NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

AGENDA

A meeting of the Council of Governors
to be held on Wednesday, 4 November 2026 at 14:00 to 17:00 hours
in the Main Boardroom at Diana, Princess of Wales Hospital, Grimsby, DN33 2BA

For the purpose of transacting the business set out below:

No.	Agenda item	Format	Purpose	Time
1. CORE BUSINESS ITEMS				
1.1	**Welcome and Apologies for absence** Murray Macdonald, Interim Trust Chair	Verbal	Information	**14:00**
1.2	**Staff Charter and Values** Murray Macdonald, Interim Trust Chair	Attached	Information	
1.3	**Declarations of Interest** Murray Macdonald, Interim Trust Chair	Verbal	Information	
1.4	**Minutes of the previous meetings held on:** • **20 August 2026 – Business Meeting** • **14 October 2026 – Joint NLaG Annual Members Meeting (AMM) & HUTH Annual General Meeting (AGM)** **Note**: The minutes of the Private meeting held on 30 September 2026 were approved virtually. Murray Macdonald, Interim Trust Chair	CoG(26)088 CoG(26)089 Attached	Approval	
1.4	**Urgent Matters Arising** Murray Macdonald, Interim Trust Chair	Verbal	Information	
1.5	**Action Tracker – Public** Murray Macdonald, Interim Trust Chair	CoG(26)090 Attached	Approval	
1.6	**Questions submitted from the Public** Murray Macdonald, Interim Trust Chair	Verbal	Information	**14:05**
2. REPORTS AND UPDATES				
2.1	**Interim Trust Chair's Update** Murray Macdonald, Interim Trust Chair	CoG(26)091 Attached	Information	**14:15**
2.2	**Interim Trust Chief Executive's Update including Group Dissolution** Therese Patten, Interim Trust Chief Executive	CoG(26)092 Attached	Information	**14:30**
2.3 2.3.1 2.3.2	**Lead Governor's Update** Ian Reekie, Lead Governor **To include:** • **Membership and Public Engagement & Assurance Group (MPEAG) Highlight Report** • **Appointments and Remuneration Committee (ARC) Highlight Report**	CoG(26)093 Attached	Information / Approval	**15:05**
3. BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS				
3.1	**Audit, Risk & Governance Committees-in-Common (CiC) Highlight / Escalation Report** Jane Hawkard, Group Non-Executive Director CiC Chair	CoG(26)094 Attached	Assurance	**15:15**

3.2	**Performance, Estates & Finance CiC Highlight / Escalation Report** Murray Macdonald, Interim Trust Chair & CiC Chair	CoG(26)095 Attached	Assurance	**15:25**
BREAK - 15:35 – 15:45				
3.3	**Quality & Safety CiC Highlight Report / Escalation Report** Julie Beilby, Group Non-Executive Director CiC Chair (representing David Sulch)	CoG(26)096 Attached	Assurance	**15:45**
3.4	**Workforce, Education & Culture CiC Highlight / Escalation Report** Julie Beilby, Group Non-Executive Director CiC Chair	CoG(26)097 Attached	Assurance	**15:55**
4. COG BUSINESS ITEMS				
4.1	**Strategic Workstreams Update** Ben Smith, Deputy Director - Intensive Support, NHS England and Ryan Sutton, Associate Director of Quality Improvement	CoG(26)098 To Follow	Information	**16:05**
4.2	**Annual Governor Elections & Lead Governor Appointment Update** Alison Hurley, Group Deputy Director of Assurance	CoG(26)099 Attached	Approval / Information	**16:35**
5. OTHER				
5.1	**Questions from Governors** Murray Macdonald, Interim Trust Chair	Verbal	Information	**16:40**
5.2	**Items for Information / To Note (as per Appendix A)** Murray Macdonald, Interim Trust Chair	Verbal	Information	
5.3	**Any Other Urgent Business** Murray Macdonald, Interim Trust Chair	Verbal	Information	
5.4	**Matters to be escalated to the Trust Board** Murray Macdonald, Interim Trust Chair	Verbal	Information	
5.5	**Council Performance and Meeting Reflection** Murray Macdonald, Interim Trust Chair	Verbal	Information	
6. DATE OF THE NEXT MEETING				
6.1	The next meetings of the Council of Governors will be held on: Thursday, 7 January 2027 from 14:00 – 17:00 hours Virtually via MS Team			

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

APPENDIX A

Listed below is a schedule of documents circulated to all CoG members for information.

The Council has previously agreed that these items will be included within the CoG papers for information.

5.2.	**Items for Information**		
5.2.1	Trust Constitution	Alison Hurley, Group Deputy Director of Assurance	CoG(26)100 Attached
5.2.2	Governors, Executive Directors, Non-Executive Directors and Other Directors Register of Interests	Alison Hurley, Group Deputy Director of Assurance	CoG(26)101 Attached
5.2.3	Finance Report	Emma Sayner, Group Chief Financial Officer	CoG(26)102 Attached
5.2.4	Group Performance Report	Rob Stones, Director of Performance	CoG(26)103 Attached
5.2.5	Acronyms & Glossary of Terms	Alison Hurley, Group Deputy Director of Assurance	CoG(26)104 Attached

PROTOCOL FOR CONDUCT OF COUNCIL OF GOVERNOR BUSINESS

- **Members should contact the 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
- In accordance with Standing Order 2.4.3 (at Annex 6 of the Trust Constitution), any Governor wishing to submit an agenda item must notify the Chair's Office in writing at least **10 clear days** prior **to the meeting at which it is to be considered.** Requests made less than 10 clear days before a meeting may be included on the agenda at the discretion of the Chair.
- Governors are asked to raise any questions on which they require information or clarification in advance of meetings. This will allow time for the information to be gathered and an appropriate response provided.

PROTOCOL FOR QUESTION(S) SUBMITTED FROM TRUST MEMBERS AND THE PUBLIC

Please note - Trust members and the public are encouraged to submit any questions requiring information or clarification at least 7 days before the meeting. This ensures sufficient time to gather the necessary details and provide an appropriate response.

Questions received within 7 days of the meeting will be addressed at the next Council of Governors business meeting.

Staff charter

NHS
Humber Health
Partnership

COMPASSION	HONESTY	RESPECT	TEAMWORK
Put the safety and care of patients and colleagues at the heart of everything you do	Take responsibility for your actions, decisions and behaviours	Trust and appreciate your colleagues - say thank you and well done	Meet regularly as a whole team, discuss goals, actions and ideas for improvement. Commit to being good team members
Listen to your colleagues and patients, understand, empathise and take action to help	Report concerns about safety, quality and negative behaviours as quickly as possible	Talk to everyone in a respectful and polite manner and listen when others want to speak	Include all colleagues in key discussions about the team or service
Treat everyone with kindness and support those who need assistance or guidance	Communicate constantly and clearly at all times; create and respond to a constant loop of honest feedback	Understand and appreciate the perspectives, choices and beliefs of others and never discriminate against anyone	Tackle poor behaviours as they arise
Do the right thing, even if this is more difficult to do	Be open about mistakes, apologise, learn and improve	Respect and use each others' strengths; act respectfully by giving, receiving and acting on constructive feedback	Agree high professional standards as a team; give yourselves time to reflect on how to constantly improve

COUNCIL OF GOVERNORS BUSINESS MEETING

Minutes of the meeting held on Thursday, 20 August 2026
at 16:00 to 17:30 hours held via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Alan Downey	Group Chair
Ahmed Aftab	Staff Governor
Mike Bateson	Deputy Lead Governor
Marian Davison	Public Governor
Cheryl George	Public Governor
Brent Huntington	Public Governor
Wendy Lawtey	Public Governor
Corrin Manaley	Staff Governor
Ian Reekie	Lead Governor
Caroline Ridgway	Public Governor
Dr Sandeep Saxena	Staff Governor
Dr Gorajala Vijay	Public Governor
Jackie Weavill	Staff Governor
Clare Woodard	Public Governor

In Attendance:

Julie Beilby	Group Non-Executive Director
Michelle Drinkall	Lead Nurse Accreditation
Charlie Grinhaff	Head of Marketing
Hilda Gwilliams	Group Chief Patient Safety Officer
Myles Howell	Director of Communications & Engagement
Alison Hurley	Group Deputy Director of Assurance
Rachel Johnson	Head of Communication & Staff Involvement
Simon Leonard	Communications Officer
Sam Peate	Group Chief Delivery Officer
Mr Peter Sedman	Group Deputy Chief Medical Officer
Suzanne Maclennan	Corporate Governance Officer (minutes)

Public Members:

Henry Anderson	- HSJ Correspondent
Robert Bain	- Public
Dr Paul Edmondson-Jones	- Public
Ekta Elston	- Public
Dean Gillon	- Senior Democratic Services Officer, North Lincolnshire Council
Bev Graham	- Public
Dr Peter Melton	- GP (Roxton Practice)
Will Melton	- Wolds Medical
John Palmer	- Trust member
Lorraine	
Alison	

Staff attendance:

Lucy Abedin - Secretary to Dr Cheruvalli, Paediatrics
Dr Yousef Adcock - Palliative Medicine Consultant
Dr Asem Ali - Consultant
James Bailey - Consultant
Rachel Beeby - Matron Neuroscience
Amy Billings - Cancer Pathway Team Leader, DPoW
Dr Lesley Buswell - Consultant Biochemist, Path Links
Saira Chacko - Team Lead, Theatre Recovery, DPoW
Dr Nick Cross - Site Medical Director
Hannah Crichton - Deputy Unit Manager
Mel Davies - Medical Secretary
Jane Day - Obstetric Secretary, SGH
Samantha Devine - Assistant Medical Secretary, Ophthalmology
Charlie Dunn - Virtual Ward/OPAT Clinical Coordinator
Scott Evans - PEG Care Navigator
Tracy Filmer - Bank Admin & Clerical
Lisa Gadd - Endoscopy Manager
Chin Hooi Gan - Consultant
Dr Sanjeev Garg - Consultant
Mr Ramana Kallam - Consultant
Dr Sandeep Kapoor - Consultant, SGH
Dr Seema Karan - Consultant Radiologist, SGH
Andrew Karvot - Bank Advanced Clinical Pharmacist
James Maclean - Chief of Service
Dr Madhav Menon - Consultant
Cara Mumby - ENT Clinical Nurse Specialist, DPoW
Amy Oswin - Upper GI Clinical Nurse Specialist, DPoW
Deepak Pai - Consultant
Louise Salt - Colorectal Clinical Nurse Specialist, DPoW
Sophie Sylvester - Secretary to Dr Ul Haq, Paediatric Department
Vicky Thain - Endoscopy Unit Manager
Louise Twells - Endoscopy Deputy Ward Manager
Colin Vize - Clinical Director
Dr Han Yin - Consultant in Rehabilitation

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 Group Chair, Alan Downey, welcomed those present to the Council of Governors (CoG) Business Meeting. A special welcome was extended to Trust members, public and staff attending their first Council of Governors meeting.

Alan Downey provided details of apologies for absence for Governor Kev Allen.

Apologies were also received from Keith Haynes, Interim Board Secretary, Jane Hawkard, Group Non-Executive Director, Murray Macdonald, Group Vice Chair,

David Sharif, Group Director of Assurance and David Sulch, Group Non-Executive Director.

1.2 **Staff Charter and Values**

Alan Downey reminded those present of the Staff Charter and Values and highlighted that everyone should adhere to these in terms of behaviours during the meeting.

Alan Downey outlined that the meeting was held in public on behalf of the CoG and was not a public meeting. It was noted that questions from members of the public were required to be submitted at least seven days in advance of the meeting date. Meeting housekeeping was highlighted in respect of keeping microphones muted and Governors were encouraged to use the virtual raised hand function within Microsoft Teams.

1.3 **Declarations of Interest**

Alan Downey requested any declarations of interests in respect of any of the agenda items. It was noted that the matter of potential conflict relating to agenda item 2.3 would be addressed when the item was reached.

No other declarations were received.

1.4 **Minutes of the Previous Council of Governors Business Meeting held on 16 July 2026**

The minutes of the business meeting held on the 16 July 2026 were reviewed and accepted as a true and accurate record.

1.5 **Urgent Matters Arising**

Alan Downey invited members to raise any matters requiring discussion not captured on the agenda.

Ian Reekie referred to page five, paragraph three of the minutes of the previous meeting on 16 July 2026 which noted scepticism from Wendy Lawtey with regards to the three reviews taking place at the same time without resulting in conflicting outcomes. Ian Reekie requested confirmation that the review of the Care Group structure had been paused pending the outcome of the Carnall Farrar review. Alan Downey confirmed this was the case noting that further review of the most appropriate Care Group structure would be required.

Alan Downey provided advance notice of an update regarding the appointment of the Senior Independent Director (SID) which would be addressed under Any Other Business.

1.6 **Action Tracker**

The Council reviewed the Action Tracker and agreed that eleven of completed actions could be moved to the closed section following the meeting.

Ian Reekie referred to COG(26)019 which relates to a review of the procedure for medical assistance required on hospital sites to be undertaken, and requested this

action was reopened as the response did not fully address the original concern. Hilda Gwilliams agreed to follow this up and provide a response.

Alan Downey outlined three important points before the main agenda items began due to concerns raised regarding patient safety, the pace of change and uncertainty around the future of the two Trusts. The highlighted points were:

Point 1 – The unacceptable decline of performance across both NLaG and HUTH following the inception of Humber Health Partnership (HHP). Decline had been noted in patient safety, quality and accessibility of services, waiting times, patient experience, staff morale and motivation, organisation change and finances. It was very evident that change was required. The Care Quality Commission (CQC) had recently completed an all-encompassing well-led review where many shortcomings were identified. It was reported that a section 29a improvement notice had been issued for each Trust which required urgent changes to be addressed within six months. This deadline was noticeably more lenient than usually expected and Alan Downey speculated that perhaps the CQC recognised the relatively new appointments within the executive team. It was reported that all points highlighted by the CQC were in the process of being incorporated into the Integrated Improvement Plan (IIP) which assigned accountability for each domain. The comprehensive IIP would be shared with Governors following the meeting.

Point 2 – The fundamental rationale for the Group. The Carnall Farrar review would answer the existential questions such as whether the Group should continue to exist and if so in what format and if not what the alternative option should be. The Trust Boards-in-Common would decide in principle the future of the Trusts on 10 September 2026 whereby all evidence and views would be considered. Alan Downey provided assurance that views of all had been heard, particularly those of colleagues on the south bank.

Point 3 – Duty to address the shortcomings. It was important to note that improvements had continued to be made in several areas which had made the negative reports in the mainstream media, social media and from colleagues all the more frustrating. Hilda Gwilliams had prepared a report which outlined improvements which would be shared with Governors following the meeting. The CQC findings demonstrated that improvements were being made, which were outlined as follows:

- CQC reported that outpatient services at Goole and District Hospital (GDH) rated as Good across all five domains
- Urgent and Emergency Care (UEC) at Hull Royal Infirmary (HRI) moved from Inadequate to Requires Improvement
- Medical care at HUTH narrowly missed out on a Good rating
- Maternity services had a section 31 notice lifted due to significant improvements
- End of Life (EoL) at Diana, Princess of Wales Hospital (DPoW) moved from Inadequate to Good
- End of Life (EoL) in the North Lincolnshire Community rated Good
- Never events between April 2024 and December 2025 there were 18 reported although between January 2026 to 20 August 2026 one was reported
- Patient falls resulting in a hip fracture – in the upper quartile nationally for positive performance
- Infection Prevention and Control (IPC) showed significant improvements

- Summary Hospital-level Mortality Indicator (SHMI) – NLaG reported better than the national average position
- Eliminated corridor care within NLaG
- Cancer faster diagnostic standard – NLaG reported in the top 4 of the region for improvement
- Cancer 31 day standard – HUTH and NLaG most improved in recent months across the region
- Complaints – 50% reduction in the Patient Advice and Liaison Services (PALS) backlog
- Finances – Month 4 NLaG reported on plan

Dr Sandeep Saxena welcomed the positive outlook presented and highlighted the findings of the ongoing survey of non-medical colleagues, noting that the results to date did not fully reflect the positive position described. It was acknowledged that the current response rate was relatively small, with approximately 500 responses received. Alan Downey recognised the concerns expressed by colleagues on the south bank, noting that these concerns were not disputed. It was emphasised that the data presented had not been selectively reported, while acknowledging that significant improvements remained necessary.

Mike Bateson sought assurance that the findings of the CQC inspection of the DPoW Emergency Department (ED), which had identified areas of concern, were being appropriately addressed. Alan Downey explained that the update had focused on positive improvements to provide balance to the prevailing narrative. It was emphasised that all areas of concern and feedback arising from the inspection had been considered and incorporated into the IIP for action. Hilda Gwilliams advised that two of the Key Lines of Enquiry (KLOE) had improved for Scunthorpe General Hospital (SGH) ED.

Jackie Weavill expressed frustration that staff had not felt listened to over a prolonged period and that some decisions had been taken without sufficient consultation and consideration of the implications. The withdrawal of the shuttle bus service was cited as an example. Jackie Weavill strongly requested that decisions affecting colleagues should not be made without appropriate discussion and involvement. Alan Downey acknowledged the importance of maintaining accountability and noted that, in response to feedback received, the shuttle bus service had been reinstated.

Ahmed Aftab sought clarification that the final decision would be made by the Trust Boards-in-Common following consideration of the Carnall Farrar review. Alan Downey confirmed that the conclusion would require endorsement from the Trust Boards-in-Common and NHS England (NHSE) and noted the importance of listening to the views of Governors.

Actions:

- Reopen COG(26)019 which relates to a review of the procedure for medical assistance required on hospital sites to be undertaken and await response from Hilda Gwilliams
- Share the IIP and Continuous Improvement Update with Governors.

1.7 **Questions submitted from the Public**

Alan Downey advised that there had been two questions submitted by the public in advance of the meeting. Alison Hurley read out the two questions and although a written response had been provided in advance by Sam Peate they were responded to verbally as follows:

Question Raised by: John Palmer, Trust Member - I understand that Outpatient Parenteral Antimicrobial Therapy (OPAT) which was run from ward 3 at GDH has now been taken away and given to City Health Care Partnership (CHCP). Why, when they are a private company and the Trust continues to run it in other areas?
Response provided by Sam Peate: The OPAT service on Ward 3 at GDH is currently running. Recently a proof of concept pilot was undertaken in line with national best practice to explore provision of some of this care in the community. The result of this pilot is currently being reviewed by the community and frailty care group. There are no plans for CHCP to undertake this work.

Question Raised by: John Palmer, Trust Member - Rheumatology clinic at GDH. What is the plan for this? I was referred in April, when I called to ask about GDH I was told by the time I was seen there would probably be no clinic as the consultant would have retired.
Response provided by Sam Peate: The process to advertise and replace one of our Rheumatology consultants has commenced. Work is underway with the team to explore coverage of all elements of the service if we experience a gap in workforce. We expect that there will be provision available for all patients that currently accessing services at Goole.

It was noted that a third question had been submitted; however, this was a duplicate of a question previously raised and responded to at the Trust Boards-in-Common meeting held on 9 July 2026.

2. COG BUSINESS ITEMS

2.1 **Governor Elections and Lead Governor Update**

Alison Hurley provided a summary of the report which was taken as read and outlined the recommendations.

Ian Reekie expressed concern regarding the proposed disbandment of Councils of Governors and noted that work was ongoing with the National Lead Governors Association to advocate against the proposal through engagement with the House of Lords. Ian Reekie confirmed support for the proposals set out within the report.

