these were not the level of detail that would usually be included in an IPR.**

			IPR to be completed in June. Move forward to July PEF.
4.2.2	Theatre Performance Update	Chris Fry to review whether the transfer of orthopaedics patients from Spire had caused an impact on the Groups performance.	**Chris to circulate to the CiC. Carry forward to June.**
4.4	Deep Dive: Diagnostics	Laura Milburn to amend the report to state that individual EQIAs were carried out.	**The report was amended. Action can be closed.**
4.4.1	Deep Dive: Diagnostics	Laura Milburn to share the expected March 2026 performance position with the CiC.	**Karena Groom circulated this update to the CiC on 16 March 2026.**
4.4.2	Deep Dive: Diagnostics	Laura Milburn to check the JAG accreditation status for each unit and circulate this outside of the meeting	**Karena Groom circulated update to the CiC on 16 March 2026.**
4.5	Directorate of Estates, Facilities and Development Update: including HRI Tower Block Update	Tom Myers to discuss with Lesley Potts the possibility of utilising council lease arrangements to accommodate homeless NCTR patients.	**Tom Myers updated that the unit opposite Scunthorpe Hospital was for families in crisis, so wouldn't be able to accommodate. Action to be closed.**
4.6.1	Contract Approval: HRI Surgical SDEC Level 3	Tom Myers to ensure that the quality elements for the HRI Surgical SDEC contract were fully included in the evaluation	**Completed for Board meeting. Can be closed.**

2 MATTERS REFERRED

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

The CiC briefly discussed a matter referred from Quality and Safety CiC on the disabled access improvements risk. Tom Myers informed members of the CiC that an accessibility survey by Access Able was being created with results expected over the summer.

Jane Hawkard and Julie Beilby agreed to add this to the action tracker, and Tom Myers to report back to this meeting within his update once the survey was complete.

Action - Lauren Rowbottom to add to action tracker

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 12

Emma Sayner presented the month 12 financial position, highlighting the Group deficit, underlying financial risks, reliance on non-recurrent income, and ongoing cash management challenges. She gave thanks to Phillipa Russell in presenting the report to the new format and highlighting key areas. She added that work was underway around the Capital and Cash position.

Philippa Russell reported a group deficit of £36.5 million, which was slightly better than forecast, but noted a worsening underlying position by £6 million compared to earlier forecasts. The group delivered £94.8 million in Cost Improvement Plan (CIP), but nearly £30 million was non-recurrent, raising concerns for the next financial year.

Philippa Russell explained that the group had requested £6.9 million in cash from NHSE for HUTH for month two and anticipated monthly Public Dividend Capital (PDC) requests due to ongoing deficits. The finance team were closely monitoring cash requirements and would request only the required minimum. The Integrated Care Systems (ICS) was at a 96.7 million deficit which was worse than the forecast protocol due to movement in Harrogate.

Julie Bielby questioned the increase in agency spend, particularly in admin and clerical roles and wondered what was being doing to sustain grip and control. Emma Sayner and Sam Peate described new weekly tracking, manual controls, and a proposal to automate processes via a Locum's Nest module, aiming for improved control within eight weeks, subject to approval.

Julie Bielby and Sam Peate discussed the significant increase in admin and clerical spend, attributed to vacancies and the need to address backlogs in clinical correspondence. Emma Sayner clarified that most admin and clerical bank spend was not at premium rates and was more cost-effective, with patient services delivering to plan.

Jane Hawkard questioned who was in charge of the Administration and Clerical Transformation plan after conversations were had at board to create a reduction programme. Emma Sayner confirmed this fell under the Human Resources Director – Paul Bunyan.

Jane Hawkard and Julie Bielby expressed concerns about the reliance on non-recurrent savings and the need for recurrent savings in 26-27. Emma Sayner and Philippa Russell acknowledged the risks, noting that while targets were met for the year, the underlying issues remain and will require continued focus.

The Committees-in-Common agreed limited assurance, alerting to the cash issues which were likely to continue due to the defict plan.

4.1.1 Transformation and Sustainability Report

The CiC discussed the development and allocation of the 26-27 CIP programme, the integration of lessons from external consultancy, the focus on variable pay and workforce reductions, and the challenges in achieving recurrent savings, with ongoing work to clarify trajectories and improve delivery.

Emma Sayner outlined the allocation of the £73.5 million CIP target across Care Groups, Corporate services, and specific portfolios such as drugs, procurement, and variable pay. All allocations were now in budgets for month one, but detailed delivery plans were still being developed for an ambitious 2026/27. She stated Ryan Sutton and the Project Management Office (PMO) were keeping track of the CIP developments.

Sam Peate reiterated that CIP was being reviewed weekly through the FPIP meetings and expressed that Care Groups were taking it seriously and were reviewing different ways of working within their budget constraints.

Emma Sayner updated that the team was focusing on reducing variable pay and whole time equivalents (WTE), with a planned reduction of over 200 posts. She described efforts to question workforce deployment, share resources across care groups, and implement internal professional standards (IPS) to drive efficiency. She assured the CiC that good grip and control measures were in place.

Emma Sayner informed the CiC that a full clinical review on how stocks are handled on the wards was being undertaken. Jo Ledger was developing a list of staff members to review all stock, with an aim to reduce the number of suppliers..

Emma Sayner explained that lessons from Rob Cooper's consultancy and the National Provider Improvement Programme (NPIP) was being integrated into an overarching improvement plan, with a focus on reducing temporary staffing and

achieving sustainable financial improvements. The group expects to have a clearer integrated plan by the next meeting.

Jane Bielby requested regular reporting on whole time equivalent reductions and financial trajectories. Emma Sayner and Philippa Russell agreed to include these metrics in future updates, with ongoing work at Senior Leaders Team (SLT) to proactively monitor progress.

Julie Bielby and Jane Hawkard highlighted the high risk and ambitious nature of the transformation programme, noting the need for more visible progress and the importance of moving to recurrent savings. Emma Sayner described efforts to simplify pathways, observing and engaging clinical leaders in transformation aiding the delivery of better outcomes for patients.

The Committees-in-Common agreed on limited assurance.

The agenda was taken out of order at this point

Advise, Alert and Assure Report (AAA) Format Feedback

Julie Bielby expressed she was pleased to see the Group move towards this format. Rebecca Crashley informed this was a recommendation from the Value Circle work and was piloted in Quality and Safety CiC.

Rebecca Crashley advised that the AAA report was still a work in progress and Performance, Estates and Facilities was the first CIC to trial it. She added that the response had been great and all had been completed as best as could have been. There were some ongoing questions about report structure, inclusion of financial and equality sections, and the need for a completion guide.

Julie Bielby and Jane Hawkard raised concerns about missing sections for financial implications and equality assessments, suggesting these should be retained to prompt consideration at committee. Sam Peate noted the importance of clear definitions for each AAA section and the need for consistency across reports after having experience in the past of using these reports.

The agenda returned to order at this point

4.2 Deep Dive: ED Performance Improvement Plan & Lessons Learned from the Perfect Week

Sam Peate provided a detailed deep dive on Urgent and Emergency Care (UEC). He explained several workshops had been created in the last 6-12 months, equalling a number of things being implemented across both organisations, including policies and ways of working.

Sam Peate reported sustained improvements in type 1 and four-hour compliance, reductions in 12-hour waits, and increased weekend discharges, particularly in

Hull. However, some metrics, such as time to see a clinician and ambulance handover, remained static or problematic, especially at NLaG.

Sam Peate described ongoing joint work with local authorities and the ICB to reduce discharge delays, including a live bed audit and a focus on pathway 0 discharges. Julie Beilby highlighted ongoing issues with patients remaining beyond expected discharge dates and the need for better demand management. By the end of October 2025, Hull had shown almost a 50% increase in patients being discharged on a weekend.

In the last four weeks, Northern Lincolnshire and Goole had improved from 69.6% of patients leaving hospital before 5pm to 74.5%, being the second highest performer in the Integrated Care Board (ICB). Sam Peate explained how both organisations were focused on ward processes within Medical Staff and Nursing teams following the perfect week, and were looking at improving discharge processes and putting a focus on discharge planning.

Sam Peate informed the CiC that ambulance handover compliance at HUTH had maintained progress. He stated key work with East Midlands Ambulance Service (EMAS) had begun to produce a rapid handover which hoped to improve ambulance handovers at NLaG. Both organisations had adopted a single set of daily bed meetings, with a number of reports in place to share pressures.

Sam Peate also confirmed he is the Senior Reporting Officer (SRO) for the UEC programme board, and all Care Groups were developing short, medium, and long-term improvement plans.

Julie Beilby and Sam Peate discussed the importance of engaging GP networks and Primary Care Navigators (PCNs) to manage demand and reduce unnecessary ED attendances. He also mentioned he was working with system leaders and the ICB to develop a single system plan and address primary care referral patterns to aid in stopping people attending A&E when they do not need to be there.

Jane Hawkard requested that future reports include clear, measurable objectives and trajectories to track progress that showed when the organisation was out of the bottom quartile. Sam Peate agreed to provide an update to July's meeting, including winter planning and more detailed metrics.

Action: Sam Peate to bring another ED Deep Dive to Julys PEF CiC which should include clear, measurable objectives and trajectories

Action: Lauren Rowbottom and Rebecca Crashley to amend workplan to ensure we're seeing more on ED performance and Cancer as agreed in agreeing the operational plan as the main priority areas.

The Committees-in-Common agreed limited assurance, they agreed they needed to see more improvement in outcomes.

Chris Fry joined the meeting at 10.43am

4.3 Group Performance Report

Chris Fry presented the Group Performance Report highlighting recent performance in RTT, ED, and cancer.

Chris Fry reported improvements in the long wait cohorts for Referral to Treatment (RTT). This was due to increased capacity in February and March, seeing a reduction in the 65 and 52 week waiters. He also noted some increases in 78 and 104 week breaches which were to undergo root cause analysis investigations. The ED performance for March 2026 was 64% overall, with type 1 at 50.7%. The 6 week wait performance showed improvement across both sites, however was still away from the 5% national driver.

Chris Fry updated that within the RTT forums across the group, trajectories have been set to a speciality level and these would be available and published once April's numbers had been solidified.

There had been a deterioration in the 18-week performance particularly at HUTH and Chris Fry explained that extended validation periods allowed the central validation team to remove approximately 2,000 waiters from the waiting list, improving data quality as reflected in the national MBI product, however, noted that waiting list size had remained static for several months.

Chris Fry reported that 62 day performance was variable, with a slight deterioration at HUTH and a slight improvement at NLaG. The data for March would be available in two weeks. Diagnostic performance remained below the national 5% target, with local plans aiming for around 20% by year-end, pending further capacity and funding.

Julie Beilby queried how the Performance Team were embedding and modifying the GPR to ensure the right metrics track the integrated improvement and operating plans. Sam Peate explained he had met with relevant teams to discuss refreshing the GPR and IPR. Chris Fry further added that everyone was working together to pull together all metrics to share through refreshed documents and was looking at ways of how to best circulate and share metrics in the correct space.

Jane Hawkard raised the need to include community and screening metrics in the performance reports, referencing recent national incidents, and Chris Fry confirmed these would be highlighted in the oversight framework, with Sam noting compliance with urgent care standards and plans to review screening assurance processes. Sam Peate further explained some of the improvements would be driven through governance and the integrated improvement plan.

Jane Hawkard requested within the executive summary it would be helpful to see what was agreed to do and what percentages had been agreed via the operational planning submission process.

The Committees-in-Common agreed limited assurance due to outcomes, but acknowledged the ongoing work.

4.4 Directorate of Estates, Facilities and Development Update: including HRI Tower Block Update

Tom Myers took the report as read.

Tom Myers outlined a smaller capital programme for the year however the group was in a better place than last year. Work was being focused on same day emergency care (SDEC), ground floor works, intensive therapy unit (ITU), and estate safety, particularly ventilation improvements and phased theatre refurbishment. He noted car parking pressures where high due to delays within the car parking infrastructure.

Tom Myers gave an update on retail catering at the North bank after no contractors made a bid. Reasons for this included unattraction to employing staff on an Agenda for Change (AFC) basis. He reported vast improvements had been seen in the performance of retail catering in the last 12 months, following working with partners to install a 'grab and go' service and a new Electronic Point of Sale (EPOS) system had been implemented to track items and locations to track progress.

Tom Myers updated that the group car parking security tender attracted significant interest, requiring a potential extension of the tender period. He informed the CiC he may need to request an extra-ordinary board meeting to approve the contract for the 1st October 2026.

Tom Myers informed the CiC he was working with finance to understand how the Group could centralise all property controls following the end of a consultation. He added that a Group-wide solution to the Fleet services tender was due to begin.

Workshops were underway regarding a decontamination issue contract, and this was being referred to Senior Leadership Team (SLT) to understand where this issue would sit.

Jane Hawkard queried whether the Security and Parking tender could have the Chairman and Chief Executive approval as opposed to bringing it back to the Board as she felt the CiC should be recommending. Rebecca Crashley confirmed the Board can delegate authority to this CiC or for Chief Executive approval and it was up to Tom Myers to ask the Board for this permission.

Julie Beilby also reported the notable loss of disable parking spots at Scunthorpe Hospital. Tom Myers assured the CiC that this was a temporary issue from a result of ongoing works to install car ports.

The Committees-in-Common agreed significant assurance.

4.4.1 Cleaning Harmonisation

Tom Myers took the report as read. He updated that OCS cleaning on the North bank was unable to extend any further than May 2027 and plans were in place to try and create a group model, with market engagement to push for a wider tender. However, there were issues with this due to the size and scale of transferring staff into an outsourced supplier. He added that to move to an outsourced cleaning solution would create additional cost on the South bank, where in-house staff were currently used. The recommendation was to keep cleaning in-house on the South bank and go out to tender for the North bank with continuous work to harmonise ways of working.

Jane Hawkard expressed she had no issue agreeing but felt it would be useful to understand the financial aspect. Emma Sayner assured that service challenges outweigh any potential financial benefit, but the only concern was how to manage both sites to deliver the service, but also ensuring they challenge new ways of working in contracts across the organisation even if they were not harmonised.

Tom Myers noted there was some changes that was required on the South bank such as a 24-hour deep clean team which was currently being reviewed.

Julie Beilby emphasised the importance of the cleaning contract for patient safety and infection prevention and control, noting that these aspects should be clearly linked in board reports and recommendations.

The Committees-in-Common approved and agreed as per the recommendations given.

Edd James joined at 11.59am

4.5 Procurement Improvement Plan / KPIs / Expired Contracts

Edd James took the report as read. He reported that the procurement team exceeded savings targets for 2025-26 and there were plans in place for 2026-27 to deliver 17.5 million and ongoing work was in place to develop plans for subsequent years. Savings calculations include both direct and cost avoidance savings. Delivery was being tracked as a team across all three trusts.

Edd James informed the CiC that a new e-procurement inventory management system has gone live at York and Scarborough, with options being considered for NLAG, potentially as part of a national rollout with NHS support.

Edd James reported that the number of the work to reduce expired contracts was making great progress. The team was looking at 2026/27 expired contracts across the Group and a piece of work had begun looking at mapping accounts payable spend to contracts and manage upcoming renewals, averaging 99 contracts per month.

Edd James described supplier requests for surcharges due to inflation, with the team's initial response being to reject such requests unless justified by quality or

safety concerns. A register of supplier requests is being compiled for national sharing.

Julie Beilby noted the significant progress on the out-of-date contracts.

Edd James explained that a number of suppliers are requesting surcharges to be added to invoices to cover increased costs and the group was declined these extra charges. He further added that linen and laundry are an area with increased costs due to fuel and energy and is managing this on a case-by-case basis but noted it was hard to make savings in this area due to inflation increases.

Jane Hawkard and Edd James discussed pre-approval processes for contract renewals with no cost increase, aiming to streamline approvals and avoid overdue contracts. Complex cases, such as the renal contract, require further clarification on ownership and extension duration. Edd James assured he would create a schedule that would determine contracts expiring to gain pre-approval before any become overdue.

The Committees-in-Common agreed reasonable assurance.

4.6 Contract Approvals

None to note.

4.7 Emerging Issues

None to note.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

This was shared for information.

5.2 Unplanned Care Board Meeting Minutes

This was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

Nothing to raise.

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 02 June 2026 via Microsoft Teams.

The meeting closed at 12.14 hours.

Cumulative Record of Attendance at PEF CiC 26/2027

Name	Title	2026/27											
		Apr No Meeting	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Murray MacDonald	Chair / Vice Chair		D										
Jane Hawkard	NED (HUTH)		Y										
Julie Beilby	NED (NLaG)		Y										
Emma Sayner	Group Chief Financial Officer		Y										
Dr Kate Wood	Group Chief Medical Officer		N										
Sam Peate	Group Chief Delivery Officer		Y										
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates		Y										
David Sharif	Group Director of Assurance or deputy		N										
Philippa Russell	Deputy Group Chief Finance Officer		Y										
Ian Reekie	Governor Observer (NLaG)		D										

***KEY**:* *Y = attended* *N = did not attend* *D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 2nd June 2026 at 09:00 to 12:30 hours via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Murray Macdonald	Vice-Chair - Chair
Julie Beilby	Non-Executive Director (NLaG)
Jane Hawkard	Non-Executive Director (HUTH)
Emma Sayner	Group Chief Financial Officer
Scott Fitzgerald	Director of Operational Transformation (Deputy for Sam Peate)

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Lauren Rowbottom	Personal Assistant (Minute Taker)
Philippa Russell	Deputy Group Chief Financial Officer
Chris Fry	Associate Director of Performance & Insight *(Item 4.2)*
James Cooke	NHSE regional team
Simon Tighe	Deputy Director of Estates & Facilities (Deputy for Tom Myers)
Ryan Sutton	Associate Director of Quality Improvement *(Item 4.1.1)*
Hayley Briggs	Care Group Operations Director *(item 4.5)*
Thomas Doo	Head of Major Projects Estates Programme Manager – HRI *(Item 4.4.1)*

Observers

Ian Reekie	Public Governor (NLaG)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Murray Macdonald, welcomed those present to the meeting. Apologies for absence were noted for Kate Wood, Group Chief Medical Officer, Peter Sedman, Deputy Group Chief Medical Officer, David Sharif, Group Director of Assurance and Sam Peate, Group Chief Delivery Officer.

1.2 Staff Charter and Values

Murray Macdonald noted the Staff Charter and Group Values and reminded everyone to follow and live these throughout the meeting.

1.3 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.4 To approve the minutes of the meeting held on 5th May 2026 and the Private meeting minutes on 5th May 2026.

The minutes of the meeting and private meeting held on 05th May, were accepted as a true and accurate record.

1.5 Matters Arising

No matters arising.

1.6 Committees-in-Common Action Tracker

Updates to the Action Tracker were provided within the agenda items.

Action: Murray Macdonald requested a meeting with Sam Peate to look through the action tracker and align actions, clarify responsibilities and timelines.

MATTERS REFERRED

2

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

None to note.

3. RISK & ASSURANCE

3.1 Board Assurance Framework / Risk Register Report (including estates risks)

Rebecca Crashley took the report as read. She reported that the Finance risk score had recently increased from 16 to 20.

Rebecca Crashley updated that following a meeting with Sam Peate, a comprehensive refresh of the BAF risks was underway, with further plans to meet with Emma Sayner. She assured that CiC that the next BAF report brought to this meeting would be completely up to date.

Jane Hawkard raised concerns about the digital risk's visibility on the BAF, and Rebecca explained that digital and capital risk had previously been managed under the Strategic Programmes and Partnership Committees-in-Common but was now proposed for transfer to the PEF work plan, pending board approval. Murray Macdonald confirmed the CiC's support for escalating digital risk reporting to the board and requested Lauren to arrange a risk update on the digital agenda for the next meeting.

Action: Rebecca Crashley to submit a report to the NED meeting to request permission for the digital and capital work streams to be added to the PEF workplan.

Action: Rebecca Crashley to bring a risk update on the digital agenda at the next PEF CiC.

Julie Beilby expressed she was happy to see a refreshed BAF, noting concerns around the transformation risk, and the digital agenda, suggesting that both digital and transformation risks require greater focus and accurate capture in reporting

Murray Macdonald requested that an extra-ordinary BAF report was brought to the next meeting following the full refresh to help track the ongoing work.

Action: Rebecca Crashley to bring a refreshed BAF report to July's meeting.

3.2 Review of Relevant Internal & External Audit Report(s), Recommendation(s) & Assurances as appropriate

Emma Sayner presented the findings from the internal audit on risk management, detailing improvements in business case compliance and interdependency tracking, and clarified the revised process flow for business case approval.

Emma Sayner summarised the internal audit's focus on decision-making and interdependency management, noting that recent governance improvements had addressed previous gaps.
Emma Sayner advised that a Business Case Compliance Group and Business Case Recommendation Group was now in place and had been for the majority of 2025/26, which would feed into the Senior Leadership Teams (SLT), the CiCs, or the Board depending on financial value and in line with the scheme of delegation.

Emma Sayner clarified that the business cases originate from Care Groups, with clinical input feeding into the groups to support decision-making.

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 1

Emma Sayner presented the month 1 Group Finance Report, highlighted that James Cook (NHS England) who was invited to the next 2 meetings was now the organisation's relationship manager, reflecting wider structural changes within NHS England. She expressed that he would be supporting regional oversight of provider performance.

Emma Sayner explained that the group has a current plan to achieve a £63 million deficit, with recent changes removing Humber Health Partnership from the ICS wide national escalation process given a separate and distinct process for NOF5 organisations is in place. She reported that the national team were meeting with York, Scarborough and Harrogate to discuss how to improve their deficit position.

Emma Sayner reported that from the 1st of April 2026 a weekly tracker was in place to track the variable pay position. Although month 1 showed small improvements, she noted not to the scale required to deliver plan.

Work was underway with external organisations (Mid and South Essex, East Kent) and Rob Cooper to benchmark approaches to variable pay and workforce reductions, aiming to ensure alignment with similarly challenged organisations and build confidence among clinical teams that improvements can be delivered without compromising patient safety.