Andy Karvot queried whether the proposal was to remove Governors from Foundation Trusts only or all NHS Trusts. Alan Downey confirmed that only Foundation Trusts had a Council of Governors.

Mike Bateson also confirmed support for the recommendations set out in the report and sought further information on how community involvement and representation would be maintained should the proposed removal of Governors proceed. Alan Downey advised that discussions with other Trusts would be undertaken to understand how they proposed to involve and engage their local communities in the future. Alison Hurley confirmed that an engagement plan was being drafted ahead of the next Membership & Public Engagement and Assurance

Group (MPEAG) meeting alongside liaison with Patient Engagement and the Communications team.

Alan Downey outlined the two matters requiring approval by the Council of Governors, as set out below:

- To proceed with the Governor elections in November 2026 noting that efforts would be made to minimise costs wherever possible, including through proportionate publicity and the use of existing communication channels
- Include a "validity of acts" clause in the NLaG Trust Constitution.

Governors were invited to cast their vote via the Teams chat function indicating either 'yes' or 'no'. A majority of ten Governors voted in support of the recommendation to proceed with the November 2026 elections.

2.2 **Putting Patients First (PPF) – Accreditation Progress Update**

Michelle Drinkell delivered an overview of the report and shared initial positive feedback from the ward manager involved in the pilot phase. The paper was taken as read and apologies noted as 23 wards had been involved in the pilot and not 22 as stated in the report. A further update at a future CoG meeting in approximately three months was suggested.

Jackie Weavill shared that feedback heard from participating matrons had been positive and requested that Governors could be involved as they were previously for A Commitment to Excellence (ACE) and 15 Steps reviews. Jackie Weavill raised concern over the data being used as data entry errors can occur and systems are not always helpful. Michelle Drinkell confirmed that there was digital data that could be relied upon and subject matter expert audits had successfully been implemented.

Ian Reekie noted that, while previous ward reviews had provided valuable insight, they did not appear to be incorporated within the new accreditation scheme. Consideration was requested for the introduction of a regular programme of ward visits for NEDs and Governors, which had previously been well received and had provided useful opportunities for engagement and learning. Michelle Drinkell acknowledged that there may be a gap in the proposed arrangements and agreed that a small '15 Steps'-style review could provide additional value. It was suggested that this could be incorporated into the accreditation programme, or alternatively delivered through a programme of scheduled walk-rounds. It was confirmed that, by March 2027, NEDs and Governors would be invited to participate in regular PPF accreditation visits.

Alan Downey agreed that a process for NEDs and Governors should be restored.

Brent Huntington queried whether the GDH Urgent Treatment Centre (UTC) would be included in the programme. Michelle Drinkell confirmed that the UTC was not run or managed by HHP staff and therefore not included for review although it was included in the Patient-Led Assessments of the Care & Environment (PLACE). Alan Downey noted that it was important to not allow organisational boundaries to effect patient services and positive discussion had taken place with Save Goole Hospital Action Group. Brent Huntington referred to a previous Chief Executive update which included GDH UTC in the reporting. Sam Peate confirmed that

some reporting on the UTC was required such as the estate regardless of who was using the premises and the four hour standard due to geographical location.

Caroline Ridgway submitted a question in the Teams chat asking how does PPF fit with the PLACE assessment/inspections we, as Governors, have just been asked to support in October? Michelle Drinkell responded that she 'is involved with the PLACE organisation alongside facilities and we will look at the actions that come out of the 2026 PLACE assessment to align any improvements identified through the accreditation programme'.

Actions:

- Invite Michelle Drinkell to the November 2026 CoG meeting for a further PPF update
- Consider a small '15 Steps'-style ward review for NEDs and Governors.

Due to a conflict of interest Alan Downey removed himself from any discussions relating to agenda item 2.3.

2.3 **To consider adoption of a resolution proposed by the Lead Governor on behalf of fellow Governors:**

> The Council of Governors wholeheartedly supports the submission of proposals for future governance and leadership made by the NLaG consultant body. The Humber Health Partnership Boards-in-Common and NHS England are urged to give serious consideration to the recommended full restoration of NLaG as an independent NHS Foundation Trust.

Ian Reekie reported that this resolution had been subject to considerable debate amongst Governors, had been drafted collaboratively and reflected the settled view of Governors. The item was on the agenda for formal Governor approval.

Governors were invited to cast their vote via the Teams chat function indicating either 'yes' or 'no'. A majority of eleven Governors voted in support of the resolution.

Alan Downey advised that, due to a conflict of interest, it would not be appropriate for him to chair discussion of the item. It was noted that, as the vote had already been cast, no further questions would be taken.

3. OTHER

3.1 **Questions from Governors**

Alan Downey welcomed any questions from Governors.

Ian Reekie presented the following questions, which had been developed collaboratively with fellow Governors:

What assurances have NEDs sought/received from Executive Directors:

- that the decision to defend the recently reported Employment Tribunal case was taken on the basis of robust legal advice and a detailed assessment of financial and reputational risk.

- that steps have been taken to ensure that the gross failures to follow established Human Resource policies and procedures revealed in the Employment Tribunal judgement cannot be repeated; and
- that, in particular, all staff still employed by the Humber Health Partnership who were involved in the disciplinary process that was the subject of the Employment Tribunal or who may be involved in overseeing future disciplinary procedures have received appropriate retraining?

Alan Downey advised that, while he was willing to provide a response, it would not be appropriate to do so during a CoG meeting held in public, given the sensitive nature of the matters raised and their relevance to named individuals. It was proposed that a private meeting of the CoG be convened immediately following the conclusion of the meeting held in public. The proposal was supported and approved by Governors.

Alison Hurley reported that one question had been submitted in advance and a written response had been provided by Sam Peate. The question together with the response provided, was presented to the meeting and addressed as set out below:

Question Raised by: Brent Huntington - Ward 3 at GDH is a 24 bed ward currently operating at between 12 to 14 beds. Why is it not operating at full capacity of 24?
Response provided by Sam Peate: Ward 3 at GDH is currently open to 16 beds in response to demand for services provided on the ward increasing from 12-14 beds being open on the ward earlier in the year. This increase reflects the level of activity and the need to maintain patient flow while ensuring safe and effective care.

The rationale for not opening the full 24-bed capacity is linked to the admission criteria for the unit. In practice, we often find it challenging to identify and maintain a sufficient cohort of patients who meet the criteria required to utilise all 24 beds appropriately. As a result, opening the full bed base on a routine basis would not always represent the most effective or efficient use of resources.

Over the winter period, we have on occasion staffed and operated up to 24 beds to respond to periods of increased demand. However, this has been the exception rather than the norm, as we have generally experienced difficulty in placing enough suitable patients to consistently occupy all 24 bed spaces.

Dr Sandeep Saxena sought assurance that lessons learned from the recent employment tribunal would be appropriately disseminated and reflected in the practice of those regularly involved in disciplinary procedures. It was reported that there was an unprecedented number of disciplinary procures underway with NLaG currently. Alan Downey highlighted that the Trust had publicly acknowledged that mistakes had been made and emphasised the importance of ensuring that lessons were learned and embedded.

Ahmed Aftab noted that the unusually high number of disciplinary cases referenced were not being led by NLaG employees. This point was noted by Alan Downey.

3.2 **Items for Information / To Note**

Alan Downey drew the Council's attention to the items for information noted in Appendix A.

3.3 **Any other Urgent Business**

Alan Downey reported that Murray Macdonald was currently undertaking the role of Senior Independent Director (SID). While it was acknowledged that this arrangement was not ideal given his position as Group Vice Chair, it was noted that such arrangements were not without precedent. In accordance with the Trust Constitution, NEDs had been invited to express an interest in the SID role, and David Sulch had subsequently indicated a willingness to be considered. It was noted that the proposed appointment would be presented to the Trust Boards-in-Common on 10 September 2026 and, subject to approval, would be submitted to the CoG for ratification.

Alan Downey provided a summary of the meeting as follows:

- confirmed approval to proceed with the Governor 2026 elections as detailed and the appointment of the Lead Governor
- useful update for Putting Patients First accreditation scheme received
- ward visit process for Governors and NEDs to be created/re-instated
- COG(26)019 action to be re-instated in relation to a review of the procedure for medical assistance required on hospital sites to be undertaken
- the proposed resolution for NLaG was approved
- the latest version of the IIP and improvement update will be circulated following the meeting
- an update on the SID appointment was provided
- an update on the amazing work taking place at both Trusts in terms of quality and standard of care and staff professionalism was received. It was noted that positive media stories would be welcomed

Post Meeting Note – **Action** - from the subsequent Private CoG meeting:

- Invite Helen Marks to attend a future private meeting of the CoG to provide an overview of the Employment Tribunal case, including the outcome of the investigation and the lessons learned, with due regard to confidentiality and the rights of any named individuals.

4. DATE AND TIME OF THE NEXT MEETING

4.1 **Date and Time of the next Council of Governors meeting:**

The next meeting of the Council of Governors meeting would be the Joint NLaG CoG Annual Members Meeting (AMM) and the HUTH Annual General Meeting (AGM) to be held on Wednesday, 14 October 2026 at 14:30 to 17:30 hours virtually via Microsoft Teams Live

Alan Downey thanked those present for their attendance and contributions and the meeting closed at 17:26 hours.

Cumulative Record of Governor / Executive and NED Attendance 2026/2027 - Public

Governors					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Ahmed Aftab	4	1	Wendy Lawtey	4	4
Kevin Allen	4	3	Corrin Manaley	4	2
Paula Ashcroft	4	0	Cllr Nigel Oliver	2	0
Mike Bateson	4	4	Emma Mundey	2	0
Marian Davison	4	3	Ian Reekie	4	4
Cheryl George	4	2	Caroline Ridgway	4	1
Cllr Anne Handley	4	2	Dr Sandeep Saxena	4	2
Dietmar Harteveld	4	3	Dr Gorajala Vijay	4	3
Brent Huntington	4	4	Jackie Weavill	4	4
David James	4	1	Clare Woodard	4	2

Executives					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Paul Bunyan	2	0	Emma Sayner	2	1
Keith Haynes	2	1	Mr Peter Sedman	4	3
Alison Hurley	4	4	David Sharif	4	2
Jo Ledger	2	1	Lyn Simpson	2	2
Sam Peate	3	2	Dr Kate Wood	2	0

Non-Executive Directors					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Julie Beilby	4	4	Murray Macdonald	4	2
Alan Downey	4	3	David Sulch	2	0
Jane Hawkard	4	1			

JOINT NLaG COUNCIL OF GOVERNORS ANNUAL MEMBERS' MEETING & HUTH ANNUAL GENERAL MEETING

Minutes of the meeting held on Wednesday, 14 October 2026 at 14:30 to 17:00 hours via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Alan Downey	Group Chair
Murray Macdonald	Interim Trust Chair (NLaG)
Mike Bateson	Deputy Lead Governor
Marian Davison	Public Governor
Cheryl George	Public Governor
Dietmar Harteveld	Public Governor
David James	Public Governor
Corrin Manaley	Staff Governor
Ian Reekie	Lead Governor
Jackie Weavill	Staff Governor
Clare Woodard	Public Governor

Executive & Non-Executive Directors, Guest Speakers and Production:

Adrian Beddow	Associate Director of Communications & Engagement
Julie Beilby	Group Non-Executive Director
Brian Clerkin	Director, Sumer Audit
Rebecca Crashley	Group Deputy Director of Assurance
Dr Ekta Elston	Group Associate Non-Executive Director, GP and North East Lincolnshire Health and Care Partnership
Jo Gander	Group Non-Executive Director
Nicola Hallas	Director, Forvis-Mazars LLP
Keith Haynes	Interim Board Secretary
Myles Howell	Group Director of Communications
Alison Hurley	Group Deputy Director of Assurance
Adam Johnston	HCP Programme Manager, Navigo
Therese Patten	Interim Trust Chief Executive (NLaG)
Helen Phillips	Director of Commissioning, Partnership and Engagement - Northern Lincolnshire
Emma Sayner	Group Chief Financial Officer
Mr Peter Sedman	Deputy Group Chief Medical Officer
Laura Sherburn	National Neighbourhood Health Implementation Programme
Lyn Simpson	Group Chief Executive
Simon Leonard	Communications Assistant (presentations)
Suzanne Maclennan	Corporate Governance Officer (minutes)

Attendees:
Mike Waites, Nikki Harrison, Carolyn Phillips, Eva Inkson, Kristina Medlinskiene, Emily Purdon, Joshua Tidswell, Helen Spence, Dr Sandeep Kapoor, Lisa Dannatt, Stephen MacAleer, James Lacey-Hatton, Louise Topliss, Bryan and Henry Anderson.

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 Group Chair, Alan Downey, welcomed those present to the second joint NLaG Council of Governors (CoG) Annual Members' Meeting (AMM) and HUTH Annual General Meeting (AGM) which was held virtually via Microsoft Teams. A particular welcome was extended to newly appointed Murray Macdonald, Interim Trust Chair and Therese Patten, Interim Trust Chief Executive for NLaG.

Those present were advised that the chairing of the meeting would be appropriately shared between Alan Downey and Murray Macdonald and the meeting would be recorded and available to view on the websites of both Trusts. An overview of the agenda was provided which outlined the focus of the meeting and notable key speakers. Any questions not provided with a response during the meeting would be followed up after the meeting and published on the websites following the meeting.

Alan Downey provided details of apologies for absence for Public Governors' Kevin Allen, Brent Huntington and Wendy Lawtey and Stakeholder Governor, Cllr Anne Handley. Late apologies were also received from Public Governor, Caroline Ridgway.

Apologies were also received for Hilda Gwilliams (Group Chief Patient Safety Officer), Jo Ledger (Acting Group Chief Nurse), Helen Marks (Group Chief People Officer) and David Sulch (Non-Executive Director). Professor John Craig (HUTH Non-Executive Director) had advised of late arrival at the meeting.

1.2 Staff Charter and Values

Alan Downey reminded attendees of the Humber Health Partnership (HHP) values of compassion, respect, honesty and teamwork.

1.3 Declarations of Interest

Dr Ekta Elston declared an interest in agenda item '3.1 - Neighbourhood Health Provision' as a contributor to the presentation on the North East Lincolnshire Trailblazer programme. No further declarations were received.

1.4 **To receive the approved minutes of the previous NLaG Council of Governors (CoG) Annual Members' Meeting (AMM) and HUTH Annual General Meeting (AGM) held on 22 October 2025**

The minutes of the NLaG CoG AMM and HUTH AGM held on the 22 October 2025 were received and accepted for information (previously approved at the CoG Business meeting on 5 November 2025 and the Trust Boards-in-Common meeting on 11 December 2025).

1.5 **Urgent Matters Arising**

No urgent matters arising were raised.

2. ANNUAL REPORTS AND ACCOUNTS

2.1 **Overview of the Annual Reports 2025/26 and Priorities for the Future (for NLaG & HUTH)**

Lyn Simpson presented an overview of activity, patient experience, quality, workforce and performance during 2025/26, together with priorities for 2026/27. Thanks were expressed to staff, volunteers and partners for their contribution to patient care during a period of considerable pressure.

Across the two Trusts, approximately 19,000 staff supported around one million patients each year, serving a combined population of approximately 1.5 million. Activity included more than 1.3 million outpatient attendances, approximately 59,000 operations and hundreds of thousands of emergency attendances and admissions. Lyn Simpson emphasised that the activity figures represented individual patients, families and communities.

It was confirmed that the clinically led Integrated Improvement Plan (IIP) had been developed from the bottom up with Chiefs of Service and clinical teams. Its seven workstreams included leadership, people, quality and safety, with the intended outcomes of a stronger patient voice, improved access and flow, safer care and clearer operational performance.

In terms of key achievements, good inspection outcomes had been achieved for Goole outpatient services, end-of-life care at Grimsby and Scunthorpe, and North Lincolnshire community end-of-life care. Never events had reduced from eight to four, the Section 31 notice had been removed from the Women and Children's Hospital, both Trusts were on plan for the 18-week referral-to-treatment standard, and cancer faster-diagnosis performance at Hull had improved from 53% to 73%. The continuing priority was to sustain improvement and move from National Oversight Framework level 4 towards level 3.

Most patients reported positive experiences, although waiting times and communication delays remained recurring concerns. Deprivation continued to affect access and patient experience. The 2025 staff survey showed improvement in four of nine themes at HUTH and seven of nine at NLaG; the ambition was to improve across all nine themes and ensure that staff felt heard, supported and able to speak up.

Dietmar Harteveld suggested that future presentations should include a greater focus on areas of challenge to ensure that Governors received a balanced view of

organisational performance. Lyn Simpson agreed to consider this approach for future presentations and explained that the intention of the presentation had been to highlight positive achievements, particularly in the context of recent negative media coverage.

Dr Ekta Elston suggested that the links between the IIP and the NHS Ten-Year Plan should be more explicit, particularly the shift from analogue to digital services and from hospital to community care. Lyn Simpson agreed that these links would be strengthened in future versions.

In response to Mike Bateson, Lyn Simpson advised that lower main-theatre activity at NLaG partly reflected activity moving to day-case theatres, GP surgeries and diagnostic centres. Increased emergency attendances were attributed to pressure in primary care, changing patient expectations and more people using Emergency Departments (ED) as their first point of contact. To add context, Dr Ekta Elston reported that across the Humber there were 500,000 GP appointments per month of which 45% were seen on the same day.

A discussion took place regarding the 95,696 missed appointments across the Group. Lyn Simpson agreed that a comprehensive review would be worthwhile, including the reasons for non-attendance and how the rate could be reduced. This would be discussed with the Executive team and added to the audit plan. Emma Sayner added that technology was being used to improve understanding and reduce non-attendance.

2.2 **Financial Report for 2025/26 (for NLaG & HUTH)**

Emma Sayner presented the 2025/26 financial reports and the 2026/27 outlook for each Trust, which remained separate sovereign organisations. Both Trusts had delivered against their revised NHS England (NHSE) financial control totals and had received unqualified audit opinions. Emma Sayner expressed her appreciation to the Finance team for their considerable hard work and commitment.

The adjusted 2025/26 deficit was just over £22 million for HUTH and just over £14 million for NLaG, following technical adjustments and agreement of revised control totals. The underlying recurrent deficits at year end were approximately £79 million for HUTH and £56 million for NLaG. Contributing factors included the withdrawal of deficit-support funding, reliance on non-recurrent savings and income, vacancy-factor assumptions, workforce growth and expenditure increases since the COVID-19 pandemic.

For 2026/27, the Boards-in-Common had approved deficit plans of £39.4 million for HUTH and £23.7 million for NLaG, subject to final agreement and compliance checks with NHSE. At month six, the Group mid-case forecast deficit was approximately £119 million and significant risk remained. The Trusts were working with NHSE, a Financial Improvement Director and Grant Thornton through the intensive recovery programme, with a focus on changing how resources and services were used rather than simply reducing expenditure.

Capital investment during 2025/26 was approximately £76 million at HUTH and £71 million at NLaG. Investment included critical infrastructure, theatres, energy efficiency, Same-Day Emergency Care (SDEC), estate safety, critical care, information management and technology, and electronic patient record work.

Cash balances had reduced due to the deficit and changes in payables; cash management and timely payment of suppliers therefore remained priorities.

In response to a question from Mike Bateson regarding car parking charges, Emma Sayner confirmed that approximately £5 million shown in the accounts related to gross income from car parking and accommodation rather than profit. It was confirmed that the Trust/Group charges benchmarked well against comparable organisations, and transforming outpatient care could reduce the need for hospital visits and associated parking costs.