Emma Sayner updated the CiC that the Locums Nest module, which automates the authorisation and tracking of variable pay, would go live on the 1st July which was expected to support improved control of clinical spend. Good progress had been made in strengthening grip and control in non-clinical areas. However, further work was required to influence behaviours and establish effective mechanisms to manage clinical pay.

Emma Sayner reported that Ann Johnson and Fiona Hibbert had been involved in a deep dive session led by Paul Bunyan focusing on workforce planning and financial delivery.

Emma Sayner noted that CIP Board session on 16 June was very important, and that work was underway to ensure the Board has sufficient detail to enable effective challenge while also gaining assurance that Care Groups were identifying opportunities for financial improvement.

Philippa Russell noted that the adjusted run rate reflects a £138m deficit, highlighting a significant financial gap. She added that whilst CIP improvements were forecast, much of the detail remains at an early stage and was not yet fully developed into deliverable plans, presenting a significant risk. She further noted that a substantial proportion of CIP remained unidentified, with approximately £30m still without a clear delivery plan.

The CiC's noted the Month 1 position and the limited assurance available at this stage. Murray Macdonald raised concerns regarding the adverse run rate, delivery of CIP, and the high level of associated risk. It was acknowledged that, despite ongoing work, the current position was off track against the agreed financial plan. Murray Macdonald proposed that given the information given, there was insufficient assurance, and this would need to be escalated to the Board as a significant concern in relation to both financial performance and CIP delivery.

Jane Hawkard revealed that the Month 1 variance of £2.2–£2.3 million was broadly in line with the cost of industrial action, noting that approximately £1.3 million was funded, providing some level of mitigation.

Jane Hawkard raised concerned that the CIP Board Session on the 16th June needed to present the Board with clear and meaningful choices to support in-year financial support. She noted that they may need to go beyond care group proposals and focus on actions that can deliver impact within the current year. Examples discussed included prioritising key services, reducing elective activity, reviewing the community contract, and considering a MARS/VR scheme. Jane Hawkard asked whether things such as prioritising key services, reducing elective activity, reviewing the community contract, and considering a MARS/Voluntary Redundancy scheme would be brought forward, and Emma Sayner confirmed this would be considered as part of the session planning

Julie Beilby agreed with the concerns raised regarding the lack of assurance and noted disappointment with the limited progress on variable pay and workforce reduction.

Julie Beilby expressed she wasn't opposed to MARS/VR schemes but emphasised the need for clearer planning around these schemes, including early implementation to ensure impact within the financial year.

Philippa Russell voiced that current national guidance indicates industrial action costs are unlikely to be funded, and therefore this couldn't be relied upon as mitigation.

Murray Macdonald agreed on the need to start the next planning round as soon as possible to secure engagement and buy-in from Chiefs of Service. He highlighted that without early involvement; there would continue to be cultural challenges in delivering financial targets. He was emphasised that clinicians must be involved in setting targets, rather than plans being developed solely by central teams.

Murray Macdonald noted that, based on the current position, there were significant concerns which would need to be escalated to the Board.

The Committees-in-Common could not provide assurance at this stage due to significant financial risks, delivery gaps in CIP, and a lack of fully developed plans. However, praised the work the teams were doing to resolve this.

Ryan Sutton joined the meeting at 9.55

4.1.1 CIP and Transformation Programme Update

Ryan Sutton took the report as read. He reported an increase in CIP forecast from £5 million to £72 million over the last eight weeks, but risk-weighted maturity reduced confidence to £51 million, with many schemes still uncosted and care groups struggling to identify further opportunities.

Ryan Sutton reported that variable pay in month 1 hadn't moved much, noting that the Care Groups and Corporate levels still had gaps to close. He confirmed that he was meeting with Sam Peate to bridge this.

Ryan Sutton confirmed there were 258 schemes yet to be costed out of 730 being tracked.

Ryan Sutton noted that work was underway with NHS England to develop an integrated improvement plan, led by the Project Management Office (PMO). This embedded CIP within the wider improvement programme, shifting the focus from standalone savings targets to broader organisational improvement, with financial benefits as one of several outcomes.

Ryan Sutton declared that future reports would include an overview of theatres, head count and performance.

Chris Fry joined the meeting at 10.13

Murray Macdonald questioned whether the current position felt different from the previous year. Ryan Sutton advised that it didn't feel significantly different but noted that delivery was becoming more challenging and required increasing difficult decisions.

Julie Beilby highlighted the need for further Board discussion on the Organisation's resource base to support transformation and improvement, including UEC, noting limited progress over the past year.

Julie Beilby also raised a concern regarding the inclusion of individual staff names alongside pay information in the report, noting it wasn't appropriate and should be addressed in line with information governance requirements. Murray Macdonald agreed, adding it's important to know individual level they're working at, such as Consultant and Registrar but not necessary to see individual staff names. Ryan Sutton apologised and assured future reports would not include this information.

Julie Beilby requested that financial implications and EQIA considerations were reinstated within the AAA reports. Rebecca Crashley confirmed that these would be included going forward.

The Committees-in-Common agreed on Limited assurance.

4.1.2 National Cost Collection Update

Emma Sayner confirmed that the national cost collection process was proceeding as planned and was noted as part of the meeting's documentation.

The Committees-in-Common agreed Reasonable assurance

4.2 Group Performance Report

Chris Fry presented the Group Performance Report highlighting recent performance in referral to treatment (RTT), ED, and cancer.

Chris Fry outlined updates to the IPR, highlighting two key areas for consistent use across committee reporting. He advised that performance metrics had been aligned to CQC domains (safe, effective, caring, responsive, and well-led) and the National Oversight Framework (NOF), creating a clear link between local reporting and national requirements.

Chris Fry noted that a standardised scorecard approach was being developed, with metrics to be used consistently across care groups and committees to support oversight and assurance. He further highlighted that benchmarking data and dashboards had been incorporated to support performance comparison and segmentation.

Chris Fry advised that work was ongoing to expand reporting to care group level and to improve how performance is presented, including the use of trajectories and trend analysis to support clearer assessment of whether performance is on track.

Chris Fry informed the CiC that tiering meetings were being streamlined into a single monthly meeting for elective care, with the first session having taken place.

Chris Fry highlighted key areas of concern, including long waiting times (with patients still waiting over 65 weeks), deterioration in diagnostic performance, and variability in cancer targets (28-day and 62-day standards), despite some improvement.

Chris Fry reported that there had been improvements in time to treatment, particularly in March, which is a key enabler of overall performance. He noted that non-admitted pathways continued to present the greatest challenge and offer the most significant opportunity for improvement within Emergency Department (ED) performance.

Jane Hawkard highlighted variation in time to treatment performance, noting improvement at HUTH and deterioration at NLaG, and queried the reasons behind this. Scott Fitzgerald provided insight that improvements at HUTH may be linked to additional resource at the front door and triage, while challenges at NLaG relate to patient flow and delays in moving patients through the department. Emma Sayner added that internal professional standards (IPS) and flow improvement work had been implemented, which had supported improvements in patient flow and time to treatment. Jane Hawkard added that it was important to understand the drivers of improvement to support progress.

Chris Fry reported a 78-week RTT breach within Plastics. Noting gender reassignment patients continued to be the biggest of breaches, stating there was no national plan to lower the demand.

Chris Fry highlighted that time to first outpatient appointment had improved and was a key driver in the RTT performance, and also that the Patient Treatment List (PTL) size at NLaG had increased due to a pattern in urgent referrals.

Jane Haward queried who was the lead for diagnostics, with Scott Fitzgerald confirming he had taken over from Laura Milburn and would continue the established plans.

Murray Macdonald reflected that, while the report contained a significant amount of detail, it did not provide the level of high-level assurance required for Board discussions. He emphasised that focus should be on overall performance against constitutional standards and the National Oversight Framework, rather than detailed data.

Jane Hawkard highlighted that while mitigations existed, they were not clearly reflected within the report.

Murray Macdonald expressed concern that the report did not provide clear assurance to the board regarding delivery of constitutional standards, noting that performance had not significantly changed over the past year. He called for more high-level commentary from operational leads and suggested a meeting with non-executives and the performance team to clarify assurance requirements. The Committees-In-Common agreed they hadn't received assurance.

Murray Macdonald suggested that further discussion was required outside of the Committee to clarify reporting requirements and ensure the Board can assess whether the organisation is delivering against its key commitments.

Action: Lauren Rowbottom to coordinate a meeting with Chris Fry, Sam Peate and Murray Macdonald.

4.3 Directorate of Estates, Facilities and Development Update: including HRI Tower Block Update

Simon Tighe took the report as read. He explained that himself and Tom Myers were having conversations around whether the report currently was meeting the needs of the CiC.

Simon Tighe provided an update on high risks within Estates and Facilities, noting that the quarterly review had been delayed due to a wider review of risks with Executive colleagues. It was noted that there were currently six high risks on the North Bank and five on the South Bank, with some duplication due to some risks needing to be sovereign specific. Simon Tighe advised that risks would be aligned at group level where possible, but kept separate where there are regulatory or enforcement requirements.

Simon Tighe noted that some risks on the South Bank, particularly at the Scunthorpe site, were linked to funding. He advised that these risks were expected to be mitigated following the upgrade of the energy centre, including the installation of electric boilers, anticipated to be operational by September.

Murray Macdonald queried if there was a date on production for the lifts at the HRI site. Simon Tighe advised that there was currently no detailed timeline, as the design team for the remediation works had only recently been appointed. He informed the CiC that the design phase, was expected to take approximately four to six months.

Simon Tighe explained in detail the risks related to low voltage (LV) infrastructure, which was present across both sites, including ageing systems, unknown cable locations, and limited backup arrangements. He noted that failures in the LV network can be difficult to predict and manage, with some infrastructure outdated and not routinely operated. These risks were being managed gradually through maintenance work and targeted funding, with checks in place to identify potential issues early.

Simon Tighe reported that car parking and security tenders would be evaluated soon, with future plans to review car parking tariffs. Jane Hawkard and Julie Beilby raised concerns about approval routes and the cumulative impact of changes on staff, including potential charges for disabled parking.

Jane Hawkard raised concerns regarding the proposed requirement for an extraordinary Board meeting to approve the car parking and security tender. She advised that an alternative approval route should be identified, such as delegated authority via the Chair and Chief Executive or an appropriate CiC. Simon Tighe confirmed he would take this forward.

The Committees-in-Common agreed Reasonable Assurance for this item.

4.4 Estates Return Information Collection (ERIC)

Simon Tighe provided an update on the Estates Return Information Collection (ERIC), highlighting its importance in informing Model Hospital data and benchmarking. He noted that ERIC data underpins estates and facilities metrics

and supports identification of improvement opportunities, although some figures require further validation. It was confirmed that initial submissions have been completed on time, with the final submission due by 29th June. He noted that validation checks were likely where there were significant changes in the reported data.

The Committees-in-Common approved and agreed as per the recommendations in the report.