In response to Dietmar Harteveld, Emma Sayner confirmed that prompt payment of small local non-NHS suppliers remained a personal and Trust/Group priority, although this was becoming increasingly difficult because of the deficit and the absence of an agreed compliant plan.

2.2.1 **Annual External Audit Reports for 2025/26**

a) Sumer Audit for NLaG

Alan Downey welcomed Brian Clerkin, Director of Sumer Audit to the meeting.

Brian Clerkin reported an unqualified audit opinion on NLaG's financial statements and confirmed that the statements provided a true and fair view.

A significant value-for-money weakness had been identified in relation to sufficient financial sustainability. The associated recommendations would be monitored through the Audit, Risk and Governance Committees-in-Common. No further matters required the use of the auditor's statutory reporting powers. Brian Clerkin thanked Emma Sayner and the Finance team for their support throughout the audit.

b) Forvis Mazars for HUTH

Alan Downey introduced Nicola Hallas, Director of Forvis Mazars to the meeting.

Nicola Hallas reported an unqualified audit opinion for HUTH. No matters had arisen from the identified revenue-fraud, management-override or asset-valuation risks. One expenditure amendment had been made and one immaterial mis-statement remained unadjusted.

Five internal-control recommendations had been accepted. Three significant value-for-money weaknesses and one further recommendation had also been reported, including matters relating to financial sustainability. The recommendations would continue to be monitored through the appropriate governance arrangements.

Alan Downey thanked both Brian Clerkin & Nicola Hallas for their reports and welcomed any questions. None were received.

A break took place at 15:37 hours and the meeting resumed at 15:45 hours.

Murray Macdonald assumed the meeting Chair role for this section of the agenda and, on behalf of Therese Patten and himself, expressed appreciation to the CoG

for their continued support, with particular thanks extended to Alan Downey and Lyn Simpson.

3. SERVICE DEVELOPMENTS

3.1 Neighbourhood Health Provision

Helen Phillips, Adam Johnston and Dr Ekta Elston presented plans to integrate primary care, community, mental health, social care and voluntary-sector services around local populations. Neighbourhood health was described as co-ordinated and preventative support organised around local community needs rather than separate organisational pathways.

The objectives included earlier identification of need, reduced inequalities and avoidable demand, more care closer to home, stronger use of community assets and a greater local voice in service design.

Helen Phillips advised that North Lincolnshire was building on its established Community First model. A partnership workshop, hosted by the Safe Care Federation, would be held on 11 November 2026 to define the vision and initial priorities for a neighbourhood plan, which was due to be submitted to the Health and Wellbeing Board for approval in March 2027.

Adam Johnston described the North East Lincolnshire model, comprising healthy neighbourhoods focused on community conditions and resident voice; neighbourhood health focused on population health management, accountability, integrated neighbourhood teams, pro-active care and outpatient transformation; and a delivery plan translating the framework into time-bound actions through to 2030.

Existing foundations included integrated neighbourhood teams, cancer and dementia coordination, multidisciplinary huddles, voluntary-sector involvement, information-sharing work and co-production for Weelsby View as a community-focused neighbourhood health centre.

NAVIGO, on behalf of the Health and Care Partnership, had been selected as a North East Lincolnshire Trailblazer site. The programme was developing an evidence-based and investable business case for up to £10 million of social finance over three years. Repayment and return-on-investment arrangements had not yet been agreed. The target group was adults with the most complex needs; presented data indicated that approximately 1% of the population used 64% of hospital bed days and 3% used between 15% and 80% of GP appointments.

Dr Ekta Elston explained that the five primary care networks would form the NHS neighbourhoods, around which community nursing, community mental health and, in due course, social-care teams could align. The proposed model included co-ordinated support for people with the highest levels of need, step-up virtual-ward support to prevent admissions and community respiratory services to identify and manage conditions such as chronic obstructive pulmonary disease (COPD) outside hospital.

The discussion highlighted transport and accessibility, differing local authority footprints, variation between North and North East Lincolnshire and the need for clear communication with communities. Murray Macdonald and Therese Patten

confirmed their shared commitment to neighbourhood health, noting that this remained a high priority area of work.

In response to Ian Reekie, Helen Phillips confirmed that residents would help determine priorities for North Lincolnshire's five neighbourhoods. Adam Johnston advised that a patient and carer reference group was being considered for the Trailblazer programme.

Dr Ekta Elston confirmed that social care in North East Lincolnshire was actively involved in the partnership groups and Helen Phillips advised that North Lincolnshire Council was working to align social care with its five neighbourhoods.

Murray Macdonald proposed a future Council of Governors presentation or detailed session on Weelsby View and neighbourhood-health implementation to allow further consideration of accessibility, community experience and operational arrangements.

Action: Schedule a future detailed update for the CoG on Weelsby View and neighbourhood-health implementation.

3.2 **Implementation of Decision to Dissolve Humber Health Partnership**

Murray Macdonald, Alan Downey and Therese Patten outlined the rationale and proposed approach for dissolving the HHP, including publication of a summary of the organisational review, seven separation workstreams, protection of safe collaboration and a phased transition towards two locally accountable Trusts.

In advance of the meeting Ian Reekie submitted the following question which framed the information for this agenda item:

> "All we as NLaG Governors know about the Carnall Farrar organisational structure review commissioned by NHSE is that it recommended the dissolution of the Humber Health Partnership. The failure of NHSE to publish the report is disappointing. Without public access to the full context contained in the report, we could well misunderstand the reasoning behind any further content that may start to leak out.
>
> For example, at the Boards-in-Common meeting last week the Interim NLaG Chair revealed what I can only assume to be a Carnall Farrar recommended principle to govern the separation of the two Trusts - namely 'nothing should change unless it needs to change'. This is no doubt a sensible approach in the narrow sense of maintaining collaborative arrangements between the two Trusts that are working well. But more broadly I'm sure fellow Governors will agree that a hell of a lot needs to change if NLaG is to start achieving constitutional standards, to significantly improve the experience of our patients and to rebuild the trust and morale of our workforce.
>
> In particular, I am hopeful that the process of separation can act as a catalyst to accelerate left shift change by moving more services out of our hospitals into community settings.
>
> So, can I ask the Interim NLaG Chair and the Interim Chief Executive how they intend to interpret the 'nothing should change unless it needs to change' maxim?"

In response to Ian Reekie, Murray Macdonald confirmed that NHSE had agreed to publish a summary of the Carnall Farrar review in the following days, which would make the rationale available to Governors, staff and other stakeholders.

Alan Downey advised that the review had concluded that the Group structure had not sufficiently supported the movement of services out of hospital, national standards were not being met consistently, workforce engagement remained a concern, executive roles had an unsustainable span of command and accountability was unclear. The case for two separate Trusts reflected their different services, populations and catchment areas, the scale of the geography and the need for clearer local leadership aligned with local authorities and neighbourhood services.

Murray Macdonald emphasised that the transition would be a deliberate and phased separation rather than an immediate break. Patient safety would be the central test. Existing cross-Humber and tertiary services would continue where joint working provided a stronger or safer service. Each service would be assessed to determine whether it should separate quickly, remain collaborative or be redesigned following further analysis.

An oversight steering group with national, regional and local representation would oversee the transition and determine the tests necessary for the Trusts to operate independently. Seven workstreams would cover areas including finance, strategy, back-office functions, clinical services and service configuration. Leaders from both Trusts and wider stakeholders would consider technical, cultural, operational and financial risks on a service-by-service basis.

No final completion date had been set. The intention was to progress the work within approximately a year and avoid allowing the process to continue indefinitely.

In response to Mike Bateson, Murray Macdonald advised that the Terms of Reference and membership of the oversight and delivery arrangements would be published in Trust Board's public session the following month. Trade-union and local-authority representation was expected, although the role of Governors remained to be defined.

Lyn Simpson added that the Integrated Care Board (ICB), primary care, local authorities and staff-side representatives should contribute to future service design. Dr Ekta Elston emphasised that emerging neighbourhood providers should also be included.

Therese Patten advised that the two organisations would require distinct future strategies reflecting their different populations. The immediate priority was safe disengagement that protected patients and staff. Therese Patten and Lyn Simpson would lead the strategy workstream and consider neighbourhood health, new commissioning intentions and alternative service-delivery models, with implementation phased proportionately.

Jackie Weavill reported that NLaG staff remained unclear about the implications of separation and had concerns about management arrangements, staffing and the likely duration of the process. Therese Patten confirmed that transition principles had been developed to address matters including line-management arrangements, the meaning of safe care and circumstances in which collaboration should

continue. The principles were expected to be launched across the organisation on Friday, 16 October or Monday, 19 October 2026.

4. OTHER

4.1 Questions to the Board of Directors

Questions were welcomed. None were received.

4.2 Items for Information / To Note

The Acronyms and Glossary of Terms were noted at Appendix A.

4.3 Any other Urgent Business

No items were raised within any other urgent business.

5. DATE AND TIME OF THE NEXT MEETING

5.1 Date and Time of the next Council of Governors meeting:

Alan Downey resumed the role of Chairing the meeting from this point.

The next CoG Business Meeting was noted as:

Wednesday, 4 November 2026 at 14:00 - 17:00 hours
In the Boardroom at Diana, Princess of Wales Hospital, Grimsby, DN33 2BA

The next Group Trust Boards-in-Common meeting was noted as:

Thursday, 12 November 2026 at 10:00 – 17:00 hours
In the Boardroom at Diana, Princess of Wales Hospital, Grimsby, DN33 2BA

The Group Chair thanked everyone for attending and their participation and closed the meeting at 16:47 hours.

NLaG CoG Cumulative Record of Governor's / Executive's and NED Attendance 2026/2027 - Public

Governors					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Ahmed Aftab	5	1	Wendy Lawtey	5	4
Kevin Allen	5	3	Corrin Manaley	5	3
Paula Ashcroft	5	0	Cllr Nigel Oliver	2	0
Mike Bateson	5	5	Emma Mundey	2	0
Marian Davison	5	4	Ian Reekie	5	5
Cheryl George	5	3	Caroline Ridgway	5	1
Cllr Anne Handley	5	2	Dr Sandeep Saxena	5	2
Dietmar Harteveld	5	4	Dr Gorajala Vijay	5	3
Brent Huntington	5	4	Jackie Weavill	5	5
David James	5	2	Clare Woodard	5	3

Executives					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Paul Bunyan	2	0	Emma Sayner	3	2
Keith Haynes	3	2	Mr Peter Sedman	5	4
Alison Hurley	5	5	David Sharif	3	1
Jo Ledger	3	1	Lyn Simpson	3	3
Therese Patten	1	1	Dr Kate Wood	2	0
Sam Peate	4	2			

Non-Executive Directors					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Julie Beilby	5	5	Jo Gander	1	1
Alan Downey	5	4	Jane Hawkard	3	1
Paul Edmondson-Jones	1	0	Murray Macdonald	5	3
Dr Ekta Elston	1	1	David Sulch	3	0

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

COUNCIL OF GOVERNORS
ACTION TRACKER

2026/27

ACTION TRACKER - CURRENT ACTIONS - 4 November 2026

COUNCIL OF GOVERNORS

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
COG(26)024	14/10/26	Neighbourhood Health Provision	3.1	Schedule a future detailed update on Weelsby View and neighbourhood-health implementation.	Foundation Trust Office	TBC	Governor Briefing session to be scheduled.		
COG(26)023	20/08/26	Employment Tribunal	2.1	Invite Helen Marks to attend a future private CoG meeting to provide an overview of the Employment Tribunal case, including the outcome of the investigation and the lessons learned.	A Downey / Helen Marks & Foundation Trust Office	TBC	Update requested and awaiting a response		Emails
COG(26)022	20/08/26	Putting Patients First - Ward Accreditation	2.2	Consider a small 15 Step style ward review for NEDs and Governors.	Foundation Trust Office / Michelle Drinkell	TBC	Update requested and awaiting a response		Emails
COG(26)021	20/08/26	Putting Patients First - Ward Accreditation	2.2	Plan a future update of the programme in three months time.	Foundation Trust Office / Michelle Drinkell	Jan-27	Michelle Drinkell advised that the January 2027 CoG meeting would be appropriate for an update		Emails
COG(26)020	20/08/26	Action Tracker	1.6	Circulate the Integrated Improvement Plan and Improvement Update.	A Downey / Foundation Trust Office	Aug-26	The Integrated Improvement Plan and Improvement Update was emailed to Governors on 21 August 2026	Complete	Emails
COG(26)019	16/07/26	Quality & Safety CiC Highlight Report	3.3	A review of the procedure for medical assistance required on hospital sites to be undertaken.	Hilda Gwilliams	Nov-26	Reopened during the 20 August CoG meeting and awaiting an update.		Emails
COG(26)011	15/04/26	Putting Patients First - Ward Accreditation	4.3	Plan a future update of the programme once the pilot phase is complete.	Foundation Trust Office / Michelle Drinkell	Aug-26	Pilot phase May - July 2026 - Michelle Drinkell suggested a further update July or August. On agenda for 20 August 2026 CoG meeting with suggested three month update.	Complete	Emails

Key:

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

ACTION TRACKER - CLOSED ACTIONS

Council of Governors

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
COG(26)020	16/07/26	Questions from Governors	5.1	Request for consideration of free Christmas parking for visitors	Tom Myers	Nov-26	Response from Tom Myers: At this time with the financial challenges that we face and the large CIP gap we have in EF&D we are not in a position to be able to provide free parking over the Christmas period.	Complete	Emails
COG(26)018	16/07/26	Quality & Safety CiC Highlight Report	3.3	Request and provide timetable for addressing the PALS & Complaints backlog	Ben Smith	Jul-26	The PALS Plan on a Page (POP) emailed to Governors on 23 July 2026 along with updates to address the backlog.	Complete	Emails & POP
COG(26)017	16/07/26	Performance, Estates & Finance CiC Highlight Report	3.2	Request for timescales to be included on CiC Highlight Reports - Particularly on long standing items showing little progress	Rebecca Crashley	Jul-26	Rebecca Crashley emailed on 23 July and request noted on 27 July 2026.	Complete	Emails
COG(26)016	16/07/26	Group Chief Executive's Update	2.2	Share the CoG Operational Log issues with the Group Chief Executive's office, as required	Foundation Trust Office	Ongoing	Foundation Trust Office have noted this request and will escalate as required.	Complete	
COG(26)015	16/07/26	Group Chief Executive's Update	2.2	To review the Volunteer role in relation to patient responsibilities (eg. ensuring a discharged patient accesses their arranged transport)	Diane Hughes, Julie Dobbs & Simon Treacher	Nov-26	Julie Dobbs, Voluntary Services Manager, confirmed that part of the Volunteer Guides role is to support a patient who is waiting for transport home, where appropriate.	Complete	Email
COG(26)014	16/07/26	Action Tracker	1.5	Patient Transport - Consider a shuttle service between hospital sites similar to the service at DBTH FT NHS Trust	Tom Myers	Aug-26	Response from Tom Myers: We spent some time early in 2025 looking at various travel options between all Group sites and have discussed these both with the Local Authorities, Stagecoach and other providers. Unfortunately to make them viable for use and running regularly the costs were prohibitive and in the current financial environment are not able to be supported.	Complete	Emails
COG(26)013	16/07/26	Action Tracker	1.5	Provide feedback to Patient Experience regarding suitability of appointment time and distance/travel to appointment	Simon Treacher & Jackie France		Feedback provided via email on 22 July 2026.	Complete	Emails
COG(26)012	16/07/26	Action Tracker	1.5	Ensure contacts details for patient transport services are easily accessible	Comms	Jul-26	Patient transport - Northern Lincolnshire and Goole NHS Foundation Trust Comms advised that there is a page on the Trust website.	Complete	Email and website

COG(26)010	15/04/26	The Group's Plan for Stabilisation	4.1	Arrange Governor briefing session for the Improvement Plan and Cost Improvement Plan	Foundation Trust Office	May/Jun	Governor briefing session delivered on 14 July 2026.	Complete	Emails & Presentations
COG(26)008	15/04/26	Interim Group Chief Executive's Update	2.2	Provide feedback on transport at the July CoG meeting	Lyn Simpson	Jul-26	Update provided by Lyn Simpson during the 16 July CoG meeting.	Complete	July CoG minutes
COG(26)002	08/01/26	Performance, Estates and Finance CiC Highlight Report	3.4	Consider briefing session to review comparative data for the model hospital	Lyn Simpson	Apr-26	Presented at the 16 July 2026 CoG.	Complete	CoG paper CoG(26)062
COG(26)012	15/04/26	Questions from Governors	6.1	Provide an email response to the three Governor questions submitted on 14 April 2026	Foundation Trust Office	Apr-26	An email response was provided on 16 April and 20 April which covered all three questions.	Complete	Emails
COG(26)009	15/04/26	The Group's Plan for Stabilisation	4.1	Request and share the Improvement Plan presentation	Foundation Trust Office	Apr-26	The presentation was shared via email with Governors on 16 April 2026	Complete	Email
COG(26)007	25/02/26	CoG ARM - Summary	4.7	Arrange a Governor briefing session the the Accountability & Holding to Account role	Foundation Trust Office	May-26	Governor Briefing session held on 10 June 2026.	Complete	Emails
COG(26)006	25/02/26	CoG ARM - Conduct of Meetings	4.4	Arrange a Governor briefing with Jason Stamp, Integrated Care Board (ICB) Chair	Foundation Trust Office	May-26	Governor Briefing session held on 27 May 2026.	Complete	Emails
COG(26)003	08/01/26	Quality & Safety Committees-in-Common Highlight Report	3.5	Consider a flowchart to outline where and how clinical decisions are determined	Murray Macdonald	Apr-26	Addressed at the 15 April CoG meeting - agenda item 4.1	Complete	CoG paper: CoG(26)040
COG(26)005	25/02/26	CoG ARM - Accountability	4.3	Share the legal definition of private versus public topics and/or documents	Foundation Trust Office	Feb-26	Legal definition of of private versus public shared via email after the CoG ARM on 25 February 2026.	Complete	Emails
COG(26)004	25/02/26	CoG ARM - Engagement wih Members & Stakeholders	4.2	Plan & progress CoG Patient Administration and Patient Experience project	Foundation Trust Office		This action has been transferred to the Membership and Public Engagement & Assurance Group (MPEAG) for monitoring and management.	Complete	MPEAG Action Tracker & Emails
COG(26)001	08/01/26	Interim Group Chair's Update	2.1	Request an update for the link corridor at SGH which should have opened	Foundation Trust Office	Jan-26	Response provided by Senior Project Manager and shared via email to Governors/NEDs on 14 January 2026.	Complete	Emails

Key:

Grey	Completed - can be closed/archived following meeting

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)091

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	4 November 2026
Director Lead	Murray Macdonald, Interim Chair
Contact Officer/Author	Murray Macdonald, Interim Chair
Title of the Report	**Interim Trust Chair's Update**
Executive Summary	Briefing for the Council of Governors on the key highlights from the recent Trust Boards and current issues
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:

Interim Chair's Update

This is my first report as the Northern Lincolnshire and Goole Hospitals Trust Interim Chair and after only a few weeks I can report that whilst it has been a very busy time I have found the positive welcome from staff, governors and system partners to be uplifting and energising. There is a lot to do in a short space of time to launch the new arrangements for the Trust but I am confident that with the continued support and enthusiasm of colleagues across the Trust that we will be successful.

1. Staff Visits and Conversations

Therese Patten and I have made it a priority since our appointments to actively listen to colleagues across the Trusts and we have spent a considerable amount of time in face to face meetings with anyone who wishes to meet with us. To encourage these conversations we have spent time visiting wards, offices, emergency departments, maternity and facilities engaging with colleagues at all levels. We still have a huge number of invitations to visit across many different teams and therefore our visits and conversations are likely to become a common part of our working week. However, by the end of next week we will have visited every site and met with the majority of teams.