Thomas Doo joined the meeting at 11.15

4.4.1 Premises Assurance Model

Thomas Doo presented the annual PAM report, noting that it would be reviewed by PEF CiC and the Trust Board before submission to NHS England.

Thomas Doo advised that assessments had been completed for both North and South Bank through structured workshops covering estates, facilities and development. Overall results indicated good compliance, with some areas requiring improvement. Thomas Doo noted that differences in scores between sites were mainly due to how the questions were interpreted and he confirmed that actions had been identified for areas of lower compliance and were being tracked through relevant workshops and safety groups.

Thomas Doo reported that future PAM workshops would be chaired by a single individual across the Group, as part of the new structure, to ensure consistent reporting.

The Committees-in-Common agreed they had been significantly assured. Murray concluded that the report provided assurance that estates and facilities arrangements are safe and compliant, with improvements being addressed.

4.4.2 Health and Safety Statement

Simon Tighe presented the updated Health and Safety Statement, noting it was a legal requirement for both organisations and had been combined under Humber Health Partnership (HHP), with changes from the previous year highlighted. Simon Tighe noted that the changes were minor and the CiC agreed to progress the document to the Board for approval.

The Committees-in-Common agreed that overall assurance was strong in relation to estates and facilities, with minor advisory points raised, including alignment with the Quality and Safety Committee in relation to cleaning.

Thomas Doo left the meeting at 11.25

The agenda was taken out of order at this point

4.6 Contract Approvals

4.6.1 Contract Approval: HUTH Energy Paper

Simon Tighe took the report as read. He requested approval from the CiC to extend the North Bank energy contract by one year to allow for future procurement decisions. The CiC agreed to verify financial thresholds and delegations, recommending board approval if required.

The Committees-In-Common approved the contract subject to ensuring financial elements were in place and was in this CiC's delegation.

Karen Bunker joined the meeting at 11.36

4.6.2 PET CT Tender

Karen Bunker presented the strategic approach to the national NHS England PET-CT procurement, outlining three potential delivery models. She explained there were three potential delivery models, and advised that Option 3 was the preferred option as it provided a balance between maintaining clinical leadership and reducing financial and operational risk. Karen Bunker advised the CiC that option 3 was expected to deliver an improvement of around £322k to the run rate.

Karen Bunker noted that Option 1 may bring some financial benefit, but would involve higher risks for the Trust in terms of delivery, staffing, and finances.

Karen Bunker highlighted several risks within the procurement, including activity growth assumptions, contract payment mechanisms, and long-term financial sustainability. She also noted that the introduction of a single regional provider for Gallium services, which may impact patient travel depending on the outcome of the procurement.

She expressed that discussions were ongoing with potential partners, and that successful delivery would depend on strong contractual arrangements and partnership working.

Jane Hawkard queried whether an extension to the current contract was possible and highlighted the importance of fully understanding the financial risks, particularly given differences between national and local demand assumptions. Karen Bunker confirmed that there was no option to extend the current contract and noted that timelines were tight due to delays in the national process.

Murray Macdonald noted that while Option 1 offered leadership potential, it carried higher risk. It was agreed that Option 3 would be more suitable at this time. He noted that the Board would need to be updated on the options, risks, and

recommendation.

Karen Bunker left the meeting at 11.46
Hayley Briggs joined the meeting at 11.46

4.5 Theatre Performance Update

Hayley Briggs provided an update on progress against actions agreed at the previous meeting.

Hayley Briggs reported that theatre session utilisation had improved. She stated that dropped sessions reduced from 31% in March to 24.8%, meeting the planned target. Further improvement was expected, with a target of 22.5% by August. This was achieved following recent alignments and job planning across theatre utilisation

Hayley Briggs updated that a new approval process for additional theatre sessions had been introduced to ensure better use of existing capacity, reporting that all additional sessions would be approved by the Theatres, Anaesthetics, and Critical Care (TACC) Group Triumvirate. She stated that early feedback had been positive, and a review was scheduled for the end of July 2026.

Hayley Briggs reported that audits of the golden patient protocol had been strengthened, with three-monthly audits introduced. She noted that the percentage of late starts had reduced, although data quality issues were still being addressed with information services.

Hayley Briggs reported that the national best practice pre-assessment model had been implemented for day surgery patients, increasing capacity by 24%. She noted that inpatient pre-assessment had been delayed due to staff sickness but has now re-commenced, with plans to build a six-week pool of pre-assessed patients.

Hayley Briggs noted that cancellation avoidance processes are now embedded as business as usual, with ongoing work to strengthen inpatient pathways.

Jane Hawkard requested future reports to link theatre performance improvements to RTT and productivity outcomes, and Hayley Briggs agreed to include this analysis.

Julie Beilby highlighted the importance of sustaining improvements from the hub optimisation initiatives and acknowledged Goole and Grimsby for being awarded Hub Accreditation by NHS’s getting it right first time (GIRFT).

The Committees-in-Common agreed they had been reasonably assured. They felt happy with the progress, and the plans implemented, along with the consistencies within the reports nothing they can see accountability and leadership.

Hayley Briggs left the meeting at 11.57

4.7 Emerging Issues

None to note.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

Jane Hawkard highlighted the need to review the upcoming deep dives to ensure focus is on the most important areas, rather than strictly following the existing work plan. Murray Macdonald agreed to review this ahead of the next meeting, in discussion with Emma Sayner and Sam Peate.

5.2 Planned Care Board Meeting Minutes

None to note

5.3 Unplanned Care Board Meeting Minutes

This was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

Philippa Russell proposed that following changes to the Strategic Partnerships function, capital business cases below Board level should be brought to this CiC for review and approval. Murray Macdonald agreed, dependant on workloads. Murray Macdonald confirmed that a paper will be taken to Non-Executive Directors meeting to agree the future approach before Board approval. In the interim, the PEF CiC would review relevant capital items.

Jane Hawkard suggested that reporting should clearly explain how responsibilities had been redistributed to avoid duplication.

Julie Beilby raised concerns about the absence of a clear forum for strategic partnership discussions and highlighted the importance of system-wide working.

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

<u>The Committees-In-Common alerted to the board;</u>

Month 1 Financial performance off plan

- Month 1 adverse out turn of £2.2m (including Industrial Action impact of £1.3m across the Group).
- YE projection £40.2m adverse
- Variable pay £0.6m worse than last year (would be a c£700k improvement without the impact of IA at £1.3m in April 26).
- CIP month 1 £4.6m adverse
- CIP Year end forecast £46.4m adverse

Constitutional Standards off plan

- All constitutional standards are below national requirements with no assurance if trajectory will achieve target.
- Improvements in 4 Hour compliance with both HUTH and NLAG above performance trajectory for Type 1 performance year to date
- RTT recovery for both NLAG and HUTH in line with operating plan submission for end of May.
- 62 day cancer performance in NLAG at highest level in over two years and highest in last 12 months at HUTH.
- FDS performance at HUTH stabilising.
- 6 week diagnostic standard off plan in month

<u>The Committees-In-Common advised the board;</u>

PET CT Tender

- Committee recommended option 3 but Board should be aware of the operational, financial and clinical opportunities and risks.

Work programme currently with Strategic Programmes and Partnership CiC

- PEF discussing the Digital, Capital business cases and Partnership working.

IPR reporting

- The Committee was presented with a revision to the IPR

<u>The Committees-In-Common assured the board;</u>

Estates, Facilities and Development

- Update including Tower Block remediation, Estates Return Information Collection, Premises Assurance Model
- Health and Safety Statement

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 07 July 2026 via Microsoft Teams.

The meeting closed at 12.11

Cumulative Record of Attendance at PEF CiC 26/2027

Name	Title	2026/27											
		Apr No Meeting	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Murray MacDonald	Chair / Vice Chair		D	Y									
Jane Hawkard	NED (HUTH)		Y	Y									
Julie Beilby	NED (NLaG)		Y	Y									
Emma Sayner	Group Chief Financial Officer		Y	Y									
Dr Kate Wood	Group Chief Medical Officer		N	D									
Sam Peate	Group Chief Delivery Officer		Y	D									
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates		Y	D									
David Sharif	Group Director of Assurance or deputy		N	D									
Philippa Russell	Deputy Group Chief Finance Officer		Y	Y									
Ian Reekie	Governor Observer (NLaG)		D	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, 7th July 2026 at 09:00 to 12:30 hours via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Murray Macdonald	Vice-Chair - Chair
Julie Beilby	Non-Executive Director (NLaG)
Jane Hawkard	Non-Executive Director (HUTH)
Emma Sayner	Group Chief Financial Officer
Peter Sedman	Deputy Group Chief Medical Officer
Sam Peate	Group Chief Delivery Officer

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Lauren Rowbottom	Personal Assistant (Minute Taker)
Philippa Russell	Deputy Group Chief Financial Officer
Tom Myers	Group Director of Estates, Facilities & Development
Ryan Sutton	Associate Director of Quality Improvement *(Item 4.1.1)*
Helen Horth	Care Group Operations Director *(Item 4.7)*
Aswanthi Shanker	Care Group Operations Director *(Item 4.3)*

Observers

Ian Reekie	Public Governor (NLaG)
James Cooke	NHSE regional team

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Murray Macdonald, welcomed those present to the meeting. Apologies for absence were noted for Kate Wood, Group Chief Medical Officer, and David Sharif, Group Director of Assurance.

1.2 Staff Charter and Values

Murray Macdonald noted the Staff Charter and Group Values and reminded everyone to follow and live these throughout the meeting.

1.3 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.4 To approve the minutes of the meeting held on 2nd June 2026 and the Private meeting minutes on 2nd June 2026.

The minutes of the meeting and private meeting held on 02nd June, were accepted as a true and accurate record.

Emma Sayner requested that the finance deficit for the Group was more expanded on in future minutes.

1.5 Matters Arising

No matters arising.

1.6 Committees-in-Common Action Tracker

Updates to the Action Tracker were provided within the agenda items.

MATTERS REFERRED

2

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

None to note.

3. RISK & ASSURANCE

3.1 Board Assurance Framework / Risk Register Report (including estates risks)

Rebecca Crashley reported that she had been meeting with Executive colleagues on a monthly basis to maintain regular oversight and keep the Board Assurance Framework (BAF) under review, despite formal BAF reporting not being required on a monthly basis. Rebecca Crashley assured that Digital risks would be included in the risk register by August's meeting.

Murray Macdonald acknowledged that a number of risks were currently scored at the highest level, making it difficult to identify where attention and resources should be prioritised. Julie Beilby agreed, and felt that the 12 score did not fully represent the Partnership's wider digital risks.

Murray Macdonald suggested that the next meeting should include an update from the digital team on the current position, including key cyber and digital risks.

Action: The digital team to bring an update to August's PEF. (Alastair Pickering)

Jane Hawkard supported the need to review how digital risks were reflected in the BAF. She noted that there was currently no reference to the Data Security and Protection Toolkit (DSPT), cyber security risks, or the potential impact these issues could have on confidence in the electronic patient record.