We intend to supplement these informal visits and conversations with a number of formal staff meetings across our sites, spread across different times and with some virtual online sessions to allow the maximum number of colleagues to attend. To supplement these general staff meetings we have added meetings with specific workforce groups such as consultants, nurses, etc. These are in addition to our formal staff side meetings which also continue.

I am of the firm belief that the key to achieving a successful future for NLaG is already in the skills, knowledge, passion and professionalism of the colleagues already here. Over the past four weeks I have been humbled by the deep desire that colleagues across the organisation have to make the changes needed to achieve patient outcomes that we can be proud of and it is our job as leaders to enable our colleagues to succeed.

2. Wider Partnerships

If our staff across the Trust have the energy and vision to succeed we know that in the complex interconnected environment that we operate within solutions often require multi partner input. This is most true when an organisation is facing difficulty, unfortunately it is also true that the natural inclination when facing difficulty is to turn inwards which can create barriers with the very partners who could offer support.

It is because of this that I have prioritised meetings with our system partners and will continue to do so as interim Chair in order to help create the environment for positive partnerships.

In these first few weeks I have met with the political and executive leadership of North and North East Lincolnshire Councils and our elected politicians. I hope to meet with Lincolnshire County Council in the near future. I have met and now have regular meetings with the Chair of the Integrated Care Board (ICB) and have begun

to explore the future commissioning landscape. I have attended the Scunthorpe Neighborhood Board and have future meetings arranged with the leaders of our neighbouring NHS Trusts acute and Ambulance, Care Plus group and Navigo.
As we begin the process of developing our strategic direction it is clear that our ability to work across the wider system, to develop sustainable community and place based approaches that support and enable people to avoid being patients whenever possible will be a key element in our strategy. Building and sustaining genuine partnership relationships will continue to be a key element of my role within the trust.

3. Transition Arrangements

As I arrived in post the NHS had agreed the arrangements by which they would approve the Board's decision to separate. This is based upon the work set out by Carnall Farrar and consists of three layers

a. Workstreams. Overall there are 7 workstreams. These are operational level groups charged with identifying the obstacles to separation and proposing solutions to the Programme Delivery Group. They include Strategy, People, Commissioning, Governance, Clinical, Finance and Communication.
b. Programme Delivery Group. This group is made up of senior executive leadership and wider staff and stakeholder reresentatives. This group is tasked with ensuring that the 7 workstreams are making progress and that the proposed solutions deliver safe and effective outcomes.
c. Transition Steering Group. This is the oversight group and has representation from NHS at national, regional and ICB levels. The Chairs and Chief Executives for both Trusts are members and it has an independent Chair. This groups role is to advice the Boards on key risks and whether the conditions have been met for safe separation.

In putting together these arrangements a number of principles have been agreed which include

a. Patient safety. This is the most important element throughout the transition (and beyond) and for this reason all services will be assessed against this and if the patient outcome is better in a shared service then those arrangements will continue.
b. Equality of representation. At all levels from workstreams to Steering group NLaG and HUTH will have equal representation and input.

As we move through the transition process I will ensure that the Governors are updated regularly and when appropriate consult on service and organisational change.

4. Non-Executive appointments

In order to operate as a stand-alone Board our constitution sets out the requirement to have five non-executive directors (NEDs) in addition to the Chair. We currently have two NEDS in post plus the Chair (plus an associate NED) and therefore need to appoint three.

In consultation with the lead Governor it was agreed that I would initially review the applications that had been submitted during the recent Group wide NED recruitment process. I am currently in the process of doing this and will work with the lead Governor to shortlist and then follow the Trust constitution to interview. If this process does not identify suitable candidates for all three positions we may then need to undertake a further round of recruitment but I am not anticipating this creating any significant delays to a transition.

Murray Macdonald
Interim Chair - NLaG
October 2026

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)092

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	4 November 2026
Director Lead	Therese Patten, Interim Chief Executive - NLaG
Contact Officer/Author	Therese Patten, Interim Chief Executive – NLaG
Title of the Report	**Interim Trust Chief Executive's Update including Group Dissolution**
Executive Summary	This report provides the Council of Governors with an update on a number of areas of work across the Trust and also outlines the last work taking place to dissolve the Humber Health Partnership.
Background Information and/or Supporting Document(s) (if applicable)	
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:

Interim Trust Chief Executive's Update

1. Welcome and initial meetings

After a short time in the Trust I want to thank everyone, including Governors, staff, trade union colleagues and external partners, for the warm welcome I have received which has been much appreciated. I have had a number of meetings and visits in the past three weeks since I started on Wednesday 7th October 2026.

I have had walk rounds, to visit clinical areas and to look at some our estates issues, at both Grimsby and Scunthorpe will a planned visit to Goole next Monday (9th November) and a visit to the main community office in Scunthorpe also in the diary for the end of this month. I've also spent time with the Group Executive Directors, the Care Group Chiefs of Service and other staff from across the partnership. I have arranged to hold two Teams meeting for all staff as well as face to face sessions at each hospital this month. I have also released two videos to talk directly to staff, for which I have received positive feedback, and I plan to do these regularly to update our workforce as we progress plans to dissolve the partnership and become an independent organisation once again.

Externally I, alongside Murray, have also held meetings with some of our local council leaders and chief executives, our local MPs and representatives from other partners in our healthcare system, including the Humber and North Yorkshire Integrated Care Board (ICB). I also attended a meeting with the local Joint Health Overview and Scrutiny Committee in Cleethorpes along with Alan Downey, Group Chair, and Lyn Simpson, Group Chief Executive.

This programme of meetings will continue throughout this month to continue my induction into the Trust.

2. Interim executive team for NLaG

I am pleased to report Emma Sayner, Group Chief Financial Officer (CFO), will be joining the Trust as Chief Financial Officer. Emma is continuing in her group role until Hull University Teaching Hospitals have appointed their own CFO to replace her.

At the time of writing I have shortlisted for a number of the interim executive team roles at the Trust. We had much interest and I spoke to a number of people, from the partnership and from external organisations, who were keen to join us. One of the key requirements I set out for the appointments was that people were able to join us quickly so I may be able to update further in the CoG meeting.

3. Progress on the dissolution of the Humber Health Partnership

I have joined the regular Transition Steering Group and the weekly Programme Delivery Group (PDG) which are the governance arrangements in place to oversee all the work related to the transition from the Humber Health Partnership into an independent Trust. There is representation on the latter of these groups from both NLaG and HUTH as well as trade union colleagues, local authorities, the ICB and clinical staff.

The work is progressing at pace and I was pleased to work with Lyn Simpson to launch the principles we will adhere to during this process through a joint video to all staff. We expect to be able to provide more details about the conditions needed to complete the transition and a timeline for doing it later this month.

As we have stated in the principles it is essential this programme secures clinical input, from medical, nursing and AHP staff, into its decisions to help ensure the quality, safety and continuity of patient care will be protected throughout the transition. Discussions at the PDG have confirmed NLaG and HUTH must be represented equally. We will be establishing a Clinical Reference Group to test emerging findings from the transition and provide clinical advice on them.

4. New patient flow initiative

Initial work to introduce a continuous flow model has started in both DPoW and SGH. It is being implemented to strengthen patient flow and to reduce the risk to undifferentiated patients waiting in the community, in ambulances and in the emergency departments. The model is aiming to bring efficiency to flow, so that patient care is improved by early specialty reviews by getting the patient to the right place at the right time and as per national guidelines. This will be supported by our local healthcare system to ensure we are able to get more patients who don't need to be in hospital discharged, and so we can create space for new patients to come earlier in the day. This work is being implemented gradually as we need to reorganise bed management, operational work and working with partners to facilitate transfers within and out of hospital as well. I will keep you informed over the coming months.

5. Staff survey 2026

The annual staff survey was launched at the start of October and closes on Friday 27th November. I am keen to see as many staff as possible complete the survey to provide me and the new executive team with a good benchmark of where we stand now and the areas we need to focus on. From my discussions with staff so far it is clear they have been through a significant period of change and that this will continue as we dissolve the partnership. At the same time the demand for our services remains very high and we also face significant performance and financial challenges. Taking all this into account my expectations are that the result of this year's survey will be very much in line with the 2025 survey.

Therese Patten
Interim Chief Executive
Wednesday 28th October 2026

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)093

Name of the Meeting	**Council of Governors**
Date of the Meeting	4 November 2026
Director Lead	
Contact Officer/Author	Ian Reekie, Lead Governor
Title of the Report	**Lead Governor's Update**
Executive Summary	The purpose of this report is to update governors on highlights from the Membership and Public Engagement & Assurance Group (MPEAG) meeting held on 22 September 2026 and the Appointments & Remuneration Committee (ARC) meeting held on 24 September 2026. The report also considers the role of governors in developing replacement engagement and accountability mechanisms should the abolition of statutory Foundation Trust membership and Councils of Governors contained in the Health Bill be enacted. It is recommended to Council of Governors: • that highlights from the MPEAG meeting held on 22 September 2026 be noted. • that the MPEAG decision to establish an Engagement Working Group be endorsed. • that highlights from the ARC meeting held on 24 September 2026 be noted.
Background Information and/or Supporting Document(s) (if applicable)	None
Prior Approval Process	None
Financial implication(s) (if applicable)	None
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None
Recommended action(s) required	✓ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

COUNCIL OF GOVERNORS

4 Novembert 2026

Lead Governor's Update

MEMBERSHIP AND PUBLIC ENGAGEMENT & ASSURANCE GROUP (MPEAG) HIGHLIGHTS

The principal item considered at the MPEAG meeting held on Tuesday 22 September was the first draft of a revised Engagement Plan. This outlined various potential initiatives aimed at filling the community feedback and local accountability gap that will be left if the statutory Foundation Trust member/governor model no longer exists following the passage through Parliament of the Health Bill.

MPEAG resolved to establish an Engagement Working Group to give detailed consideration to this draft Engagement Plan. The aim would be to ensure that we leave a lasting legacy if governors are abolished which could take place as early as April 2027. We therefore need to move with some urgency. As a first step a date is being sought for the Working Group to hold an initial meeting with the Interim Chair and Interim Chief Executive to ascertain the appetite of the new NLaG leadership for the development of some form of replacement body to represent the interests of patients and the public which can perpetuate the existing governor role albeit on a non-statutory basis.

APPOINTMENTS & REMUNERATION COMMITTEE (ARC) HIGHLIGHTS

An ARC meeting was held on Thursday 24 September when the following issues were discussed:

- Appointment of Interim NLaG Chair – It was agreed to recommend the appointment of Murray Macdonald as Interim NLaG Chair to the Extraordinary CoG meeting held on 30 September.
- Appointment of Group Senior Independent Director (SID) – It was agreed to recommend the appointment of David Sulch as Group SID to the Extraordinary CoG meeting held on 30 September.
- NED Appraisals – The positive outcomes were noted of the annual appraisals of Murray Macdonald and Julie Beilby both of whose performance was rated as good.

ACKNOWLEDGEMENTS

As this is my final report to CoG prior to standing down after six years as Lead Governor I would like to take the opportunity thank:

- The Chairs/Vice Chairs I have worked with – Terry Moran, Linda Jackson, Sean Lyons, Murray Macdonald and Alan Downey – all of whom have been meticulous in keeping me informed and seeking my advice on key issues affecting governors.
- The many executive directors I have encountered who have been prepared to seek to answer my often naïve questions.
- The Foundation Trust Office – Alison, Suzanne and Katrina – who have always responded positively to my sometimes unreasonable demands.
- Mike Bateson, Deputy Lead Governor, and all my fellow governors for the support they have given me throughout my term of office.

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)094

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	4 November 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 the Report	**Audit, Risk and Governance Committees-in-Common Highlight / Escalation Report – July 2026**
Executive Summary	The attached highlight / escalation report to the July 2026 Trust Boards-in-Common summarises the key matters presented to, and discussed by the meeting of the Audit, Risk and Governance Committees-in-Common on 30 July 2026.
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk and Governance Committees-in-Common Agenda Papers – 30 July 2026
Prior Approval Process	Jane Hawkard, Non-Executive Director / Chair of HUTH Audit, Risk and Governance Committee-in-Common
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

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. 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

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)095

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	4 November 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 the Report	**Performance, Estates & Finance CiC Highlight / Escalation Report**
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 and 29 September 2026 including those matters which the committees specifically wish to escalate to either or both Trust Boards. **Recommendation/s** The Council of Governors are asked to note the contents of the report.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Trust-Boards-in-Common
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 ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

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.	

ADVISE, ALERT and ASSURE REPORT	
Meeting	Performance, Estates and Finance Committees-in-Common
Meeting date	29 September 2026
Chair	Murray Macdonald, Non-Executive Director
Quoracy requirements met	Yes

1. **Key items discussed**

TO ALERT (Areas of non-compliance or matters that need addressing urgently)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Performance				
UEC non-compliance with constitutional standards	Performance was broadly static between July and August with a 1.2% fall in four-hour performance. Twelve-hour waits at HUTH have improved compared with previous years and the continuous flow model is planned for NLAG in October.		Frailty SDEC has recently gone live at HUTH, subject to safety checks and internal professional standards.	
RTT 52+ non-compliance with constitutional	A deep dive was presented showing the Groups waiting list is at its highest level, 18 week	Care Group capacity was raised as a concern by the CiC, particularly	The CiC supported a tactical recovery approach focused on activity, prioritisation,	

standards	performance is off trajectory and 52 week waits have deteriorated.	NLAG with a 35% workforce capacity gap. Further Demand and Capacity model shows 22.2% capacity gap in first appointments (n= 55,549) and 42.1% in follow ups (195,100).	governance and clinical ownership before March 2027. A private Board session was in place to explore the detail and likely risks relating to resource and improvement.	
Cancer 28/62 day non-compliance with constitutional standards	62-day cancer performance at NLAG was static but on plan, while HUTH was also being monitored. 31-day first treatment performance is improving at HUTH. The 28-day faster diagnostic standard is improving and is expected to be delivered during the year.		New appointment of a cancer recovery expert.	
Operational Planning	A revised planning process based on specialty-level demand and capacity was taking place. Methodology included GIRFT approved demand and capacity plan	The CiC expressed the requirements for specialty built plans rather than imposed benchmark data.	The CiC requested that Board members and clinical leaders to be involved earlier so that difficult choices and compromises become collectively owned and	

	aligned with recovery.		defended in national discussions. The CiC approved the approach.	
Finance				
Year to date £55m adverse to plan	The forecasted year-end position remains significantly adverse to plan (£55m), with the most likely scenario indicating a deficit substantially in excess of the agreed plan despite financial recovery support and intervention.	Grant Thornton had undertaken discovery work with Care Groups and was providing 20 people as delivery support alongside Keith Pringle as the Financial Improvement Director.	The CiC agreed right-sizing the substantive establishment and matching staff to demand was fundamental in reducing bank, agency and extra-contractual pay. This was linked to improving UEC and reducing waiting times as this would release funds for under-resourced services. Discussions are ongoing with NHS England in terms of the forecast outturn in 2026/27.	
CIP – Financial Recovery Plan	The risk-adjusted Cost Improvement Programme forecast remains materially behind target, with a significant gap between identified and required savings.	Despite the paper on the financial recovery being included in the report and action notes from the FRP Board being shared with PEF the Non-Executive Directors expressed some concern over a lack of	The CiC noted the need for accelerated delivery through the Financial Recovery Programme. PMO to discuss briefing sessions with NED	

		sufficient visibility of the overall recovery programme on all aspects of performance and needed to understand schemes before signing off future plans.	colleagues ahead of scheduling something with the Board.	
Cash Position	The Group's cash position is challenging because of the deficit, with additional cash support requests required and increasing challenges in maintaining supplier payments.	The CiC agreed to increase the Cash risk to 12.	The CiC escalated the risk to the Group's future ability to meet the cash demands.	
Variable Pay	Agency, bank and other variable pay expenditure remains above trajectory, despite the targeted reduction programmes.		The CiC noted limited movement against the expected reduction target and requested continued Board scrutiny.	
Digital				
EPR delivery challenges	The EPR programme has experienced supplier delivery issues and there is increasing concern regarding likely delays and potential reductions in planned functionality.	Concerns were raised relating to patient safety due to the digital requirements.	The CiC agreed this represents a significant Board-level risk requiring detailed discussion at the planned Board Development session.	

Digital Principles for disestablishment of the Board	The separation of the Group into two organisations requires urgent strategic decisions regarding digital infrastructure, data warehouses, integration engines, server architecture and shared systems.		The CiC agreed this requires Board-level direction as several decisions cannot be deferred without operational risk.	
ADVISE (Areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Estates				
Security Incidents and Violence against Staff	A significant increase in reported security incidents has been observed, particularly at HUTH. This included an 80% increase in violent and aggressive incidents.		The CiC noted the potential workforce impact and the need for continued Board oversight of staff safety and violence reduction measures.	
Linen and Laundry Contract	The proposed extension of the linen and laundry contract introduces a recurring cost pressure of approximately £576k across the Group. This will be managed by a joint innovation programme for cost reduction with the supplier on the volume of units specifically.	Whilst recognising the market constraints and resilience risks within the national supplier market, the committee agreed the financial impact should be made explicit to the Board alongside proposed mitigation through innovation projects	The CiC endorsed the extensions for recommendation to the Board for approval.	

Age Profile of Estates Workforce	Vacancy control and recruitment difficulties have increased estates vacancies, with approximately 25% vacancies at SGH. 42% of the Estates workforce is over 55 and 52% is over 50. It was reported that apprenticeships were being explored.	Some posts have now been approved and advertised, but the vacancy position has impacted reactive maintenance and planned preventative maintenance, particularly after an exaggerated August reduction.	The CiC requested a future paper to include transitional arrangements.	
GPR	The Faster diagnostic standard was highlighted as it was showing improvement and there was high confidence that this metric would be delivered this year.	Showing some improvement, some increased concern. No consistency of movement across the dial.	The CiC agreed that the same metrics did not hit the constitutional standards. The CiC noted that although there had been slight movement, there was no sustained improvements.	
ASSURE (Areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Committee Business				
RL Datix Contract	It was proposed that the contract was renewed on a two-plus-one year basis	This contract meant that a three year cost pressure was reported of £201k	Quantification of the potential benefits was requested, linking job planning and E-Rostering.	

	before the current contract expired.	across the Group.	The CiC gave approval in principle providing the benefits were explored with the Senior Leadership Team.	

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)096

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	4 November 2026
Director Lead	David Sulch, Non-Executive Director Chair of Quality & Safety CiC
Contact Officer/Author	Rebecca Crashley, Deputy Director of Assurance
Title of the Report	**Quality & Safety CiC Highlight Report / Escalation Report**
Executive Summary	This report sets out the items of business considered by the Quality and Safety Committees-in-Common at their meetings held on 23 July and 24 September 2026 including those matters which the committees specifically wish to escalate to either or both Trust Boards. **Recommendation/s** The Council of Governors are asked to note the Triple A escalation report attached.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Trust-Boards-in-Common
Financial implication(s) (if applicable)	All financial implications will be included in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	All EDI implications will be included in the report.
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

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.	

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

1. **Key items discussed**

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

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

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

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

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

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

		taken regarding the new organisational changes and the relevance of the actions against each Trust.	delivery against the warning notices.	
Learning from deaths	SHMI and HSMR positions across the Group were favourable and there was improved SJR oversight.	There had been two Regulation 28 cases involving sepsis and a fall. The cases were currently being investigated.	Clarity was required as to how Urgent Treatment Centres recognise and route patients meeting sepsis criteria.	