Jane Hawkard also raised concerns regarding the financial risk section, noting that the actions described appeared too reasonable when compared to the level of risk identified. She suggested that either the actions or the risk ratings should be reviewed to ensure they accurately reflected the level of concern. Emma Sayner acknowledged the concerns raised and explained that some actions had been rated as reasonable because the relevant processes and controls were already in place. However, she recognised that, despite these processes, the desired outcomes were not always being achieved.

Samuel Peate made a minor observation regarding the colour ratings used within the report. He noted that the colour assigned to a "limited" rating gave the impression that the position was better than it actually was.

3.2 Review of Relevant Internal & External Audit Report(s), Recommendation(s) & Assurances as appropriate

None to note.

3.3 Review of Relevant External Report(s), Recommendation(s) & Assurances as appropriate

Murray Macdonald noted that there were currently no internal or external reports, recommendations or assurances to consider. However, he suggested that future external reports, such as those relating to maternity services or mortuary provision, could be relevant to the Committee's work as they may include operational as well as quality-related issues.

Murray Macdonald suggested that Samuel Peate and Pete Sedman bring relevant external reports and emerging issues to future meetings to help keep the Group informed of wider risks and developments.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

<u>Joint Business Items</u>

4.1 Group Finance Report: Month 2, including Care Group trajectories following

CIP Board Session

Emma Sayner presented the month 2 Group Finance Report and noted that the Month 2 report already felt out of date due to the pace of work taking place. She explained that the year-to-date position was not where the Partnership wanted it to be, and that spending levels had not yet reduced as needed.

Emma Sayner advised that more focused work had started with the Care Groups and clinical leaders, including shared learning sessions with other NHS organisations. A session had taken place with Maidstone and Tunbridge Wells, which showed the importance of clinical and operational teams taking ownership of financial recovery, not just finance teams.

Emma Sayner noted that further support and learning sessions were planned, including a session with NHS England colleagues on productivity and efficiency. This would use the Partnership's own data to help care groups better understand cost growth, workforce pressures and productivity opportunities.

Emma Sayner reported that care groups had been reviewed using the RIDGWAY rating approach, with the most challenged care groups being highlighted in the Month 2 report, as previously agreed.

Emma Sayner also advised that NHS England was putting additional support in place for the Partnership. This included a financial turnaround lead and support from Grant Thornton. She informed the CiC that they would have a focus on understanding why existing controls and actions were not yet having the required impact, and what needed to change quickly. Emma Sayner explained that this support would not be a short-term review, but a wider package of support over several months, funded by NHS England.

Emma Sayner noted that the Partnership remained off plan financially. She advised that, if the current position continued, the year-end position could be significantly worse than planned. She added that the level of financial risk had been highlighted during the planning process, with estimates suggesting a potential deficit of around £118 million if savings targets were not achieved. She explained that the scale of the challenge had led to increased scrutiny and the additional support being put in place.

Philippa Russell advised that the year-to-date position was mainly being driven by delays in delivering planned savings (CIP), alongside the impact of industrial action. While some progress had been made, it was not happening quickly enough and challenges remained around reducing variable pay costs and workforce numbers.

Philippa Russell reported that care groups had been asked to develop recovery plans, with a number of areas requiring significant improvement to meet their targets. She also noted that a further £30 million savings gap remained without an identified solution.

On the year-end forecast, Philippa Russell advised that the current position showed a gap of around £42 million, although this relied on delivering savings opportunities that were not yet fully developed. She noted that a more realistic risk-adjusted position could be closer to £60 million if further improvements were not achieved.

Philippa Russell also highlighted pressures on cash flow, with cash support requirements currently higher than planned. The Committees-In-Common were asked to approve a maximum revenue support request of £37.5 million for Quarter 2, noting that monthly requests would continue to be reviewed and reduced where possible.

Philippa Russell highlighted a number of risks, including the tower block cladding scheme, which could create financial pressures if it could not be moved into future years. She also noted potential delays to other capital projects and advised that work was underway to identify options to manage these risks during the second half of the year.

Murray Macdonald highlighted concerns about the year-to-date financial position, year-end forecast, delivery of CIP and progress against the variable pay reduction target. He noted that variable pay reductions were not yet progressing at the expected pace and should continue to be closely monitored. He also noted that current risks relating to cash and capital appeared manageable at this stage, although they would require ongoing oversight. He suggested that the additional support and controls being put in place, including the work with Grant Thornton, the financial recovery support, and the increased focus on care group performance, should be reflected in the Board Assurance Framework (BAF).

Tom Myers joined the meeting at 9.39am

Jane Hawkard asked for an update on whether a voluntary redundancy (VR) or MARS scheme was being considered as part of the financial recovery plans, as this had been raised previously but had not been discussed further. Emma Sayner advised that a vacancy pause had recently been introduced but has been delayed to avoid unintended consequences, such as increased spending on temporary staffing. The introduction of the Locum's Nest system on 1st July would provide greater oversight and control of variable pay costs, helping to reduce the risk of these costs increasing as vacancies were managed. Emma Sayner noted that the vacancy pause would support planned workforce reductions across Care Groups. She confirmed that voluntary redundancy remained an option, although funding for any scheme had not been identified within the current financial plan. Discussions with NHS England may take place in future if additional support was required.

Jane Hawkard asked whether a formal rating or assessment process had been considered for care groups as part of the recovery programme. She also questioned whether stronger controls on variable pay should be introduced, similar to the controls currently in place for recruitment.

Jane Hawkard sought clarification on references to business cases within recovery plans, noting that any new spending would need to demonstrate clear benefits and

value for money. Emma Sayner explained that the organisation was seeking to reduce reliance on requests for additional funding in relation to business cases. However, a small number of them remained necessary where there were a clear operational need and the potential to improve value for money or reduce costs elsewhere. She added that work was continuing to identify areas where spending was above expected levels, particularly within urgent and emergency care services, with the aim of improving efficiency and supporting financial recovery.

Philippa Russell clarified that the endoscopy business case was not a request for additional funding. The service was already incurring the cost, and the business case was intended to confirm the appropriate level of funding and budget. She noted that there may be opportunities to reduce current spending levels once this work was completed. Philippa Russell also reported that recent reviews of agency staffing requests had shown increased recruitment activity, particularly for medical staff. Many temporary staffing requests now included end dates linked to permanent recruitment, providing some assurance that action was being taken to reduce reliance on agency staff over time.

Samuel Peate provided further context on the endoscopy business case, noting that he had been working closely with the service over recent weeks. He explained that the review had identified opportunities to make better use of existing resources before additional investment was considered.

Julie Beilby noted that the discussion with Care Groups had identified a number of common themes, including the potential use of a MARS scheme and concerns that some HR processes may be slowing recruitment. She suggested that these themes should be discussed collectively to ensure any organisation-wide issues are considered and addressed. Emma Sayner advised that NHS England had also undertaken detailed reviews of workforce and HR processes with early findings reflecting many of the same themes raised by care groups, including opportunities to improve existing processes and controls.

Julie Beilby also expressed concern about the ongoing level of variable pay expenditure. While controls were reported to be in place, spending remained above target. She suggested that future reports should place greater emphasis on performance against the current year's target rather than comparisons with the previous year, to provide a clearer picture of the scale of the challenge.

Julie Beilby also noted that progress towards the 30% variable pay reduction target was significantly behind plan and that, with the organisation already in Quarter 2, achieving the target would require a substantial improvement in performance over the remainder of the year.

Emma Sayner expressed that further work was underway in areas such as medical rostering and workforce management, with updates to be provided through existing reporting arrangements.

Philippa Russell requested members of the CiC to formally approve the Quarter 2 cash drawdown request. The CiC approved the maximum revenue support request

of £37.5 million for Quarter 2, noting that monthly requests would continue to be reviewed and adjusted where possible.

The Committees-in-Common agreed limited assurance for this item and approved the Quarter 2 cash drawdown request.

Ryan Sutton joined the meeting at 9.58am

4.1.1 CIP and Transformation Programme Update

Ryan Sutton took the report as read. He reported that many of the savings' schemes were still at an early stage of development and informed the CiC that a detailed review was underway to assess whether schemes would deliver the expected benefits, need to be delayed, or were unlikely to proceed. He noted that a number of schemes had not yet been fully costed and may provide further opportunities to improve the financial position.

Ryan Sutton highlighted the introduction of the Locum's Nest system across the Group, which has digitised the management of expenditure on Speciality and Specialist (SAS) doctors and consultants. He noted that this would provide greater oversight and control of variable pay spending and improve monitoring and approval processes.

Ryan Sutton advised that recovery plans were being developed for the Care Groups identified as requiring additional support, with progress being monitored through the established performance and accountability arrangements.

Ryan Sutton also reported that discussions were taking place with NHS England regarding external support. He noted that, while current efforts were focused on addressing immediate financial challenges, external support could help the organisation develop longer-term transformation plans to deliver sustainable improvements over the next two to three years.

Jane Hawkard asked what actions were most likely to improve the financial position and also checked on the wellbeing and capacity of his team. Ryan Sutton thanked Jane for her comments and advised that his team was under pressure due to supporting both the financial recovery programme and the Integrated Improvement Plan. He noted that work was underway to prioritise workloads and that additional external support was being explored.

Ryan Sutton said that stronger financial control across care groups would be key to improving the financial position. He noted that premium pay costs remained a challenge and that a more coordinated approach to managing spending could help.

Jane Hawkard left the meeting at 10.16am

Jane Hawkard joined the meeting at 10.19am

The Committees-in-Common agreed on limited assurance.

Ryan Sutton left the meeting at 10.21am

Julie Beilby said that the report should place more focus on transformation. She noted that while controlling costs was important, long-term change would be needed to improve the financial position and support the workforce. She suggested that future reports included clearer updates on transformation work and progress. She also raised concerns about organisational capacity to deliver this work and stressed the need to maintain focus on longer-term improvement alongside immediate financial pressures.

Murray Macdonald agreed that transformation was important but said it needed a clear long-term plan. He noted that much of the current focus was on short-term challenges rather than future priorities.

Murray Macdonald also raised concerns that planning often started too late, making it harder to focus on longer-term improvements rather than short-term savings.

In closing the discussion, Murray Macdonald noted that the Committee's overall position remained one of very limited assurance, with key concerns relating to the financial position, delivery of savings plans (CIP), variable pay and cash flow. Members acknowledged that work was ongoing to address these issues and hoped to see improvement in future reports.

The Committees-in-Common agreed limited assurance for this item, due to concerns about the financial position, savings delivery, variable pay and cash flow. They noted that work was underway to address these issues.

4.2 Group Performance Report including theatre trajectory metrics

Sam Peate presented the Group Performance Report. He reported that the refreshed performance report provided a clearer overview of progress against key performance measures across the Group.

In urgent and emergency care, performance against the four-hour standard remained below plan in some areas. This was being driven by Type-3 performance delivered by CHCP and not the trust. Work was underway to review triage processes, improve patient flow and strengthen alternatives to Emergency Departments. NHS England continued to provide support, including work on ward models and urgent care pathways.

Samuel Peate noted that recent multi-agency work had helped reduce delays in discharging patients, although it was too early to assess the long-term impact. Further work was also taking place to review site management processes across the Group.