ADVISE (Areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)

Issue	Update	Assurance received	Action	Timescale
Quality				
Integrated Performance Report	The IPR remains under development because data sources do not yet align consistently and the current report contains excessive alerts and repetition.		The metrics to be refined before further use at the Committees and the Board.	
Triangulate Themes Report incidents, legal, complaints and PALs.	The report brings together themes from incidents, legal matters, complaints and PALS. It identifies learning and outcomes within each source, and consolidates group-wide themes for action		The CiC supported the shared priorities and learning across the Group and suggested this continued after the dis-establishment of the Group.	

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

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)097

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	4 November 2026
Director Lead	Julie Beilby, Non-Executive Director Chair of WEC Committees-in-Common
Contact Officer/Author	Rebecca Crashley, Deputy Director of Assurance
Title of the Report	**Workforce, Education & Culture CiC Highlight / Escalation Report**
Executive Summary	This report sets out the items of business considered by the Workforce, Education and Culture Committees-in-Common at their meetings held on 22 July and 23 September 2026 including those matters which the committees specifically wish to escalate to either or both Trust Boards. **Recommendation/s** The Council of Governors are asked to note the contents of the escalation report.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Trust Boards-in-Common
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 ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

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.		

ADVISE, ALERT and ASSURE	
Meeting:	Workforce, Education and Culture Committees in Common
Meeting Date:	23 September 2026
Chair:	Julie Beilby, Non-Executive Director
Quorate:	Yes

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Board to areas of non-compliance or matters that need addressing urgently)				
Issue	**Update**	**Assurance received:**	**Action**	**Timescale**
Workforce				
Medical Education and GMC Trainee survey	The two reports were taken together. The issues around the GMC survey were still high risk but there were mitigations in place. There was a low fill rate for Deanery training posts and a floating post was required at DPOW and SGH. Educational and clinical	The CiC supported the paper and requested that all collaborative working highlighting benefits should continue once the Group was dis-established.	Generic induction plan was being developed and work was ongoing with the OD team. Additional trainees were required, along with an increase in the establishment for doctors in training.	

	supervision was discussed as not being consistently allocated. A review of education funding was being undertaken to establish whether allocations were appropriate.			
People strategy Update	The CiC received an update regarding the five IIP workstreams relating to the People Strategy. The workstreams are: - Establish and embed a Group wide safety culture model - Civility and Respect Framework - Equality, diversity and inclusion programme - Single raising concerns framework - Leadership visibility The CiC noted the ongoing challenges with mandatory training.	The CiC agreed that the target and messaging around zero tolerance to bullying should be clear. Targets should be both ambitious and realistic, wording and targets should be reviewed without weakening the zero tolerance ambition	The Boards are requested to ensure any work programmes relating to culture continues collaboratively, once the Group has been dis-established. The Committees-in-Common request that the Trust Boards consider the establishment of an Independent Investigation Team for medical workforce cases to ensure investigations are completed in a timely manner and unnecessary delays are avoided.	
Integrated Workforce Data and Assurance	A new workforce performance pack that combined workforce and finance data into one validated source, enabling the CiC and board to assess vacancies, variable pay,	The CiC heard of strengthened controls for vacancies, variable pay, operational workforce usage, establishments, bank staffing and agency	Workforce control steering group Areas requiring attention were:	

	sickness, turnover, training, appraisals and job planning consistently and triangulate information. The CiC agreed that the report was comprehensive with a focus on data quality and triangulation of data which fed into the IIP and FRP. It was noted that significant improvements had been made in this area of work.	costs. It was emphasised that patient safety was central to the decision making in relation to pausing vacancies. Assurance was provided regarding the significant progress made in aligning workforce and finance data to create a single, reliable source of information. Whilst there is still work to do in relation to variable pay and headcount reduction, the improvements made to date are noteworthy.	- Rolling sickness (4.9%); - Return-to-work compliance remains at 14.1%, with 2,163 reviews overdue - First year turnover is 17.1% - Time to Hire remains amber while the seasonal intake clears The CiC suggested that a Board Development Session may be beneficial to enable a deeper exploration of the workforce data and associated trends.	
WRES	The report highlighted concerns regarding the recruitment pathway and disparity between the interview and appointment outcomes for BAME candidates. The CiC noted the worsening position and the need for focused improvement actions. There were issues raised regarding racism from colleagues and patients, the Board diversity and fear of	Whilst there remains more work to do, the Committee received assurance that the organisations have a clear understanding of the areas requiring improvement, based on the data presented, and the actions needed to address them. The CiC thanked Mano Jamison and Karl Portz for the quality of the reports	The CiC were assured due to the comprehensive action plan in place which covered the following themes: - Development of a Zero Tolerance to Racism framework - Develop and grow the BAME staff Network - Support internationally educated staff - Introduce an inclusive recruitment project and toolkit	

	detriment or negative consequences from using reporting mechanisms.	presented and their leadership and expertise within the BAME and Disability Networks.	- Ensure BAME staff are treated equitably in HR processes - Introduce patient racism SOP - Collaborative working across the organisations to develop inclusivity to BAME staff	
WDES	The under-declaration of disability was raised as an issue along with recruitment and career progression disparities and the pressure felt by disabled colleagues to attend work. The importance and value of the staff networks was emphasized as well as the importance of EDI training attendance. Neurodivergent colleagues were being recognised for their strengths and what they could bring to the organisation.	The CiC reiterated that any form of discrimination is not acceptable. Whilst there remains more work to do, the Committee received assurance that the organisations have a clear understanding of the areas requiring improvement, based on the data presented, and the actions needed to address them.	The CiC were assured due to the comprehensive action plan in place which covered the following themes: - Embed the zero tolerance to Ableism framework - Develop and Grow the Disability Staff Network - Introduce an Inclusive Recruitment Project - Embed the reasonable adjustments for Equity, Accessibility and Confidence Hub (REACH) - Supporting staff who are Neuro Divergent	
Educational Funding – NHS England Education Income	The report emphasised that the additional investment received from NHS England was positive and reflected the role of both	The report set out the complex education funding from NHS England. The Group receives	The CiC noted that NHS England benchmarking was underway and would provide a clearer comparative picture in	

	organisations as teaching hospitals. The report provided assurance that all funding received is spent on educational activities and transferred into relevant services rather than being top-sliced centrally.	approximately £65m education income but provides substantial additional investment, estimated at a minimum of £51m. Assurance was provided that the education funding received by the organisations is being utilised appropriately for educational purposes.	the future.	
Job Evaluation	The CiC received an overview of recent actions regarding Job Evaluation. Work was ongoing under joint arrangements with joint panels but reporting as sovereign bodies. There were capacity issues across the Group, but specifically at NLAG which pre-dated the Group formation. There were ongoing challenges for managers to release trained staff as well as funding requirements, but action plans were in place to address this.	The CiC commended discussions with both NLAG and HUTH JNCC's regarding the openness of partnership working in the future.	A risk was highlighted relating to the requirement for executive approval to introduce a mandatory job description review at least every three years as part of the appraisal process. This would have resource and capacity implications for managers, HR teams and Job Evaluation panels.	

ADVISE (Provide here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Workforce				
Policy harmonisation	The CiC discussed how the recommendation to dissolve the Group changes the priority and governance of policy harmonization, but that it was useful to retain shared work and align to national HR policy developments.		Policy development to retain the strongest aspects of both sovereign organisation's policies. The CQC had been approached regarding this particular area to ensure they are fully sighted on the challenges that the organisation now faces in this area.	
Learning Improvement and Safety Academy	The Report highlighted six key programme deliverables which were aligned with the IIP. A significant risk was escalated relating to workforce capacity, with an unmitigated risk score of 20	The CiC confirmed BAU post Carnall Farrar report and Board decision. The CiC requested that future governance arrangements should clarify which elements of the programme will continue collaboratively following the disestablishment	The six deliverables are: -Support the implementation of a single HHP Improvement Methodology and Assurance Framework - Establish a Board-to-Ward Leadership and Management Development approach - Support the HHP Civility and Respect Framework -A governance led, risk based LISA deployment framework to be established -Development of a patient	

			safety, experience and organisational learning programme -Develop and maintain a high quality learning education service	
ASSURE (Provide any areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Workforce				

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)099

Name of the Meeting	**Council of Governors**
Date of the Meeting	4 November 2026
Director Lead	Keith Haynes, Interim Board Secretary
Contact Officer/Author	Alison Hurley, Group Deputy Director of Assurance
Title of the Report	**Annual Governor Elections and Lead Governor Appointment Update**
Executive Summary	The annual Governor elections have now concluded. All vacant constituency seats were uncontested, with newly appointed and re-elected Governors due to commence their terms of office on 13 November 2026. Due to their decision to stand down one Public Governor will retire on 13 November 2026. The term of office for the current Lead Governor is due to expire in November 2026 and expressions of interest were sought from Public Governors for this role. **Recommendation** The Council of Governors is asked to note: • the elections update • the retirement of one Public Governor • upcoming expressions of interest required for the Appointments and Remuneration Committee (ARC) and the Membership and Public Engagement and Assurance Group (MPEAG) The Council of Governors is asked to ratify: • the appointment of the Lead Governor
Background Information and/or Supporting Document(s) (if applicable)	Trust Constitution
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 ☐ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other – please detail below:

1. Governor Elections Update

1.1 Introduction

The election for East and West Lindsey, North Lincolnshire, North East Lincolnshire public constituencies and the Staff Governor seats was uncontested and candidates will commence in post as of 13 November 2026.

1.2 Elections position to date

The uncontested results are as follows:

East & West Lindsey

3 Vacancies

North East Lincolnshire

David James (re-elected)

Andrew Karvot

North Lincolnshire

Kevin Allen (re-elected)

Caroline Ridgway (re-elected)

Dr Gorajala Vijay (re-elected)

Staff

Mr Ahmed Aftab (re-elected)

Corrin Manaley (re-elected)

Dr Sandeep Saxena (re-elected)

These above results mean that three seats will remain vacant for the East & West Lindsey public constituency as no nominations were received.

1.3 Retirement of Public Governor

The Council of Governors (CoG) are asked to note that one public Governor will be retiring from the Governor role in November 2026, and we would like to thank them for their service representing North Lincolnshire as follows:

Paula Ashcroft (3 years)

2. Lead Governor Appointment

2.1 Introduction

The term of office for the current Lead Governor, Ian Reekie is due to expire in November 2026, and therefore the role required appointment/election. Expressions of interest were sought from public Governors for this role by 5pm on 22 October 2026. We received one expression of interest and can now advise that following this process Dietmar Harteveld has been appointed as the Lead Governor.

2.2 Ratifying the Appointment

As only one expression of interest was received the CoG are asked to ratify the appointment of Dietmar Harteveld as the Lead Governor.

The Lead Governor's term of office will commence from 13 November 2026 for a period of three years or until the end of the Governor's current term of office.

3. Expressions of Interest for Council of Governor Sub-groups

There will be upcoming vacancies within both the Appointments and Remuneration Committee (ARC) and the Membership and Public Engagement and Assurance Group (MPEAG).

Expressions of interest for these roles will be sought via e-mail. Governors wishing to express their interest for these sub-groups need to be aware of the time commitment to attend the relevant meetings.

4. Recommendation

The Council of Governors is asked to note:

- the elections update
- the retirement of one Public Governor
- upcoming expressions of interest required for the Appointments and Remuneration Committee (ARC) and the Membership and Public Engagement and Assurance Group (MPEAG)

The Council of Governors is asked to ratify:

- the appointment of the Lead Governor

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)100

Name of Meeting	**Council of Governors Business Meeting**
Date of the Meeting	4 November 2026
Director Lead	Keith Haynes, Interim Board Secretary
Contact Officer / Author	Alison Hurley, Deputy Director of Assurance
Title of Report	**Trust Constitution - Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)**
Executive Summary	The amendments in the updated version cover the inclusion of a "validity of acts" clause. This is a protective clause which provides that the acts, decisions or proceedings of the Trust remain valid despite a vacancy among Governors or Directors, or a defect in the appointment or election of a Governor or Director. In practical terms, it helps reduce the risk that otherwise lawful decisions could be challenged solely because of a technical vacancy or appointment issue. It would not remove the need to comply with the Trust Constitution and relevant statutory requirements, but it would provide additional assurance in the event of unavoidable vacancies or interim governance arrangements. The following was included in the updated and attached Trust Constitution: 10.4 (Governors) - The validity of any act of the Trust is not affected by any vacancy among the Council of Governors or by any defect in the appointment or election of any Governor. 24.5 (Non-Executive Directors) and 26.4 (Executive Directors) - The validity of any act of the Trust is not affected by any vacancy among the Board of Directors or by any defect in the appointment of any Director.
Background Information and/or Supporting Document(s) (if applicable)	NHS Constitution
Prior Approval Process	Council of Governors' meeting on 20 August 2026 and the Trust Boards-in-Common meeting on 9 October 2026.
Financial Implication(s)	N/A
Implications for equality, diversity and inclusion, including health inequalities	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

Humber Health Partnership

TRUST CONSTITUTION

Document control use only	
Reference	DCM001
Directorate / Care Group	Group Chief Executive Officer Directorate
Version	8.1
Result of last review	Minor Changes
Issue date	28/10/26

Author / Owner Use Only	
Group or Trust specific document	NLaG
Date approved by owner (for minor changes only outside committee)	N/A
Date approved	20/08/26 / 09/10/26
Approving body	Council of Governors / Trust Board
Next full review date	October, 2029
Lead Director	Alan Downey, Group Chair / Lyn Simpson, Group Chief Executive
Document type	Miscellaneous
Author / Contact	Keith Haynes, Interim, Board Secretary
Key words	Trust Constitution

Printed copies valid only if separately controlled

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

United by Compassion:
Driving for Excellence

Contents

Section Page

Contents 2

1. Name 4

2. Principal Purpose 4

3. Powers 4

4. Membership and Constituencies 4

5. Application for Membership 5

6. Public Constituency 5

7. Staff Constituency 5

8. Restriction on Membership 6

9. Annual Members' Meeting 6

10. Council of Governors – Composition 6

11. Council of Governors – Election of Governors 6

12. Council of Governors – Tenure 7

13. Council of Governors – Disqualification and Removal 7

14. Termination of Office and Removal of Governors 8

15. Council of Governors – Duties of Governors 9

16. Council of Governors – Meetings of Governors 9

17. Council of Governors – Standing Orders 9

18. Council of Governors – Referral to the Panel for Advising Governors 10

19. Council of Governors – Conflicts of Interest of Governors 10

20. Council of Governors – Expenses 10

21. Trust Board – Composition 11

22. Trust Board – General Duty 11

23. Trust Board – Qualification for Appointment as a Non-Executive Director (including the Chair) 11

24. Trust Board – Appointment and Removal of Chair and other Non-Executive Directors 12

25. Trust Board – Appointment of Vice Chair 12

26. Trust Board – Appointment and Removal of the Chief Executive and other Executive Directors 13

27. Trust Board – Disqualification 13

28. Trust Board – Meetings 13

29. Trust Board of Directors – Standing Orders 14

30. Trust Board – Liability of Directors 14

31. Trust Board – Conflicts of Interest of Directors 14
32. Trust Board of Directors – Remuneration and Terms of Office 15
33. Committees in Common and Pooled Funds 15
34. Registers 16
35. Registers – Inspection and Copies 16
36. Documents Available for Public Inspection 16
37. Appointing & Removing the NHS Foundation Trust's External Auditor 18
38. Audit, Risk and Governance Committee 18
39. Accounts 18
40. Annual Report, Forward (Operational) Plans and non-NHS Work 19
41. Presentation of the Annual Accounts and Reports to the Governors and Members 20
42. Resolution of Disputes 20
43. Instruments 20
44. Amendment of the Constitution 20
45. Significant Transactions 22
46. Interpretation and Definitions 23
ANNEX 1 – THE PUBLIC CONSTITUENCIES 27
ANNEX 2 – THE STAFF CONSTITUENCY 28
ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS 29
ANNEX 4 – THE MODEL RULES FOR ELECTIONS 32
ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS 72
ANNEX 6 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS 78
ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE TRUST BOARD 96
ANNEX 8 – FURTHER PROVISIONS 116

1. Name

1.1 The name of the foundation Trust is Northern Lincolnshire and Goole NHS Foundation Trust (“the Trust”).

2. Principal Purpose

2.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England (the "Principal Purpose").

2.2 The Trust does not fulfil its Principal Purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3 The Trust may provide goods and services for any purposes related to:

2.3.1 The provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

2.3.2 The promotion and protection of public health.

2.4 Subject to the requirements of paragraph 40.2, the Trust may also carry on activities other than those mentioned in paragraph 2.3 for the purpose of making additional income available in order to better carry on its Principal Purpose.

3. Powers

3.1 The powers of the Trust are set out in the 2006 Act, and within the Health and Care Act 2022, subject to any restrictions in its Licence.

3.2 All the powers of the Trust shall be exercised by the Trust Board on behalf of the Trust.

3.3 Any of these powers may be delegated to a committee of directors or to an executive director.

4. Membership and Constituencies

4.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

4.1.1 a public constituency and

4.1.2 a staff constituency.

5. Application for Membership

5.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust.

5.2 Applications for membership shall be dealt with by the Trust in accordance with the provisions of Annex 8.

6. Public Constituency

6.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

6.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the public constituency.

6.3 The minimum number of members in each area specified as an area for a public constituency is specified in Annex 1.

7. Staff Constituency

7.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided that:

7.1.1 he or she is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least twelve months; or

7.1.2 he or she has been continuously employed by the Trust under a contract of employment for at least twelve months.

7.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised those functions continuously for a period of at least twelve months.

7.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the staff constituency.

7.4 The minimum number of members in the staff constituency is specified in Annex 2.

7.5 An individual who is:

7.5.1 eligible to become a member of the staff constituency, and

7.5.2 invited by the Trust to become a member of the staff constituency, shall become a member of the Trust without an application being made, unless they inform the Trust that they do not wish to do so, in accordance with the process more fully set out in Annex 8.

8. Restriction on Membership

8.1 An individual who is a member of a constituency may not while membership of that constituency continues, be a member of any other constituency.

8.2 An individual who satisfies the criteria for membership of the staff constituency may not become or continue as a member of any constituency other than the staff constituency.

8.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 8.

9. Annual Members' Meeting

9.1 The Trust shall hold an annual members' meeting which shall be open to members of the public. Further provisions about the annual members meeting are set out Annex 6.

10. Council of Governors – Composition

10.1 The Trust shall have a Council of Governors, which shall comprise both elected and appointed governors.

10.2 The composition of the Council of Governors is specified in Annex 3.

10.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency. The number of governors to be elected by each constituency is specified in Annex 3.

10.4 The validity of any act of the Trust is not affected by any vacancy among the Council of Governors or by any defect in the appointment or election of any Governor.

11. Council of Governors – Election of Governors

11.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections, as may be varied from time to time.

11.2 Staff members must liaise with the Trust Secretary and then consult their Line Manager prior to nominating themselves as a Staff Governor. [Note: this is to ensure that staff members have discussed the Governor role commitments with their Line Manager.]

11.3 The Model Rules for Elections, as may be varied from time to time, form part of this Constitution and are attached at Annex 4.

11.4 A variation of the Model Rules by the Department of Health and Social Care shall not constitute a variation of the terms of this Constitution. For the avoidance of doubt, the Trust cannot amend the Model Rules.

11.5 An election, if contested, shall be by secret ballot.

11.6 In the event that a vacancy is not filled by election, or a vacancy arises, the Council of Governors, by agreement at a meeting, may co-opt to that vacancy from a reserved list (as paragraph 11.7) until the next Governor elections, but the co-optee must be from the same constituency as the vacancy.

11.7 A reserved list from the most recent Governor elections will be maintained to allow succession planning and for use as co-optees until the next election process.

12. Council of Governors – Tenure

12.1 Subject to the transitional provisions, governors, both elected and nominated, shall hold office for three years and will be eligible for re-election or re-appointment as applicable at the end of that period.

12.2 A Governor may hold office for no more than three consecutive terms of three years, unless approved by the Council of Governors. An elected Governor may not immediately stand for election again on completion of the maximum term of nine years.

12.3 Should a governor's term of office end before the annual governor election process, the term of office may be extended by the Chair or Trust Secretary.

12.4 An elected governor shall cease to hold office if they cease to be a member of the constituency by which they were elected.

12.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship and / or terminates the appointment.

13. Council of Governors – Disqualification and Removal

13.1 The following may not become or continue as a member of the Council of Governors:

13.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

13.1.2 a person who has made a composition or arrangement with, or granted a Trust deed for, creditors and has not been discharged in respect of it;

13.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed.

13.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

13.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

14. Termination of Office and Removal of Governors

14.1 A governor shall immediately cease to hold office if:

14.1.1 They resign by notice in writing to the Trust Secretary.

14.1.2 They fail to attend half of the council meetings in any financial year, unless the other governors are satisfied that:

- the absences were due to a reasonable cause and
- they will start attending council meetings within such a period as the governors consider reasonable.

14.2 In the case of an elected governor, they cease to be a member of the constituency by whom they were elected.

14.3 In the case of an appointed governor, the appointing organisation withdraws its sponsorship or terminates the appointment.

14.4 Without good reason the governor has failed to undertake any training required by the Council of Governors and / or fails to engage with the development review process for governors as agreed by the Council of Governors.

14.5 They have failed to sign and deliver to the Chair a statement in the form required by the Council of Governors confirming acceptance of the code of conduct and / or complete the Disclosure and Barring Service process within the specified time period.

14.6 They refuse to sign a declaration, in the form specified by the Council of Governors, that they are a member of one of the public constituencies or one of the classes of staff constituency as the case might be and are not prevented from being a member of the Council of Governors.

14.7 Any of the exclusion criteria listed in Annex 5 become applicable.

14.8 They are removed from the Council of Governors by a resolution, approved by a two-thirds majority of the remaining governors, that:

14.8.1 they have committed a serious breach of the code of conduct;

14.8.2 they have acted in a manner detrimental to the interests of the Trust,

14.8.3 the Council of Governors considers that it is not in the best interests of the Trust for that person to continue as governor.

14.9 Where there is any disagreement as to whether the proposal for removal of a governor is justified, an independent assessor agreeable to both parties shall be requested to consider the evidence and conclude whether the proposed removal is reasonable or otherwise.

15. Council of Governors – Duties of Governors

15.1 The general duties of the Council of Governors are:

15.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board;

15.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public within the Trust constituencies and wider integrated health and care system area; and

15.1.3 to assist with collaborative place-based system working.

15.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

15.3 While the business of the Council of Governors is primarily conducted through or with the support of digital platforms, the Trust commits to provide full support to Governors (and candidates to be Governors) who feel unable to use digital platforms to engage in the business of the Council of Governors.

16. Council of Governors – Meetings of Governors

16.1 The Chair or, in the absence of the Chair, the Vice Chair or, in the absence of the Vice Chair, any other Non-Executive Director, shall preside at meetings of the Council of Governors.

16.2 Meetings of the Council of Governors shall be open to members of the public except as provided for in Annex 6.

16.3 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

17. Council of Governors – Standing Orders

17.1 The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are provided for, are attached at Annex 6.

18. Council of Governors – Referral to the Panel for Advising Governors

18.1 The Panel is both independent and national and is appointed by NHSE. Its role is to answer questions raised by the governors of an NHS foundation Trust about whether the Trust has failed or is failing to act in accordance with:

18.1.1 its own Constitution; or

18.1.2 Chapter 5 of the NHS Act 2006.

18.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral. Evidence of the vote will need to be provided to the Panel before it can consider a question from governors. The Panel's remit is to support governors in fulfilling their role in representing the interests of their members and the public. Best interests are served by governors seeking to resolve any questions or issues with their Trust chair and other Non-Executive Directors before posing a question to the Panel. However, the Panel is available as a free resource in the event of continued uncertainty.

19. Council of Governors – Conflicts of Interest of Governors

19.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he or she becomes aware of it. The standing orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

20. Council of Governors – Expenses

20.1 The Trust shall pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

21. Trust Board – Composition

21.1 The Trust Board which shall comprise both Executive and Non-Executive Directors:

21.1.1 a Non-Executive Chair;

21.1.2 five other Non-Executive Directors; and

21.1.3 five Executive Directors.

21.2 One of the Executive Directors shall be the Chief Executive.

21.3 The Chief Executive shall be the accounting officer.

21.4 One of the Executive Directors shall be the Chief Financial Officer.

21.5 One of the Executive Directors shall be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984 (amendment order 2005)).

21.6 One of the Executive Directors shall be a registered nurse or a registered midwife.

22. Trust Board – General Duty

22.1 The general duty of the Trust Board and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

23. Trust Board – Qualification for Appointment as a Non-Executive Director (including the Chair)

23.1 A person may be appointed as a Non-Executive Director only if:

23.1.1 they are a member of a public constituency, or

23.1.2 they can demonstrate close personal or professional links with one or more of the public constituencies, or

23.1.3 they serve as a Non-Executive Director with another NHS body with which the Trust has entered into a Memorandum of Understanding, or

23.1.4 where any of the Trust's hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university, and

23.1.5 they are not disqualified by virtue of paragraph 27 below.

24. Trust Board – Appointment and Removal of Chair and other Non-Executive Directors

24.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors.

24.2 The Council of Governors shall appoint a Chair who is independent. This provision shall exclude anyone who:

- is a former Chief Executive of the Trust.
- has been an employee of the NHS foundation Trust within the last five years.
- has, or has had within the last three years, a material business relationship with the NHS foundation Trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation Trust.
- has received or receives additional remuneration from the NHS foundation Trust apart from a director's fee, participates in the NHS foundation Trust's performance-related pay scheme, or is a member of the NHS foundation Trust's pension scheme;
- has close family ties with any of the NHS foundation Trust's advisers, directors or senior employees;
- holds cross directorships or has significant links with other directors through involvement in other companies or bodies;
- has served on the board for more than nine years from the date of his or her first appointment;
- is an appointed representative of the NHS foundation Trust's university medical or dental school.

[These criteria shall apply only on appointment, thereafter the test of independence is not appropriate in relation to the Chair.]

24.3 Removal of the Chair or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

24.4 Subject to a Memorandum of Understanding, a Non-Executive Director from another NHS body, may undertake the role of Non-Executive Director at the Trust.

24.5 The validity of any act of the Trust is not affected by any vacancy among the Board of Directors or by any defect in the appointment of any director.

25. Trust Board – Appointment of Vice Chair

25.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as Vice Chair.

25.2 The Vice Chair may undertake the role of Vice Chair or equivalent, in accordance with a Memorandum of Understanding with another NHS body.

26. Trust Board – Appointment and Removal of the Chief Executive and other Executive Directors

26.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

26.2 The appointment of the Chief Executive shall require the approval of the Council of Governors. This shall be a subject of the first general meeting after the selection process and prior to the appointment being made.

26.3 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other executive directors.

26.4 The validity of any act of the Trust is not affected by any vacancy among the Board of Directors or by any defect in the appointment of any director.

27. Trust Board – Disqualification

27.1 The following shall not become or continue as a member of the Trust Board:

27.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

27.1.2 a person who has made a composition or arrangement with, or granted a Trust deed for, creditors and has not been discharged in respect of it;

27.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed;

27.1.4 a person who does not satisfy all of the 'fit and proper person' requirements set out in regulation 5(3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, or/

27.1.5 a person who falls within the additional grounds for disqualification set out at Annex 8.

28. Trust Board – Meetings

28.1 Meetings of the Trust Board shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

28.2 Before holding a meeting, the Trust Board must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Trust Board must send a copy of the minutes of the meeting to the Council of Governors.

28.3 The Chair (or Vice Chair) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public such as to ensure that business shall be conducted without interruption and disruption.

28.4 There may be times and reasons why the Trust Board meetings are held 'virtually online' and not in person. The Chair (or Vice Chair) will decide these times in consultation with the Chief Executive.

29. Trust Board of Directors – Standing Orders

29.1 The standing orders for the practice and procedure of the Trust Board, as may be varied from time to time, are attached at Annex 7.

30. Trust Board – Liability of Directors

30.1 The Trust shall indemnify Non-Executive Directors in respect of any personal civil liability they incur as a result of carrying out their duties, provided that they have acted honestly, in good faith and without recklessness.

30.2 The Trust shall indemnify executive directors in respect of any personal civil liability they incur as a result of carrying out their duties, provided that they have acted honestly, in good faith, without recklessness and within the remit of their contractual duties as set out by the Trust.

31. Trust Board – Conflicts of Interest of Directors

31.1 The duties that a director of the Trust has by virtue of being a director include in particular:

31.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust; and

31.1.2 a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

31.2 The duty referred to in sub-paragraph 33.1.1 is not infringed if:

31.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

31.2.2 the matter has been authorised in accordance with the Constitution.

31.3 The duty referred to in sub-paragraph 33.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

31.4 In sub-paragraph 33.1.2, "third party" means a person other than:

31.4.1 the Trust; or

31.4.2 a person acting on its behalf.

31.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

31.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

31.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

31.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

31.9 A director need not declare an interest:

31.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

31.9.2 if, or to the extent that, the Trust Board are already aware of it;

31.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered:

- by a meeting of the Trust Board; or
- by a committee of the directors appointed for the purpose under the Constitution.

32. Trust Board of Directors – Remuneration and Terms of Office

32.1 The Council of Governors at a general meeting of the Council of Governors, following a recommendation by the Appointments & Remuneration Committee for Non-Executive Directors (including Chair, Vice Chair and Senior Independent Director), shall decide the remuneration and allowances, and the other terms and conditions of office, of the Group Chair and the other Non-Executive Directors.

32.2 The Trust shall establish a committee of Non-Executive Directors (the 'Remuneration and Terms of Service Committee') to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

33. Committees in Common and Pooled Funds

33.1 The Trust may form Committees in Common, with two or more providers, to make joint arrangements and pool funds. [Note: Providers means: Trusts, Foundation Trusts, NHSE, Integrated Care Boards and Local Authorities].

34. Registers

34.1 The Trust shall have:

34.1.1 a register of members showing, in respect of each member, the constituency to which they belong;

34.1.2 a register of members of the Council of Governors;

34.1.3 a register of interests of governors;

34.1.4 a register of directors; and

34.1.5 a register of interests of the directors.

34.2 The process of admission to and removal from the register shall be as set out in Annex 8.

35. Registers – Inspection and Copies

35.1 The Trust shall make the registers specified in paragraph 35 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

35.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

35.3 So far as the registers are required to be made available:

35.3.1 they are to be available for inspection free of charge at all reasonable times; and

35.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

35.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

36. Documents Available for Public Inspection

36.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

36.1.1 a copy of the current Constitution:

36.1.2 a copy of the latest annual accounts and of any report of the auditor on them; and

36.1.3 a copy of the latest annual report and quality account;

36.1.4 a copy of the latest Care Quality Commission report and ratings. The Care Quality Commission report will also be available / published on the Care Quality Commission website.

36.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

36.2.1 a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

36.2.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act;

36.2.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act;

36.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

36.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

36.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHSE's decision), 65KB (Secretary of State's response to NHSE's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

36.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

36.2.8 a copy of any final report published under section 65I (administrator's final report);

36.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and

36.2.10 a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act.

36.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

36.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37. Appointing & Removing the NHS Foundation Trust's External Auditor

37.1 The Trust shall have an external auditor.

37.2 The Council of Governors shall appoint or remove the external auditor at a general meeting of the Council of Governors.

37.3 When appointing or removing the external auditor, governors must consider the criteria set out in the 'National Audit Office – Code of Audit Practice. In all matters regarding the appointment, re-appointment, removal, remuneration and terms of engagement of the external auditor, and in discharging its responsibilities in this regard as referred to above, the Council of Governors will be advised by the audit committee.

37.4 Should the Council of Governors not accept the recommendation of the audit committee then the Trust Board shall ensure that the annual report both includes a statement from the audit committee explaining the recommendation and also sets out the reasons why the Council of Governors has taken a different position.

37.5 Should the Council of Governors remove the auditor contrary to the advice of the audit committee then the Chair will advise NHSE in writing of the reasons behind the decision.

38. Audit, Risk and Governance Committee

38.1 The Trust shall establish a committee of Non-Executive Directors as an audit, risk and governance committee to perform such monitoring, reviewing and other functions as are appropriate.

38.2 The Council of Governors may appoint up to one governor (and one governor deputy to cover in their absence) as **observers**.

39. Accounts

39.1 The Trust shall keep proper accounts and proper records in relation to the accounts.

39.2 NHSE may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

39.3 The accounts shall be audited by the Trust's auditor.

39.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHSE may, with the approval of the Secretary of State, direct.

39.5 The functions of the Trust with respect to the preparation of the annual accounts shall as set out in paragraph 25 of schedule 7 of the 2006 Act, shall be delegated to the Accounting Officer.

40. Annual Report, Forward (Operational) Plans and non-NHS Work

40.1 The Trust shall prepare an annual report and send it to NHSE.

40.2 The Trust shall give information as to its forward (operational) planning in respect of each financial year to NHSE.

40.3 The document containing the information with respect to forward (operational) planning (referred to in paragraph 40.2 above) shall be prepared by the directors.

40.4 In preparing the said document with respect to forward (operational) planning, the directors shall have regard to the views of the Council of Governors.

40.5 Each forward (operational) plan must include information about:

40.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and

40.5.2 the income it expects to receive from doing so.

40.6 Where a forward (operational) plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 40.5.1 the Council of Governors must:

40.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its Principal Purpose or the performance of its other functions; and

40.6.2 notify the directors of the Trust of its determination.

40.7 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England may implement the proposal only if more than half of the members of the Council of Governors voting approve its implementation.

41. Presentation of the Annual Accounts and Reports to the Governors and Members

41.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

41.1.1 the annual accounts;

41.1.2 any report of the auditor on them; and

41.1.3 the annual report.

41.2 The documents shall also be presented to the members of the Trust at the annual members' meeting by at least one member of the Trust Board of Directors in attendance.

41.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 41.1 with the annual members' meeting.

42. Resolution of Disputes

42.1 Should a disagreement arise between the Trust Board of Directors and the Council of Governors, such as would impair the decision making process or the successful operation of the Trust, then the Chair shall convene a joint meeting of the two bodies to consider the issue in dispute.

42.2 Should this meeting not resolve the issue then the Chair shall have the authority to make a decision on behalf of the Trust. This decision, and the reasons supporting it, will be communicated in writing to all members of both the Trust Board of Directors and the Council of Governors.

43. Instruments

43.1 The Trust shall have a seal.

43.2 The seal shall not be affixed except under the authority of the Trust Board of Directors and as delegated to the Trust Secretary.

44. Amendment of the Constitution

44.1 The Trust may make amendments of its Constitution only if:

44.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments; and

44.1.2 More than half of the members of the Trust Board of Directors of the Trust voting approve the amendments.

44.2 Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

44.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

44.3.1 At least one member of the Council of Governors must attend the next annual members' meeting and present the amendment; and

44.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

44.4 If more than half of the members voting approve the amendment, the amendment will continue to have effect; otherwise, it will cease to have effect and the Trust must take such steps as are necessary as a result.

44.5 Amendments by the Trust of its Constitution are to be notified to NHSE. For the avoidance of doubt, NHSE's function do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

45. Significant Transactions

45.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors – not just half the number that attends the meeting at which the decision is taken.

45.2 The Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Trust voting approve of the Trust entering into the transaction.

45.3 "Significant Transaction" means:

45.3.1 the acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 25% of the value of the Trust's gross assets before the acquisition; or

45.3.2 the disposition of, or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 25% of the value of the Trust's gross assets before the disposition; or

45.3.3 a transaction that has or is likely to have the effect of the Trust acquiring rights or interests or incurring obligations or liabilities, including contingent liabilities, the value of which is more than 25% of the value of the Trust's gross assets before the transaction.

45.4 For the purpose of this paragraph:

45.4.1 "gross assets" means the total of fixed assets and current assets;

45.4.2 in assessing the value of any contingent liability for the purposes of sub-paragraph 45.3.3, the directors:

- must have regard to all circumstances that the directors know, or ought to know, affect, or may affect, the value of the contingent liability; and
- may rely on estimates of the contingent liability that are reasonable in the circumstances; and
- may take account of the likelihood of the contingency occurring.

45.5 Where the Trust is considering organisational transactions (mergers and acquisitions, transfer and dissolutions) or non-organisational transactions (significant capital investments, joint ventures and private finance initiatives), early engagement with NHSE is required. This process aims to reduce costs and allow Trusts to identify issues prior to committing significant resources to a particular transaction. Further guidance on the process for Trusts to follow when considering such transactions is outlined in the NHSE, Assuring and supporting complex change, Statutory transactions, including mergers and acquisitions, October 2022.

45.6 Where the Trust is undertaking significant transactions / proposals, a report should be presented to the Council of Governors.

46. Interpretation and Definitions

46.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act.

46.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

46.3 References in this Constitution to legislation include all amendments, replacements or re-enactments made in references to paragraph numbers or references to paragraphs of this Constitution unless the context provides otherwise.

46.4 References to legislation include all regulations and statutory guidance.

46.5 Headings are for ease of reference only and are not to affect interpretation.

46.6 If there is a conflict between the provisions of this Constitution and the provisions of any document referred to herein then the provisions of this Constitution shall prevail unless the law requires otherwise.