Samuel Peate updated that in elective care, performance against referral-to-treatment (RTT) standards was ahead of plan, although overall waiting lists had

increased. Work to improve waiting list management and data quality was ongoing, including the introduction of new digital tools.

Samuel Peate noted that the number of patients waiting more than 65 weeks had increased, largely due to capacity pressures within plastic surgery. Actions were being put in place to address this, including additional medical support. He advised that further work with NHS England would focus on outpatient transformation and reviews of key specialties, including ophthalmology, plastic surgery and gynaecology.

Samuel Peate reported that diagnostic performance had slightly worsened at the start of the year, although some areas remained on track. Funding had been allocated to support improvements in areas including neurophysiology and echocardiography.

Samuel Peate noted that endoscopy remained an area of concern, and work was continuing to reduce waiting times and improve performance.

Jane Hawkard asked for an update on the CHCP contract, the plans for a 24/7 UTC at Hull Royal, and the new bed management system (TeleTracking). Samuel Peate advised that CHCP was aiming for implementation in October, subject to approval. He confirmed that the issue had been raised with the ICB and remained under discussion.

Samuel Peate assured that moving the Hull Royal UTC to a 24/7 service should help improve urgent care performance, but this was dependent on ICB approval. Samuel Peate also updated that the new bed management system would help staff track patients more effectively, supporting patient flow, discharges and bed management. The first phase was expected to go live later in the summer, with further rollout to follow.

Julie Beilby queried why there wasn’t a target set for patients who were clinically ready for discharge in an inpatient bed. Samuel Peate confirmed that this related to patients with no criteria to reside. He noted that the TeleTracking system would improve how this was tracked and reported in future reports.

Samuel Peate reported that work was underway to improve care for frail patients and reduce unnecessary hospital stays. He said discussions were taking place with local authority and system partners to improve discharge arrangements and community support, with the aim of reducing the number of patients who no longer needed to be in an acute hospital bed. Samuel Peate reported that the National Frailty Collaborative Team had visited the Trust to support work on improving care for frail patients. He noted that frail patients make up a large proportion of unplanned hospital admissions, highlighting the opportunity to improve patient flow and reduce delays.

Julie Beilby asked what was being done to reduce the number of people attending A&E who could be treated elsewhere. Samuel Peate expressed that work was underway to identify patients who could use other services instead of A&E. Discussions were taking place with CHCP and the ICB to make better use of

alternative services, including Urgent Treatment Centres. He added that new Same Day Emergency Care services planned for later in the year would provide more options for patients and help reduce pressure on A&E departments.

Ashy joined the meeting at 10.42am

4.3 Cancer Performance Update

Aswathi Shanker shared a presentation on screen highlighting cancer performance.

Aswathi Shanker reported that performance had been maintained in most areas, with improvements seen in some services. She highlighted strong breast cancer performance in HUTH, supported by additional temporary capacity while longer-term workforce solutions were developed. Progress had also been made in reducing histology turnaround times through closer working between pathology services across the Group.

Aswathi Shanker noted that radiotherapy remained a challenge, although recruitment was progressing following approval of a business case. Improvements were expected over time, but the full benefit would take longer to be realised. Work was continuing to address pressures in endoscopy, diagnostic services and consultant vacancies. Recruitment was ongoing in a number of areas, and reviews were underway to ensure services had the right capacity in place.

Aswathi Shanker advised that some services continued to rely on non-recurrent funding to maintain performance, although steps had been taken to reduce long-term reliance on this approach. She assured that cancer governance arrangements had been strengthened, with dedicated groups in place to oversee performance, delivery and clinical quality.

Aswathi Shanker also reported that oversight of clinical harm had improved, with new arrangements in place to monitor risks and support timely action where concerns were identified.

Murray Macdonald asked for an assessment of likely performance against cancer standards by the end of the financial year. Samuel Peate stated he was confident that the Faster Diagnosis Standard (FDS) would be achieved and noted that revised plans showed the target being reached earlier than originally expected. Samuel Peate reported that modelling work was helping to identify where further improvements were needed across cancer pathways. While he believed the planned performance for the 62-day cancer standard could be achieved, he noted that it would remain challenging and require continued focus and effort throughout the year.

Jane Hawkard asked when improvements in the 62-day cancer standard, particularly at HUTH, were likely to be seen. Samuel Peate explained that the benefits of the radiotherapy recruitment programme were not expected to be seen until Quarter 3. He noted that there were opportunities to improve performance,

particularly within lung and urology cancer pathways, where focused work was underway.

Jane Hawkard welcomed the progress that had been made and noted that regular updates from Aswathi Shanker had helped the CiC see improvements over time.

Aswathi Shanker left the meeting at 11.12am

Murray Macdonald thanked Samuel Peate and Aswathi Shanker for the update. He welcomed the progress made and noted that the programme continued to deliver against the plans previously presented to the Committee.

The Committees-in-Common agreed Reasonable Assurance for this item.

4.4 Outpatient Transformation Deep Dive

Sam Peate took the report as read and provided an update on the Outpatient Transformation Programme. He advised that work was focusing on two main areas: the introduction of a Single Point of Access model in key specialties, and reducing delays in follow-up appointments.

Samuel Peate noted that national guidance suggested there may be opportunities to reduce the number of first outpatient appointments through improved clinical triage and new ways of working. Work was underway to assess the potential impact locally. He also reported that further work was taking place to improve follow-up processes, including the use of digital tools and patient engagement systems.

Samuel Peate advised that the programme was being developed in partnership with primary care and other system partners. He noted that progress had been made in strengthening engagement and developing clearer plans for delivery. Members noted the update and the ongoing work to improve outpatient services across the Group.

Murray Macdonald noted that the Outpatient Transformation Programme involved major changes to services and asked how confident Samuel Peate was that it could be delivered. Samuel Peate said he was confident that the first phase could be implemented, with good support from clinical teams. However, he noted that there were some risks and that the changes would take time to deliver. Work was ongoing to understand and manage the impact.

Jane Hawkard asked whether a plan was being developed to reduce the large follow-up backlog and when a trajectory for improvement would be available. Samuel Peate said that work was underway to review the backlog, including the use of the patient engagement portal and discussions with primary care about reviewing some follow-up activity. He noted that improvements had already been made in some specialties, including ophthalmology, where the number of highest-risk patients waiting had reduced significantly. Samuel Peate advised that a clearer

picture was expected after the summer as further review work was completed. He noted that the size of the backlog remained a significant risk nationally.

Jane Hawkard asked how the follow-up backlog would be monitored and reported going forward. Samuel Peate suggested including the backlog as a regular measure within the Integrated Performance Report (IPR) so that progress could be tracked over time. Murray Macdonald supported this approach and suggested that the Committee receive a further update on the Outpatient Transformation Programme in the autumn to review progress and any challenges to delivery.

Action: Samuel Peate to bring an update on the Outpatient Transformation Programme to Octobers meeting.

Julie Beilby asked for more information about the risks relating to job planning reviews, noting Workforce, Education and Culture (WEC) CiC's interest in this area. Samuel Peate explained that the risk related to changes being made through the Outpatient Transformation Programme. He explained how referrals were going to be managed differently under the new Single Point of Access model, and as a result clinical workload may change across some services. He noted that job planning reviews were being used to ensure the right staffing and resources were in place to support these changes. The full impact was not yet known and would continue to be reviewed as the programme was implemented.

The Committees-in-Common agreed limited assurance.

4.5 Directorate of Estates, Facilities and Development Update: including HRI Tower Block Update

Murray Macdonald thanked Tom for his patience and suggested that future agendas could be reordered, with digital and estates items being considered earlier in the meeting.

Action: Agenda format to be changed for next meeting; digital, estates, operations and finance.

Tom Myers provided an update on estates and facilities.

Tom Myers reported that there had been no change to the 11 high-level estate risks previously reported. Work was continuing to address these risks through a range of capital projects, including roofing and electrical infrastructure improvements.

Tom Myers reported progress on a new estates management system, which would improve asset management, maintenance planning and reporting across the Group.

Tom Myers noted that a £32 million estates programme was underway, with further projects moving through design and procurement stages.

Tom Myers advised that a diesel leak at Scunthorpe had been reported to the Environment Agency and Severn Trent. The incident was contained quickly and an investigation was underway. He also reported improvements within catering services following the introduction of a new sales system, which had improved oversight and supported efforts to reduce losses.

Tom Myers noted that occupancy surveys had identified underused office space, supporting plans to reduce estate costs and make better use of existing buildings.

Tom Myers reported that work on the Group Estates Strategy was progressing and would be presented to the CiC later in the year.

Murray Macdonald asked whether future reports could include a high-level summary of compliance checks and any overdue inspections or remedial actions, to provide assurance that key estates and health and safety requirements were being managed. Tom Myers agreed and noted that the new estates management system would make this information easier to report. He confirmed that the team would look at including this in future reports.

The CiC noted that Estates, Return, Information Collection (ERIC) data had been submitted on time and that Diana Princess of Wales Hospital had maintained its five-star patient catering rating.

Murray Macdonald noted that members had received assurance on estates, facilities and development matters. However, he highlighted the tower block funding and timescales as a key issue that would continue to require close monitoring.

The Committees-in-Common agreed they had been significantly assured. Murray concluded that the report provided assurance that estates and facilities arrangements are safe and compliant, with improvements being addressed.

4.6 Cleaning Harmonisation

Tom Myers took the report as read and provided an update on the cleaning harmonisation programme. He reported that plans remained on track to procure cleaning services through the existing HUTH contract model (Mitie). Cabinet had already approved, removing the need for a full business case process and reducing programme risk.

Tom Myers advised that work was continuing to finalise the service specification ahead of procurement. He noted that a review of functional risk (FR) ratings had identified the potential for increased costs, although further review and challenge of these ratings was still required before the full impact could be confirmed.

Members of the CiC were advised that the potential financial impact had been highlighted as an early alert and would continue to be reviewed as part of the specification process.

Tom Myers also reported that work was underway to assess whether deep cleaning services could be brought in-house. Business cases were being developed for an in-house deep cleaning team and equipment, with the aim of reducing costs currently spent on external providers while maintaining infection prevention standards.

Julie Beilby expressed she was pleased to see the Group moving forwards with a tender due to concerns around Infection Control measures being discussed it Quality and Safety CiC.

Helen Horth joined the meeting at 11.40pm

4.7 Contract Approvals

4.7.1 Contract Approval: Radiology Reporting Contract Award

Helen Horth reported that the procurement process for the new teleradiology contract had been completed successfully, with strong support from the procurement team and clinical colleagues throughout.

Helen Horth advised that the new contract would deliver significant savings without any increase in headcount. The current annual cost of teleradiology services across both Trusts was £8.2 million, and following a competitive procurement process this would reduce to £5.8 million, delivering annual savings of around £2.4 million. This represented savings of around £7.2 million over a three-year contract term.

Helen Horth highlighted that the joint procurement approach had provided a valuable opportunity to align arrangements across the Group and achieve better value for money.

Helen Horth sought approval to proceed with the contract award as outlined in the report, and the Committees-In-Common approved the contract which would now be presented to the Boards-In-Common for approval as per the scheme of delegation.