46.7 References to this paragraph are to paragraphs in this Constitution.

46.8 All Annexes referred to in this Constitution form part of it.

46.9 In this Constitution:

"accounting officer"	is the person who from time to time discharges the functions specified in paragraph 25(5) in Schedule 7 to the 2006 Act
"annual members' meeting"	means the annual meeting of all the members
"appointed governors"	means the local authority governors and the partnership organisation governors
"authorisation"	means the authorisation for the Trust to become an NHS foundation Trust given by Monitor at that time* [*Monitor became part of NHS Improvement as of 1 April 2016] [*NHS Improvement became part of NHS England as of 1 July 2022]
"Trust Board of Directors"	means the Trust Board of Directors of the Trust as constituted in accordance with this Constitution and referred to in paragraph 21
"Group **Chair"**	means the Group Chair of the Trust and Group as appointed in accordance with the Constitution

“Chief Executive”	means the Chief Executive (and Accounting Officer) of the Trust appointed in accordance with paragraph 27
“constituencies”	means the public constituencies and the staff constituency of the Trust
“Constitution”	means this constitution of the Trust
“Council of Governors”	means the Council of Governors of the Trust as constituted in accordance with this Constitution
“deputy lead governor”	means the deputy of the lead governor
“director"	means a director on the Trust Board of Directors
“elected governors”	means the public and staff governors respectively
“election rules”	means the election rules set out in Annex 4 and which are to be used in connection with the election of the elected governors
“executive director”	means an executive director of the Trust
“financial year”	means-: (a) the period beginning with the date on which the Trust is authorised and ending with the next 31st March; and (b) each successive period of twelve months beginning with 1st April
“governor”	means a governor on the Council of Governors and being either an elected governor or an appointed governor
“group”	refers to the partnership established with Hull University Teaching Hospitals NHS Trust under a Memorandum of Understanding
“integrated care board”	means a statutory NHS organisation with responsibility for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area
“integrated care system”	means the partnership between NHS organisations, local councils and others, who take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve

“lead governor”	means the main governor contact in a few specific circumstances in which NHSE may need to contact the council of governors or the other way round (further details on this role are provided within the Standing Orders of the Council of Governors at Annex 6, 1.9)
"Licence"	means the Trust's licence granted by NHSE at the time under the 2012 Act
“member"	means a member of the Trust as determined in accordance with this Constitution
“members’ meetings”	means a meeting of the members
“membership”	means membership of the Trust through being a member of one of the constituencies
“model election rules”	means the model form rules for the conduct of elections published from time to time by the Department of Health and Social Care and as currently set out in Annex 4
“NHSE”	means the regulator for the purposes of the 2006 Act
“Non-Executive Directors”	means a Non-Executive Director of the Trust
“partnership organisation governor”	means a member of the Council of Governors appointed by a partnership organisation referred to in Annex 3
“partnership organisations”	means organisations designated as partnership organisations for the purposes of this Constitution and referred to in Annex 3
“public constituencies”	means that part of the Trust’s membership consisting of members from the area of the public constituency as described in Annex 1
“public governor”	means a member of the Council of Governors elected by the members of a public constituency
“qualifying local authorities”	means those Councils referred to in Annex 3 all of which are Councils for an area which includes the whole or part of the area of the Trust
“qualifying local authority governors”	means a member of the Council of Governors appointed by qualifying local authorities and referred to in Annex 3

“Trust Secretary”	means the Trust Secretary [this role is undertaken within NLAG by the Group Director of Assurance] of the Trust or any other person appointed to perform the duties of a ‘company secretary’
“senior independent director”	means the Non-Executive Director appointed as an alternative point of contact for governors and directors when they have concerns that have not been resolved through the normal channels of Chair, Chief Executive, Chief Financial Officer or Trust Secretary or for which such contact is inappropriate
“staff constituency”	means that part of the Trust’s membership consisting of staff of the Trust and other persons as described in paragraph 7
“staff governor”	means a member of the Council of Governors elected by the staff constituency
“the 2006 Act"	means the National Health Service Act 2006
“the 2022 Act”	means the Health and Care Act 2022
“the Trust”	means the Northern Lincolnshire and Goole NHS Foundation Trust
“transitional provisions”	means those provisions relating to the terms of office of the initial governors as set out in Annex 3
“Vice Chair”	means the Vice Chair of the Trust

ANNEX 1 – THE PUBLIC CONSTITUENCIES

Name of the Public Constituency	Area of the public constituency by Electoral Wards	Minimum number of members	Number of Governors to be elected
North Lincolnshire	The Wards of: Ashby Central; Ashby Lakeside; Axholme Central; Axholme North; Axholme South; Barton; Bottesford; Brigg & Wolds; Broughton & Scawby; Brumby; Burringham & Gunness; Burton upon Stather & Winterton; Crosby & Park; Ferry; Frodingham; Kingsway with Lincoln Gardens; Messingham; Ridge; Town.	500	5
North East Lincolnshire	The Wards of: Croft Baker; East Marsh; Freshney; Haverstoe; Heneage; Humberston & New Waltham; Immingham; Park; Scartho; Sidney Sussex; South; Waltham; West Marsh; Wolds; Yarborough.	500	5
Goole & Howdenshire	The Wards of Goole North; Goole South; Howden; Howdenshire; Snaith, Airmyn & Rawcliffe and Marshlands.	200	3
East & West Lindsey	The Wards of: Binbrook; Fulstow; Grimoldby; Holme; Holton Le Clay and North Thoresby; Legbourne; Louth North Holme; Louth Priory and St James; Louth St Margaret's; Louth St Mary's, Louth St Michael's; Louth Trinity; Mablethorpe; Marshchapel and Somercotes; Sutton on Sea; Tetney; Withern and Theddlethorpe. Caistor and Yarborough; Gainsborough East; Gainsborough North; Gainsborough South West; Hemswell; Kelsey Wold; Scotter and Blyton; Waddingham and Spital; Wold View.	200	3
Rest of England	The Rest of England excluding the areas above	10	0

ANNEX 2 – THE STAFF CONSTITUENCY

There are no classes within the staff constituency.

The minimum number of members in the staff constituency is 150.

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

1. Introduction

1.1 The Council of Governors shall comprise governors who are:

1.1.1 elected by the respective constituencies in accordance with the provisions of this constitution; and

1.1.2 appointed in accordance with paragraph 2 below.

1.2 The Council of Governors shall at all times be constituted so that more than half the Council of Governors shall consist of governors who are elected by members of the Trust other than those who are members of the staff constituency.

2. Bodies entitled to appoint a member of the Council of Governors

2.1 The following bodies in this paragraph 2 shall be entitled to appoint a governor or governors (as the case may be) to the Council of Governors as provided for in this paragraph 2.

2.2 Qualifying Local Authorities

There are four qualifying local authorities covering the areas specified within the Trust's Constitution as a public constituency, as follows:

- East Riding of Yorkshire
- Lincolnshire
- North East Lincolnshire
- North Lincolnshire

2.3 There will be four local authority seats on the Council of Governors for the four qualifying local authorities.

2.4 A governor appointed under paragraph 2.3 above shall then serve on the Council of Governors for the period stipulated in the Constitution.

2.5 Partnership Organisations

2.5.1 Place Health and Care Partnerships (North Lincolnshire and North East Lincolnshire)

2.5.1.1 Place Health and Care Partnerships for North Lincolnshire and North East Lincolnshire shall be entitled to appoint one governor each in accordance with a process of appointment agreed by them with the Trust. The absence of any such agreed process of appointment shall not preclude the said Place Partnerships from appointing their governors provided the appointment is duly made in accordance with the Place Partnerships' own internal processes.

2.5.1.2 If a Place Partnership named in paragraph 2.5.1.1 above declines or fails to appoint a governor within three months of being requested to do so by the Trust, the Trust shall in its absolute discretion be entitled to invite any of those

other Place Partnerships to whom it provides goods and services to appoint a governor in substitution for the Place Partnerships detailed which has failed or declined to do so.

2.5.1.3 If the invitation referred to in paragraph 2.5.1.1 above is accepted by a member or officer of either Place Partnership, they shall be appointed as governor. Any Place Partnership appointment that has previously failed, shall cease to be entitled to do so. The Trust shall give notice of that invitation to NHS England.

2.5.1.4 Subject to paragraph 2.5.1.5 below, if the invitation is not accepted within a reasonable period or such period as may have been specified in the invitation, the Trust shall invite any other such Place Partnership to appoint a governor until the invitation, is accepted and a governor is appointed.

2.5.1.5 Any governor appointed under paragraphs 2.5.1.3 and 2.5.1.4 above shall serve on the Council of Governors for the period stipulated in the constitution. At the end of that period the Trust shall in its absolute discretion decide whether to permit that which had first failed or declined to appoint a governor to do so for the next period of office or to invite the Place Partnership which had appointed a governor in substitution to do so.

2.5.2 Notwithstanding the foregoing provisions of this paragraph, the Trust shall in its absolute discretion be entitled to:

2.5.2.1 give not less than six months' notice to the Place Partnership referred to in paragraphs 2.5.1.1 above (or any substituted Place Partnership appointed under paragraphs 2.5.1.2 and 2.5.1.4 above) terminating their right to appoint a governor and upon the expiration of that notice period or such other date as the Trust and the relevant Place Partnership may agree that Place Partnership right to appoint a governor shall be terminated and the period of office of the governor appointed by that Place Partnership shall also come to an end on that date; and

2.5.2.2 appoint another Place Partnership for which the Trust provides goods and services to replace that Place Partnership to which notice has been given under paragraph 2.5.3 above save that these provisions shall at all times be operated so as to ensure that the number of Place Partnership entitled to appoint a governor remains as provided for in paragraph 2.5.1.1 and 2.5.1.2 above.

2.6 The Composition of the Council of Governors

The composition of the Council of Governors shall be as set out in Table 1 below

Table 1:

	Electing/Appointing Body	Number of Governors
1.	**Public Constituency Governors**	
1.1	North East Lincolnshire Constituency	5
1.2	North Lincolnshire Constituency	5
1.3	East and West Lindsey Constituency	3
1.4	Goole & Howdenshire Constituency	3
2.	**Staff Governors**	4
3.	**Partnership Organisations**	
3.1	North East Lincolnshire Health and Care Partnership	1
3.2	North Lincolnshire Health and Care Partnership	1
4.	**Qualifying Local Authority Governors**	
4.1	East Riding of Yorkshire	1
4.2	Lincolnshire	1
4.3	North East Lincolnshire	1
4.4	North Lincolnshire	1
	Total number of governors	**26**

ANNEX 4 – THE MODEL RULES FOR ELECTIONS

(Paragraph 11 of the Trust Constitution refers)

Part 1 – Interpretation

1. Interpretation

Part 2 – Timetable for election

2. Timetable
3. Computation of time

Part 3 – Returning officer

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election
9. Nomination of candidates
10. Candidate's consent and particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination papers
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination papers
17. Withdrawal of candidates
18. Method of election

Part 5 – Contested elections

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope

26. E-voting systems

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers
30. Lost voting information
31. Issue of replacement voting information
32. Declaration of identity for replacement ballot information
33. Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

36. Receipt of voting documents
37. Validity of votes
38. De-duplication of votes
39. Declaration of identity but no ballot paper
40. Sealing of packets

Part 6 – Counting the votes

41. Single Transferable Vote (STV) - Interpretation of Part 6
42. Arrangements for counting of the votes
43. The count
44. STV - Rejected ballot papers
45. First Past the Post (FPP) - Rejected ballot papers
46. STV - First stage
47. STV - The quota
48. STV - Transfer of votes
49. STV - Supplementary provisions on transfer
50. STV - Exclusion of candidates
51. STV - Filling of last vacancies
52. STV - Order of election of candidates
53. FPP - Equality of votes

Part 7 – Final proceedings in contested and uncontested elections

54. STV - Declaration of result for contested elections
55. FPP - Declaration of result for contested elections
56. Declaration of result for uncontested elections

Part 8 – Disposal of documents

57. Sealing up of documents relating to the poll
58. Delivery of documents
59. Forwarding of documents received after close of the poll
60. Retention and public inspection of documents
61. Application for inspection of certain documents relating to election

Part 9 – Death of a candidate during a contested election

62. STV- Countermand or abandonment of poll on death of candidate
63. FPP - Countermand or abandonment of poll on death of candidate

Part 10 – Election expenses and publicity Expenses

64. Election expenses
65. Expenses and payments by candidates
66. Expenses incurred by other persons

Publicity

67. Publicity about election by the corporation
68. Information about candidates for inclusion with voting information
69. Meaning of “for the purposes of an election”

Part 11 - Questioning elections and irregularities

70. Application to question an election

Part 12 - Miscellaneous

71. Secrecy
72. Prohibition of disclosure of vote
73. Disqualification
74. Delay in postal service through industrial action or unforeseen event

Part 1 – Interpretation

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"corporation" means the public benefit corporation subject to this Constitution;

"election" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;

"the regulator" means the Independent Regulator for NHS foundation trusts; and "the 2006 Act" means the National Health Service Act 2006;

"e-voting" means voting using the internet;

"internet voting system" means such computer hardware and software, data, other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"method of polling" means voting either by post or internet;

"voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting.

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for election

2. Timetable

The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday; or,
(c) a day appointed for public thanksgiving or mourning, shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

4. Returning officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 – Stages Common to Contested and Uncontested Elections

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held;
(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;
(d) the details of any nomination committee that has been established by the corporation;
(e) the address and times at which nomination papers may be obtained;
(f) the address for return of nomination papers and the date and time by which they must be received by the returning officer;
(g) the date and time by which any notice of withdrawal must be received by the returning officer;
(g) the contact details of the returning officer; and,
(h) the date and time of the close of the poll in the event of a contest,

9. Nomination of candidates

9.1 Each candidate must nominate themselves on a single nomination paper.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination paper, and;
(b) is to prepare a nomination paper for signature at the request of any member of the corporation;

but it is not necessary for a nomination to be on a form supplied by the returning officer and it can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination paper must state the candidate's:

(a) full name;
(b) contact address in full; and,
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination paper must state:

(a) any financial interest that the candidate has in the corporation; and,
(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination paper must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the Constitution; and,
(b) for a member of the public constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination paper must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

14.1 Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination paper is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election;
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11;
(d) that the paper does not include a declaration of eligibility as required by rule 12; or,
(e) that the paper is not signed and dated by the candidate, as required by rule 13.

14.3 The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address, and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing, as given in their nomination paper.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

16.1 The corporation is to make the statement of the candidates and the nomination papers supplied by the returning officer under rule 15.4 available for inspection by members of the public free of charge at all reasonable times.

16.2 If a person requests a copy or extract of the statement of candidates or their nomination papers, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

Part 5 – Contested elections

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide if eligible voters, within a constituency, or class within a constituency, may, subject to rule 19.4, cast their vote by any combination of the methods of polling.

19.4 The corporation may decide if eligible voters, within a constituency or class within a constituency, for whom an e-mail mailing address is included in the list of eligible voters may only cast their votes by, one or more, e-voting methods of polling.

19.5 If the corporation decides to use an e-voting method of polling then they and the returning officer must satisfy themselves that:

(a) if internet voting is being used, the internet voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the internet voting record of any voter who chooses to cast their vote using the internet voting system.
(b) if telephone voting is being used, the telephone voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the telephone voting record of any voter who choose to cast their vote using the telephone voting system.
(c) if text message voting is being used, the text message voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the text voting record of any voter who choose to cast their vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation;
(b) the constituency, or class within a constituency, for which the election is being held;
(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) instructions on how to vote by all available methods of polling, including the relevant voters and voter ID number if e-voting is a method of polling;
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll; and,
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public constituencies)

21.1 In respect of an election for a public constituency a declaration of identity must be issued with all ballot information.

21.2 The declaration of identity is to include a declaration:

(a) that the voter is the person to whom the ballot information was addressed;
(b) that the voter has not marked or returned any other voting paper in the election; and,
(c) for a member of the public constituency, of the particulars of that member's qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

21.3 The declaration of identity is to include space for:

(a) the name of the voter;
(b) the address of the voter;
(c) the voter's signature; and,
(d) the date that the declaration was made by the voter.

21.4 The voter must be required to return the declaration of identity together with the ballot information, or complete the electronic declaration prior to voting electronically.

21.5 The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, or if it is not completed prior to electronic voting, the voter's ballot paper may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member, a postal mailing address and if available an e-mail address, where their voting information may be sent.

22.3 The corporation may decide if the voting information is to be sent only by e-mail to those members, in a particular constituency or class within a constituency, for whom an e-mail address is included in the list of eligible voters.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation;
(b) the constituency, or class within a constituency, for which the election is being held;
(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency;
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;
(e) the methods of polling by which votes may be cast at the election by a constituency or class within a constituency as determined by the corporation in rule 19.3;
(f) the address for return of the ballot papers, and the date and time of the close of the poll;
(g) the uniform resource locator (url) where, if internet voting is being used, the polling website is located;
(h) the telephone number where, if telephone voting is being used, the telephone voting facility is located;
(i) the telephone number or telephone short code where, if text message voting is being used, the text message voting facility is located;
(j) the address and final dates for applications for replacement voting information; and,
(k) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following voting information to each member of the corporation named in the list of eligible voters:

(a) by post to each member of the corporation named in the list of eligible voters and on the basis of rule 22 able to cast their vote by post:
   i. a ballot paper and ballot paper envelope;
   (ii) a declaration of identity (if required);
   (iii) information about each candidate standing for election, pursuant to rule 68 of these rules; and,
   (iv) a covering envelope.

(b) by e-mail or by post, to each member of the corporation named in the list of eligible voters and on the basis of rule 19.4 able to cast their vote only by an e-voting method of polling:
   (i) instructions on how to vote;
   (ii) the eligible voter's voter ID number;
   (iii) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate;
   (iv) contact details of the returning officer.

24.2 The documents are to be sent to the mailing address or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it; and,
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer:

(a) the completed declaration of identity if required; and,
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The provision of the polling website and internet voting system will:

(a) require a voter, to be permitted to vote, to enter his voter ID number;
(b) specify:
  (i) the name of the corporation;
  (ii) the constituency, or class within a constituency, for which the election is being held;
  (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency;
  (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;
  (v) instructions on how to vote.
(c) prevent a voter voting for more candidates than they are entitled to at the election;
(d) create a record ("the internet voting record") that is stored in the internet voting system in respect of each vote cast using the internet of:
  (i) the voter ID number used by the voter;
  (ii) the candidate or candidates for whom he has voted; and,
  (iii) the date and time of his vote;
(e) if their vote has been cast and recorded, provide the voter with confirmation;
(f) prevent any voter voting after the close of poll.

26.5 The provision of a telephone voting facility and telephone voting system, will:

(a) require a voter to be permitted to vote, to enter his voter ID number;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held
  (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote.

(c) prevent a voter voting for more candidates than he is entitled to at the election;

(d) create a record ("the telephone voting record") that is stored in the telephone voting system in respect of each vote cast by telephone of-
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote

(e) if their vote has been cast and recorded, provide the voter with confirmation;

(f) prevent any voter voting after the close of poll.

26.6 The provision of a text message voting facility and text messaging voting system, will:

(a) require a voter to be permitted to vote, to provide his voter ID number;

(b) prevent a voter voting for more candidates than he is entitled to at the election;

d) create a record ("the text voting record") that is stored in the text messaging voting system in respect of each vote cast by text message of:
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote

(e) if their vote has been cast and recorded, provide the voter with confirmation;

(f) prevent any voter voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

29. Spoilt ballot papers

29.1 If a voter has dealt with their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless:

(a) satisfied as to the voter's identity; or,
(b) the declaration of identity, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter and confirmation of the voter's identity;
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it); and,
(c) the details of the unique identifier of the replacement ballot paper.

30. Lost voting information

30.1 Where a voter has not received their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information for lost voting information unless they:

(a) are satisfied as to the voter's identity;
(b) have no reason to doubt that the voter did not receive the original voting information;
(c) has ensured that the declaration of identity if required has not been returned.

30.3 After issuing replacement voting information, the returning officer shall enter in a list ("the list of lost ballots"):

(a) the name of the voter;
(b) the details of the unique identifier of the replacement ballot paper; and,
(c) if applicable, the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, they are also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list ("the list of tendered ballot papers"):

(a) the name of the voter; and,
(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

32. Declaration of identity for replacement voting information (public constituencies)

32.1 In respect of an election for a public constituency a declaration of identity must be issued with all replacement ballot information.

32.2 The declaration of identity is to include a declaration:

(a) that the voter has not voted in the election with any ballot information other than the ballot information being returned or completed with the declaration; and,
(b) of the particulars of that member's qualification to vote as a member of the public constituency, or class within a constituency, for which the election is being held.

32.3 The declaration of identity is to include space for:

(a) the name of the voter;
(b) the address of the voter;
(c) the voter's signature; and,
(d) the date that the declaration was made by the voter.