Helen Horth left the meeting at 11.50am

4.7.2 Contract Approval: Total Waste Management Service

Tom Myers apologised for the late submission of the paper, explaining that this was due to changes within the team and would be addressed for future meetings.

Tom Myers presented the proposal for the Total Waste Management contract. He explained that waste services currently operate differently across the North and South Bank sites, and that further work was needed before a single Group-wide model could be introduced. To allow time for this review, a new contract had been proposed through an existing framework arrangement. The contract would run for an initial three years, with options to extend, and would provide an estimated

annual saving of around £78,000 compared to the current arrangement.

Tom Myers noted that there was also potential for additional savings through reducing waste volumes and increasing recycling and appropriate waste segregation.

Murray Macdonald sought assurance that the proposed contract was compliant with legal and procurement requirements, aligned with organisational policies and strategy, and could be funded within existing budgets.

Tom Myers confirmed that the proposal met all legal and procurement requirements, aligned with organisational policies, and could be delivered within existing budgets. He noted that the contract had been approved through the appropriate procurement framework and would cost slightly less than the current arrangement.

The Committees-In-Common approved the contract.

4.8 Emerging Issues

None to note.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

Murray Macdonald noted that the work plan should be updated to better reflect digital matters. He advised that work would take place to incorporate digital priorities into the programme and confirmed that a comprehensive update on digital and cyber issues would be a main agenda item at the next meeting.

Action: Lauren Rowbottom and Rebecca Crashley to incorporate the digital agenda into the work plan.

5.2 Planned Care Board Meeting Minutes

This was shared for information.

5.3 Unplanned Care Board Meeting Minutes

This was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

Nothing raised.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

None to note.

7.2 Matters for Escalation to the Trust Boards including any proposed changes to the BAF

Key highlights were noted during the meeting. Any Alerts, Assurances and Advisories would be included in the Highlight Report submitted to the Board following the meeting.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and time of the next PEF CiC meeting:

The next meeting will take place on Tuesday 4th August 2026 via Microsoft Teams.

The meeting closed at 12.03pm

Cumulative Record of Attendance at PEF CiC 26/2027

Name	Title	2026/27											
		Apr No Meeting	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Murray MacDonald	Chair / Vice Chair		D	Y	Y								
Jane Hawkard	NED (HUTH)		Y	Y	Y								
Julie Beilby	NED (NLaG)		Y	Y	Y								
Emma Sayner	Group Chief Financial Officer		Y	Y	Y								
Dr Kate Wood	Group Chief Medical Officer		N	D	D								
Sam Peate	Group Chief Delivery Officer		Y	D	Y								
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates		Y	D	Y								
David Sharif	Group Director of Assurance or deputy		N	D	D								

Philippa Russell	Deputy Group Chief Finance Officer		Y	Y	Y								
Ian Reekie	Governor Observer (NLaG)		D	Y	Y								

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)228

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	10 September 2026
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Neil Gammon, Independent Chair, The Health Tree Foundation
Title of Report	The 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)	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:

Bi-annual Report to Humber Health Partnership Group Boards-in-Common

Smile Contract Update

The contract for the management of The Health Tree Foundation (HTF) has been awarded to the HEY Smile Foundation for two years with an option to extend for a further two years. The effective start date is 1 July 2026. This followed a period of negotiation between NLAG and Smile, following there being no response to the ITT for contract renewal. Smile were the existing contract holders.

Current Financial Position and Associated Challenges

As reported in February 2026, charities across the UK continue to face significant challenges in fundraising amidst the ongoing cost-of-living crisis. Inflation and economic pressures have led to reduced disposable income, impacting individual donations and corporate sponsorships. The Health Tree Foundation continues to implement cost-effective fundraising strategies, focusing on targeted events and corporate partnerships. At the July 2026 Trustees' meeting, it was reported that at May 26, income was £26K versus a plan of £45K, whilst expenditure was £33K versus a plan of £26K. The reduced staffing levels (see below) plus the dislocation caused by contract renewal has not helped the situation.

Reduced Staffing Levels

The current staffing level of HTF is 3 FTEs, compared with an establishment of 5. This situation, obtaining for the past 6 months, will be rectified following the recent contract renewal. It was not possible to fill the vacancies until the contract situation was resolved. It has however meant that progress with some initiatives has been slower than planned.

Circle of Wishes

The automated Circle of Wishes, the system for fulfilling requests for charitable funding, continues to perform well. The reduced staffing levels have not, therefore, had any impact on this aspect of HTF business.

Annual Report

The FY 25/26 Annual Report has been completed, and a copy has been sent to the Trust Boards-in-Common for information.

Audit Report

The Audit report for FY 25/26 has also been completed, with no adverse comment or remarks. This too has been submitted for information to the Trust Boards-in-Common.

NHS Arts Pilot Programme

The NHS Arts Programme is intended to use creative activities like visual art, music, and performance to improve patient healing, mental health, and staff wellbeing across healthcare settings. It is a supporting framework, not a standalone project, and aligns with the NHS's 10 Year Plan. NLAG, via the HTF Charity Manager, has been approached by CW+, the charity that supports Chelsea and Westminster Hospitals, to take part in the pilot programme. CW+ is leading on this for NHS England and has approached other charitable partners in N E Lincolnshire to take part. Following a meeting, involving HTF Chair of Trustees and Charity Manager, at CW+'s offices on 20 August 2026, work is underway to scope the pilot and put a firm

proposal to NLAG. It has been made clear to the CEO CW+ that NLAG does not have any funding for the pilot but would be willing to consider a proposal. A brief to NLAG Chair has taken place and Alan Downey has agreed to be the initial NLAG point of contact at this stage.

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)299

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	10th September 2026
Director Lead	Sam Peate – Group Chief Delivery Officer
Contact Officer / Author	Jennifer Orton – Interim Director of Transformation (South)
Title of Report	Winter Planning 2026/27 – UEC Improvement, Winter Readiness, Safety, Capacity and Financial Assurance
Executive Summary	**Purpose.** To provide assurance on the developing HHP winter plan, linking the North and South Bank UEC deep dives, UEC improvement programme, 2025/26 winter debrief, Winter Planning Group and care group submissions. **Alert.** Full assurance cannot yet be given. Key gaps are the South Bank capacity deficit, North Bank surge arrangements, workforce and clinical oversight, system dependencies, validated costs and September stress testing. **Assure.** A coherent, clinically grounded framework is in place across vaccination, IPC, ward flow, capacity and elective protection, and admission avoidance. The recommended assurance rating is AMBER. **Advise.** The final plan should include named owners, site-level trajectories, milestones, benefits, dependencies and costs, with Finance validation and base, surge and extreme-scenario testing before Board sign-off by 30 September 2026. **Recommendations.** Note progress; endorse the six principles and five-section delivery framework; and require closure of the outstanding capacity, clinical, workforce, system and financial actions before final approval.
Background Information and/or Supporting Document(s) (if applicable)	Revised Winter Planning 2026/27 assurance paper, supported by the North and South Bank UEC deep dives, UEC improvement workstreams, 2025/26 winter debrief, Winter Planning Group outputs, care group submissions and demand/capacity modelling.
Prior Approval Process	Developed through the Winter Planning Group and aligned to the UEC Improvement Board. Final Board assurance and sign-off are required by 30 September 2026.
Financial Implication(s)	The financial requirement is not yet fully validated. A Finance-

(if applicable)	approved affordability assessment is required, including the full-year costs of South Bank capacity, North Bank surge options, workforce and enabling services, and each operating scenario, before final approval.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The plan is intended to improve safe and timely access. Final delivery should assess differential access, vaccination uptake and outcomes for groups experiencing health inequalities, and ensure alternatives to ED and escalation arrangements are accessible and responsive to need.
Recommended action(s) required	☐ Approval by CiC ☒ Information ☒ Endorse for approval by Trust Board(s) ☒ Assurance ☐ Other – please detail below

BAF to which the paper relates:	**Tick all those appropriate**
Our Patients - Access	✓
Our Patients - Safety	✓
Our People	✓
Our Partnerships	✓
Our Pioneers	
Our Public Purse	✓

BOARD ASSURANCE PAPER
Winter Planning 2026/27
UEC improvement, winter readiness, safety, capacity and financial assurance

- **Executive summary**

- **Key message.** This paper brings together the North Bank and South Bank UEC deep dives, the 2025/26 winter debrief, Winter Planning Group outputs and care group submissions into a single HHP winter readiness position. It sets out the current level of assurance, the decisions required, the remaining gaps and the route to final Board sign-off.
- **Committee ask.** The Committee is asked to note the progress made, endorse the proposed delivery framework, and require closure of the outstanding capacity, clinical oversight, workforce, finance and stress-testing actions before final approval.
- **Assurance position.** The direction of travel is clear and clinically grounded, but full assurance cannot yet be given. The principal outstanding issues are the final demand and capacity position, South Bank capacity response, North Bank surge arrangements, detailed delivery milestones, clinical oversight model and validated financial requirement.

Planning Group outputs and care group submissions into a single HHP winter readiness position. It sets out the current level of assurance, the decisions required, the remaining gaps and the route to final Board sign-off.

Committee ask. The Committee is asked to note the progress made, endorse the proposed delivery framework, and require closure of the outstanding capacity, clinical oversight, workforce, finance and stress-testing actions before final approval.

Assurance position. The direction of travel is clear and clinically grounded, but full assurance cannot yet be given. The principal outstanding issues are the final demand and capacity position, South Bank capacity response, North Bank surge arrangements, detailed delivery milestones, clinical oversight model and validated financial requirement.

Recommended assurance rating: AMBER There is sufficient evidence to support continued development of the plan and endorsement of the direction of travel. However, the Committee should require the remaining actions, decisions, costs and stress-test outputs to be closed before final Board sign-off.

2. Decisions and actions requested

1. Note the direct link between the two UEC deep dives, the established UEC improvement programme and the winter plan described in this paper.
2. Endorse the six planning principles in section 4 and the five delivery sections in section 5 as the organising framework for the final HHP plan.

3. Require the final organisational plan, including named owners, milestones, site-level trajectories and costs, to be completed by 31 August 2026.
4. Require the South Bank capacity deficit and North Bank surge opportunities to be translated into an approved, safe and fully costed capacity plan before final Board sign-off.

Require September stress testing, a Finance-validated affordability assessment and formal Board assurance/sign-off by 30 September 2026

3. How the plan has been developed

The winter plan has not been produced as a standalone document. It brings together operational learning, the UEC improvement programme, site-level analysis and clinical review. This provides the line of sight the Committee requires from identified problem, to intervention, to delivery milestone and assurance evidence.

Input / work completed	How it has shaped the plan	Current position and next gate
North and South Bank UEC deep dives	Established the performance baseline, key constraints and priority improvement actions for each bank.	Improvement work is active. Actions and trajectories will be cross-referenced in the final winter plan by 31 August.
UEC improvement workstreams	Provides the delivery route for Model ED, SDEC, frailty, alternatives to ED, discharge and paediatric flow actions.	Workstreams established; milestones, benefits and interdependencies to be consolidated.
2025/26 winter debrief	Identified learning on occupancy, outbreaks, isolation, corridor care, workforce pressure and discharge dependencies.	Learning incorporated; evidence of closure to be included in the final assurance pack.
Winter Planning Group	Brings together care groups, operations, clinical leadership, IPC, vaccination, workforce, finance, estates, diagnostics and system partners.	Governance established; outstanding decisions and ownership to be closed by 31 August.
Care group and site submissions	Tests specialty pressures, mitigations, workforce needs, escalation triggers and local dependencies.	North and South Bank consolidation in progress.
Demand, capacity and bed modelling	Quantifies base, surge and extreme scenarios and tests whether proposed actions create sufficient headroom.	South Bank deficit and North Bank surge options require final validation and decision.

4. HHP winter planning principles

- Ensure patients get to the right place as quickly as possible, with early senior decision-making and clear pathways across hospital and community services.

- Protect staff and patients through clear vaccination, infection prevention and control, staff welfare and safe staffing strategies.
- Make pathways and processes as efficient as possible and align them with national best practice, including Model ED, the Model Acute Pathway and the Model Discharge Pathway.
- Reduce avoidable hospital admission through SDEC, frailty pathways, single point of access, virtual wards and other alternatives to ED and admission.
- Right-size beds, staffing, diagnostics, estates and enabling services to meet forecast demand across base, surge and extreme scenarios. Protect access for elective and cancer patients through explicit ring-fencing, escalation thresholds, executive decision rules and recovery plans.

5. Five delivery sections: agreed position, next steps and timing

The six operational themes requested are organised into five connected delivery sections by combining frailty, SPA and SDEC within a single admission-avoidance section. For each section the final plan will distinguish what is agreed, what remains to be completed, when it will be completed and how delivery will be measured.

5.1 Vaccination

What is agreed / in place.

- An Occupational Health-led seasonal vaccination programme using hubs, booked clinics, roving delivery and targeted catch-up for lower-uptake services.
- Care group ownership of uptake and active use of staff communications and local clinical champions.

What will be completed and by when.

- Final campaign plan, eligibility, delivery locations, vaccine availability assumptions, data reporting and communications to be confirmed by 31 August 2026.
- September commencement of comms for all areas but internally and externally.
- The campaign will commence in line with national guidance and vaccine availability, with weekly operational oversight and monthly Committee reporting once delivery starts.
- National information regarding vaccination for pts over 21 days or those anticipated to have a long stay, along with patients returning to care homes.

Assurance measures: uptake overall and by service; uptake in high-risk areas; staff sickness; vaccine supply; clinic recovery actions; roving vaccinator updates and compliance against the national target on a weekly update across the organisation.

5.2 Infection prevention and control

What is agreed / in place.

- Existing outbreak, cohorting, symptomatic-patient, cleaning, PPE and escalation procedures will form the basis of the winter IPC plan.
- The plan will reflect the significant operational impact of norovirus in 2025/26 as well as influenza and respiratory viruses.
- Rapid testing, point-of-care testing and isolation capacity are being reviewed with operational and laboratory teams.

What will be completed and by when.

- A single HHP winter IPC plan, including triggers, responsibilities, testing, cohorting, cleaning, PPE, ventilation/estates dependencies and communication arrangements, to be complete by 31 August 2026.
- Site-specific isolation and surge cohort capacity to be confirmed through the capacity decisions and tested during September.
- In-season outbreak reviews will identify transmission route, lost bed days, control effectiveness and learning, with rapid escalation where capacity or staffing is compromised.

Assurance measures: outbreaks; hospital-onset infections; lost bed days; isolation utilisation; test turnaround; staff sickness; compliance with outbreak actions.

5.3 Ward processes and flow

What is agreed / in place.

- The UEC improvement programme includes length-of-stay, discharge and NCTR reduction, supported by daily operational flow management.
- Long-length-of-stay reviews, senior ward rounds, discharge planning, criteria-led discharge and earlier-day discharge are core ward controls. Reviews commencing SGH 7th September, DPOW 14th September and HRI 21st September every Tuesday and Thursday 21 day plus working down as these become more embedded.
- TeleTracking in quarter two next year will superseded current tools but currently and for this winter other flow tools will be used consistently to provide a reliable operational view of beds, constraints, predicted discharges and actions.

What will be completed and by when.

- Agree the HHP minimum ward operating standard by 31 August, including board/ward round expectations, LLOS review frequency, discharge milestones, flow data quality and escalation routes.
- Complete baseline compliance and improvement trajectories by site during September, with daily review in winter and monthly Committee assurance.
- Quantify the discharge uplift and NCTR reduction required to support the bed plan and obtain explicit commitments from system partners.

Assurance measures: average and long length of stay; discharges before midday; predicted discharge accuracy; NCTR count/days; ward-round compliance against new NHSE guidance.

5.4 Right-sizing capacity and protecting elective access

What the modelling currently indicates.

- South Bank modelling is showing a deficit in the substantive bed base. The final plan must set out how much of this is addressed through flow and admission avoidance and how much requires additional physical capacity and staffing, once the LoS is achieved and the NCTR position over 72 hours is achieved.
- North Bank has closed capacity and therefore potential surge opportunities. These options require assessment of estates readiness, workforce, IPC, equipment, opening lead time and impact on other services. With the changes to ward moves and LOS this should create the bed base required for surge.

- Additional beds cannot be considered in isolation: diagnostics, pharmacy, therapies, portering, cleaning, transport, critical care and on-call support must be sized to the same scenarios. Planned work for additional beds will be worked up and enacted as required through a structured trigger level format.

What will be completed and by when.

- Validate site- and specialty-level demand, occupancy, length of stay and discharge assumptions for base, surge and extreme scenarios by 31 August.
- Complete options appraisals for the South Bank deficit and North Bank surge capacity, with safe staffing, estates, IPC, quality and full-year financial consequences, before final approval.
- Agree elective and cancer protection rules, including ring-fenced capacity, services that may be flexed, escalation thresholds, executive authorisation and recovery expectations, before September stress testing.

Assurance measures: occupancy; open/closed beds; escalation capacity readiness; ED crowding; elective cancellations; cancer/P2 protection; staffing fill; triggers for additional trauma and reduction in electives proactively formulated; cost per scenario.

5.5 Admission avoidance: frailty, SPA and SDEC

What is agreed / in progress.

- Implementation of frailty SDEC across North and South Bank is a priority, with early frailty identification, senior assessment and same-day alternatives to admission.
- The SPA work will improve professional access to advice and routing so that patients reach the right service first time, working through alternatives to ED by end August and clear timeframes for ICB colleagues to implement by end September.
- SDEC expansion, EEMAC and additional alternatives-to-ED pathways will extend hours, pathway coverage and access while maintaining clinical criteria and safety.
- Flow out of ED implementation, on the SGH and DPOW sites.
- Partnership work with YAS for North Bank and EMAS for South Bank will focus on identification and direct conveyance of appropriate frailty and SDEC cohorts, supported by agreed clinical pathways and feedback.

What will be completed and by when.

- Confirm the FSDEC, SPA and SDEC operating models, hours, workforce, inclusion criteria, direct-access routes and implementation milestones in the final plan by 31 August.
- Agree ambulance pathway protocols, clinical governance, data-sharing and outcome measures with YAS/EMAS, with pathway tests included in the September exercise programme.
- Set site-level trajectories for SDEC activity, conversion, admission avoidance and return rates, with weekly in-season review.

Assurance measures: SDEC activity and hours; conversion and admission-avoidance rates; frailty cohort outcomes; direct ambulance referrals; unplanned returns; patient experience.

6. Clinical oversight and patient safety through winter

EPRR work to develop clinical oversight of the winter plan is a central safety control. The framework should connect professional leadership to operational decision-making, ensuring that changes to capacity, pathways, staffing and elective services are clinically reviewed rather than driven by operational pressure alone.

Clinical control	Minimum requirement	Timing / evidence
Pre-winter clinical assurance	Clinical review of each workstream, capacity option, workforce model, IPC control and pathway change.	Framework and named clinical leads confirmed by 31 August.
Daily in-season oversight	Clinical input to site huddles and escalation decisions, including crowding, infection, staffing and service risk.	Tested in September; operational throughout winter.
Safety triggers and escalation	Clear thresholds for corridor care, unsafe staffing, outbreaks, critical-care pressure and elective de-escalation.	Included in stress tests and escalation cards.
Quality surveillance	Review harm, incidents, complaints, deterioration, readmission/return and staff concerns alongside performance.	Weekly clinical review; monthly Committee summary.
Learning and revery	Rapid debrief after material escalation or outbreak, with actions, owners and retest dates.	Event-triggered and included in winter governance.

7. Governance, monitoring and communication

The Committee's assurance should be based on a single delivery framework rather than a collection of narrative plans. Each action will have a named executive or operational owner, clinical owner, delivery date, expected benefit, cost, dependency, RAG and recovery action.

Level	Purpose	Frequency	Output / escalation
Operational sites and care groups	Manage demand, flow, staffing, IPC and pathway delivery.	Daily in season	Actions, safety issues and exceptions escalated through site command.
Clinical oversight	Challenge safety, clinical effectiveness and proportionality of escalation decisions.	Daily/weekly in season	Clinical risk assessment, recommendations and documented escalation.
Winter Planning Group / UEC Improvement Board	Track milestones, benefits, interdependencies, system actions and risks.	Fortnightly pre-winter; weekly in season	Integrated action log, dashboard and decisions required.

Level	Purpose	Frequency	Output / escalation
Executive / Performance and Finance Committee	Assure readiness, performance, affordability and risk exposure.	Monthly	Bank- and HHP-level dashboard, exceptions, decisions and financial forecast.
Board	Approve the final plan and Board Assurance Statement; oversee material risk.	By 30 September and through winter	Formal assurance, risk acceptance and executive accountability.

Communication will include a concise plan-on-a-page for staff, clear escalation cards, care group briefings, regular updates through established staff channels, and aligned messages with system and ambulance partners. Patient-facing communications will explain seasonal vaccination, alternatives to ED, service access and any temporary pathway changes. Material changes will be communicated before implementation wherever possible and immediately where urgent safety action is required.

8. Best-practice alignment

The plan is designed around national expectations for the Model Emergency Department, the first 72 hours of acute care, the Model Acute Pathway and Model Discharge Pathway. Final assurance will require each workstream to evidence the relevant standards, identify any gap, state the action and completion date, and show the measurable benefit. September stress tests will cover base, surge and extreme scenarios, including outbreaks, workforce sickness, delayed discharge, critical-care pressure and

12. Conclusion and recommendation

HHP has a coherent basis for the 2026/27 winter plan, derived from the two UEC deep dives, established improvement work, the winter debrief, the Winter Planning Group, care group input and emerging demand and capacity analysis. The five delivery sections give a clear route from current work to final action, timing and assurance.

The Committee is asked to endorse the direction and principles, maintain an AMBER assurance rating, and require closure of the capacity, clinical oversight, system, workforce and financial gaps before final Board approval. The test of the plan will be whether it keeps patients and staff safe while improving urgent care flow and protecting elective and cancer access.

Sam Peate
Chief Delivery Officer

Humber Health Partnership