32.4 The voter must be required to return or electronically complete the declaration of identity together with the ballot paper.

32.5 The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, or electronically completed prior to e-voting, the replacement ballot information may be declared invalid.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast their vote using the internet the voter must gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter must enter their voter ID number.

33.3 If the internet voting system authenticates the voter ID number the system must give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast their vote the voter may then key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast their vote.

33.5 The voter must not be able to access the internet voting facility for an election once their vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast their vote by telephone the voter must gain access to the telephone voting facility by calling the designated telephone number provided on the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter must enter their voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter must be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his vote by keying in the code of the candidate or candidates, allocated in accordance with Part Five of these rules, for whom they wish to vote.

34.5 The voter must not be able to access the telephone voting facility for an election once their vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast their vote by text the voter must gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided on the voter information.

35.2 The text message sent by the voter must contain their voter ID number and the code for the candidate or candidates, for whom they wish to vote.

35.3 The text message sent by the voter must be structured in accordance with the instructions on how to vote contained in the voter information.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives a:

(a) covering envelope; or,
(b) any other envelope containing a declaration of identity if required, a ballot paper envelope, or a ballot paper, before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any ballot paper covering envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted; or,
(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, they should:

(a) put the declaration of identity if required in a separate packet; and,
(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, they should:

(a) mark the ballot paper “disqualified”;
(b) if there is a declaration of identity accompanying the ballot paper, mark it as “disqualified” and attach it the ballot paper;
(c) record the unique identifier on the ballot paper in a list (the “list of disqualified documents”); and,
(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet, telephone or

text voting record has been received by the returning officer before the close of the poll.

38. De-duplication of votes

38.1 Where a combination of the methods of polling are being used, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in an election.

38.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in an election they shall:

(a) only accept as duly returned the first vote received that contained the duplicated voter ID number;

(b) mark as "disqualified" all other votes containing the duplicated voter ID number

38.3 Where a ballot paper is "disqualified" under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) record the unique identifier and voter id number on the ballot paper in a list (the "list of disqualified documents"); and

(c) place the ballot paper in a separate packet.

38.4 Where an internet, telephone or text voting record is "disqualified" under this rule the returning officer shall:

(a) mark the record as "disqualified",

(b) record the voter ID number on the record in a list (the "list of disqualified documents".

(c) disregard the record when counting the votes in accordance with these Rules.

39. Declaration of identity but no ballot paper (public constituency) – Where the returning officer receives a declaration of identity if required but no ballot paper:

(a) mark the declaration of identity "disqualified";
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity has been received from the voter without a ballot paper; and,
(c) place the declaration of identity in a separate packet.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it;
(b) the declarations of identity if required;
(c) the list of spoilt ballots;
(d) the list of lost ballots;
(e) the list of eligible voters;
(e) the list of tendered ballots; and,
(f) complete electronic copies of records referred to in rule 26 held in a device suitable for the purpose of storage.

Part 6 – Counting the votes

Note: the following rules describe how the votes are to be counted manually but it is expected that appropriately audited vote counting software will be used to count votes where a combination of methods of polling is being used and votes are contained as electronic e-voting records and ballot papers.

41. Single Transferable Vote (STV) - Interpretation of Part 6

In part 6 of these rules:

"ballot" means a ballot paper, internet voting record, telephone voting record or text voting record;

"continuing candidate" means any candidate not deemed to be elected, and not excluded;

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates;

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll;

"mark" means a figure, an identifiable written word, or a mark such as "X";

"non-transferable vote" means a ballot:

(a) on which no second or subsequent preference is recorded for a continuing candidate; or,
(b) which is excluded by the returning officer under rule 49 - STV below;

"preference" as used in the following contexts has the meaning assigned below:

(a) “first preference” means the figure “1” or any mark or word which clearly indicates a first (or only) preference;
(b) “next available preference” means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and,
(c) in this context, a “second preference” is shown by the figure “2” or any mark or word which clearly indicates a second preference, and a third preference by the figure “3” or any mark or word which clearly indicates a third preference, and so on;

“quota” means the number calculated in accordance with rule 46 - STV below;

“surplus” means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballots from the candidate who has the surplus;

“stage of the count” means:

(a) the determination of the first preference vote of each candidate;
(b) the transfer of a surplus of a candidate deemed to be elected; or,
(c) the exclusion of one or more candidates at any given time;

“transferable vote” means a ballot on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate;

“transferred vote” means a vote derived from a ballot on which a second or subsequent preference is recorded for the candidate to whom that ballot has been transferred; and,

“transfer value” means the value of a transferred vote calculated in accordance with rules 47.4 - STV or 47.7 - STV below

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

43. The count

43.1 The returning officer is to:

(a) count and record the number of votes that have been returned; and,
(b) count the votes according to the provisions in this Part of the rules.

43.2 The returning officer, while counting and recording the number of votes and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or a voter's voter ID number.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

44. STV - Rejected ballot papers

44.1 STV - Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;
(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate;
(c) on which anything is written or marked by which the voter can be identified except the unique identifier; or,
(d) which is unmarked or rejected because of uncertainty;

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

44.2 STV – The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

44.3 STV - The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule 44.1 - STV

44. First Past the Post (FPP) - Rejected ballot papers

44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;
(b) on which votes are given for more candidates than the voter is entitled to vote;
(b) on which anything is written or marked by which the voter can be identified except the unique identifier; or,
(c) which is unmarked or rejected because of uncertainty;

shall, subject to rules 44.2- FPP and 44.3 - FPP, be rejected and not counted.

44.2 FPP - Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

44.3 FPP - A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place;
(b) otherwise than by means of a clear mark;
(c) by more than one mark;

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

44.4 FPP - The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted; and
(b) in the case of a ballot paper on which any vote is counted under rules 44.2 - FPP and 44.3 - FPP, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

44.5 FPP - The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to;
(c) writing or mark by which voter could be identified; and,
(d) unmarked or rejected because of uncertainty;

and, where applicable, each heading must record the number of ballot papers rejected in part.

45. STV - First stage

45.1 STV - The returning officer is to sort the ballots into parcels according to the candidates for whom the first preference votes are given.

45.2 STV - The returning officer is to then count the number of first preference votes given on ballots for each candidate, and is to record those numbers.

45.3 STV - The returning officer is to also ascertain and record the number of valid ballots.

46. STV - The quota

46.1 STV - The returning officer is to divide the number of valid ballots by a number exceeding by one the number of members to be elected.

46.2 STV - The result, increased by one, of the division under rule 46.1 - STV (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

46.3 STV - At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules 47.1 - STV to 47.3 - STV has been complied with.

47. STV - Transfer of votes

47.1 STV - Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballots on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballots for any continuing candidate; or,
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.2 STV - The returning officer is to count the number of ballots in each parcel referred to in rule.

47.3 STV - The returning officer is, in accordance with this rule and rule 48 - STV, to transfer each sub-parcel of ballots referred to in rule 47.1(a) - STV to the candidate for whom the next available preference is given on those papers.

47.4 STV - The vote on each ballot transferred under rule 47.3 - STV shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus; and,
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballots on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

47.5 STV - Where at the end of any stage of the count involving the transfer of ballots, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballots in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballots for any continuing candidate; or,
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.6 STV - The returning officer is, in accordance with this rule and rule 48 - STV, to transfer each sub-parcel of ballots referred to in rule 47.5(a) - STV to the candidate for whom the next available preference is given on those ballots.

47.7 STV - The vote on each ballot transferred under rule 47.6 - STV shall be at:

(a) a transfer value calculated as set out in rule 47.4(b) - STV; or,
(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

47.8 STV - Each transfer of a surplus constitutes a stage in the count.

47.9 STV - Subject to rule 47.10 - STV, the returning officer shall proceed to transfer transferable ballots until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

47.10 STV - Transferable ballots shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are**:**

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote; or,
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

47.11 STV - This rule does not apply at an election where there is only one vacancy.

48. **STV - Supplementary provisions on transfer**

48.1 STV - If, at any stage of the count, two or more candidates have surpluses, the transferable ballots of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballots of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first; and,
(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballots of the candidate on whom the lot falls shall be transferred first.

48.2 STV - The returning officer shall, on each transfer of transferable ballots under rule 47 - STV:

(a) record the total value of the votes transferred to each candidate;
(b) add that value to the previous total of votes recorded for each candidate and record the new total;
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes; and,
(d) compare**:**
    (i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes; with,
    (ii) the recorded total of valid first preference votes.

48.3 STV - All ballots transferred under rule 47 - STV or 48 - STV shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot or, as the case may be, all the ballots in that sub-parcel.

48.4 STV - Where a ballot is so marked that it is unclear to the returning officer at any stage of the count under rule 47 - STV or 48 - STV for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot as a non-transferable vote; and votes on a ballot shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

49. STV - Exclusion of candidates

49.1 STV - If:

(a) all transferable ballots which under the provisions of rule 47 – STV (including that rule as applied by rule 49.11 - STV and this rule are required to be transferred, have been transferred; and,
(b) subject to rule 50 - STV, one or more vacancies remain to be filled;

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule 49.12 - STV applies, the candidates with the then lowest votes).

49.2 STV - The returning officer shall sort all the ballots on which first preference votes are given for the candidate or candidates excluded under rule 49.1 - STV into two sub-parcels so that they are grouped as:

(a) ballots on which a next available preference is given; and,
(b) ballots on which no such preference is given (thereby including ballots on which preferences are given only for candidates who are deemed to be elected or are excluded).

49.3 STV - The returning officer shall, in accordance with this rule and rule 48 - STV, transfer each sub-parcel of ballots referred to in rule 49.2 - STV to the candidate for whom the next available preference is given on those ballots.

49.4 STV - The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

49.5 STV - If, subject to rule 50 - STV, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballots, if any, which had been transferred to any candidate excluded under rule 49.1 - STV into sub- parcels according to their transfer value.

49.6 STV - The returning officer shall transfer those ballots in the sub-parcel of transferable ballots with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballots (thereby passing over candidates who are deemed to be elected or are excluded).

49.7 STV - The vote on each transferable ballot transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

49.8 STV - Any ballots on which no next available preferences have been expressed shall be set aside as non-transferable votes.

49.9 STV - After the returning officer has completed the transfer of the ballots in the sub-parcel of ballots with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballots with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

49.10 STV - The returning officer shall after each stage of the count completed under this rule:

(a) record:
  (i) the total value of votes; or,
  (ii) the total transfer value of votes transferred to each candidate;
(b) add that total to the previous total of votes recorded for each candidate and record the new total;
(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total; and,
(d) compare:

  (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes; with,
  (ii) the recorded total of valid first preference votes.

49.11 STV - If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules 47.5 - STV 47.10 - STV and rule 48 - STV.

49.12 STV - Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

49.13 STV - If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest**:**

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded; and,
(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

50. STV - Filling of last vacancies

50.1 STV - Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

50.2 STV - Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to

other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

50.3 STV - Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

51. STV - Order of election of candidates

51.1 STV - The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule 47.10 - STV.

51.2 STV - A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

51.3 STV - Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

51.4 STV - Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

51. FPP - Equality of votes

51.1 FPP - Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 – Final proceedings in contested and uncontested elections

52. STV - Declaration of result for contested elections

52.1 STV - In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected;
(b) give notice of the name of each candidate who they have declared elected:

(i) where the election is held under a proposed Constitution pursuant to powers conferred on the Northern Lincolnshire and Goole Foundation NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust; or,
(ii) in any other case, to the Chair of the corporation; and,

(c) give public notice of the name of each candidate who they have declared elected.

52.2 STV - The returning officer is to make**:**

(a) the number of first preference votes for each candidate whether elected or not;
(b) any transfer of votes;
(b) the total number of votes for each candidate at each stage of the count at which such transfer took place;
(d) the order in which the successful candidates were elected; and,
(e) the number of rejected ballot papers under each of the headings in rule STV- 44.1,
available on request.

52. FPP - Declaration of result for contested elections

52.1 FPP - In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected;

(b) give notice of the name of each candidate who they have declared elected:
(i) where the election is held under a proposed constitution pursuant to powers conferred on the Northern Lincolnshire and Goole Foundation NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or
(ii) in any other case, to the Chair of the corporation; and,

(b) give public notice of the name of each candidate whom they have declared elected.

52.2 FPP - The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not); and,
(b) the number of rejected ballot papers under each of the headings in rule 44.5 - FPP, available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected;
(b) give notice of the name of each candidate who they have declared elected to the Chair of the corporation; and,
(c) give public notice of the name of each candidate who they have declared elected.

Part 8 – Disposal of documents

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers;
(b) the ballot papers endorsed with “rejected in part”;
(c) the rejected ballot papers;
(d) papers; and,
(e) the complete electronic copies of records referred to in rule 26 held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it;
(b) the list of spoilt ballot papers;
(c) the list of lost ballots;
(d) the list of eligible voters;
(e) the complete electronic copies of records referred to in rule 26 held in a device suitable for the purpose of storage; and,
(f) the list of tendered ballot papers.

54.3 The returning officer must endorse on each packet a description of**:**

(a) its contents;
(b) the date of the publication of notice of the election;
(c) the name of the corporation to which the election relates; and,
(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 54, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll; or,
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent; or,
(c) any applications for replacement voter information is made too late to enable new ballot papers to be issued.

The returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow the inspection of, or the opening of any sealed packet containing:

(a) any rejected ballot papers, including ballot papers rejected in part;
(b) any disqualified documents, or the list of disqualified documents;
(c) any counted ballot papers;
(d) any declarations of identity;
(e) the list of eligible voters; or,
(f) the complete electronic copies of records referred to in rule 26 held in a device suitable for the purpose of storage by any person without the consent of the Regulator.

58.2 A person may apply to the Regulator to inspect any of the documents listed in rule 58.1, and the Regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The Regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to:

(a) persons;
(b) time;
(c) place and mode of inspection;
(d) production or opening, and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1:

(a) in giving its consent, the regulator, and
(b) making the documents available for inspection, the corporation, must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that their vote was given; and,
(ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

59. STV - Countermand or abandonment of poll on death of candidate

59.1 STV - If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died; and,

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that:

(i) ballots which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted; and,

(ii) ballots which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

59.2 STV - The ballots which have preferences recorded for the candidate who has died are to be sealed with the other counted ballots pursuant to rule 54.1(a).

59. FPP - Countermand or abandonment of poll on death of candidate

59.1 FPP - If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class; and,
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

59.2 FPP - Where a new election is ordered under rule 59.1 - FPP, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

59.3 FPP - Where a poll is abandoned under rule 59.1(a) - FPP, rules 59.4 - FPP to 59.7 - FPP are to apply.

59.4 FPP - The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 37 and 38, and is to make up separate sealed packets in accordance with rule 39.

59.5 FPP - The returning officer is to:

(a) count and record the number of ballot papers that have been received; and,
(b) seal up the ballot papers into packets, along with the records of the number of ballot papers;
(c) seal up the electronic copies of records that have been received referred to in rule 26 held in a device suitable for the purpose of storage.

59.6 FPP - The returning officer is to endorse on each packet a description of:

(a) its contents;
(b) the date of the publication of notice of the election;
(c) the name of the corporation to which the election relates; and,
(d) the constituency, or class within a constituency, to which the election relates.

59.7 FPP - Once the documents relating to the poll have been sealed up and endorsed pursuant to rules 59.4 - FPP to 59.6 - FPP, the returning officer is to deliver them to the Chair of the corporation, and rules 57 and 58 are to apply.

Part 10 – Election expenses and publicity

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the regulator under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to

(a) personal expenses;
(b) travelling expenses, and expenses incurred while living away from home; and,
(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or their family any money or property (whether a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates; and,
(b) organise and hold such meetings to enable the candidates to speak and respond to questions, as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be**:**

(a) objective, balanced and fair;
(b) equivalent in size and content for all candidates;
(c) compiled and distributed in consultation with all of the candidates standing for election; and,
(d) must not seek to promote or procure the election of a specific candidate or candidates, the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words;
(b) a photograph of the candidate;
(c) an optional video statement may also be submitted.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of their own services voluntarily, on their own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to the Regulator by:

(a) a person who voted at the election or who claimed to have had the right to vote; or,
(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity; and,
(b) be in such a form as the Regulator may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If the Regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 The Regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the Regulator.

66.8 The determination by the person or persons nominated in accordance with rule 64.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency including all the candidates for the election to which the application relates.

66.9 The Regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

67. Secrecy

67.1 The following persons:

(a) the returning officer;
(b) the returning officer's staff, must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voter information or who has or has not voted;
(ii) the unique identifier on any ballot paper;
(iii) the voter ID number allocated to any voter;
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter id number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is**:**

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in**:**

(a) the delivery of the documents in rule 24; or,
(b) the return of the ballot papers and declarations of identity;

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

1. Council of Governors: Terms of Office (see also Section 13)

1.1 A Governor:

1.1.1 shall cease to hold office if:

(a) they cease to be a Member of a Trust constituency or, in the case of an Appointed Governor, if the body which appointed them withdraws its appointment at any time;

(b) their term of office is terminated in accordance with paragraph 3 below and/or they are disqualified from or are otherwise ineligible to hold office as a Governor; or

1.1.2 they resign by notice in writing to the Trust.

1.2 Notwithstanding the provisions of paragraph 1.1.1(a) above, a Public Governor elected by a Public Constituency who ceases to be eligible to be a Member of that Public Constituency but who is eligible to be and forthwith becomes a Member of another Public Constituency shall not by virtue of paragraph 1.1.1(a) above cease to hold office but shall continue in office as Public Governor for the Constituency which elected them for the remainder of the term for which he was elected.

2. Council of Governors: Nomination of, Disqualification and Removal

2.1 In addition to those provisions in Section 13 of the Constitution, the following persons shall not become or continue to be eligible as a member of the Council of Governors:

2.1.1 anyone who is a director or chair of the Trust or a governor of another healthcare Trust or equivalent NHS funded provider.

2.1.2 persons defined as a vexatious complainant or litigant, as determined by the Trust Chair, Chief Executive and Trust Secretary (two out of the three have to agree).

2.1.3 staff and appointed governors with current disciplinary action, ongoing investigations, or who have a disciplinary sanction still in force will not be permitted to be elected, or if already elected carry out the role of a governor.

2.1.4 members who have been dismissed otherwise than by reason of redundancy or ill health from any paid employment with a health service body.

2.1.5 whilst the Trust will not automatically reject nominations for potential governors based on previous adverse employment / relationships issues with the Trust or other organisations, it does reserve the right to reject / not support applications if it believes that such an appointment would not support the Trust's culture or values. This decision will be made by Trust Chair, Chief Executive and Trust Secretary (two out of the three have to agree). Each case will be considered on a case by case basis.

2.1.6 persons whose name appears or is added to the Sex Offenders Register, of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and / or the Children and Young Person's Act 1933-and updated in 2008.

2.1.7 a person whose tenure of office as the Chair, governor or director of a health service body has been terminated on the grounds that the appointment was not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

2.1.8 anyone who is suffering from a mental disorder and is either admitted to hospital in pursuance of an application for admission for treatment under the Mental Health Act 1983 or is subject to an order made by a court having jurisdiction in matters concerning mental disorder for detention or for the appointment of a receiver; and is, therefore, incapable by reason of mental disorder of carrying out the duties of a governor.

2.1.9 has failed to make, or has falsely made, any declaration as required to be made under Section 60 of the 2006 Act or has spoken or voted in a meeting on a matter in which they have direct or indirect pecuniary or nonpecuniary interest and they are judged to have acted so by a majority of not less than 75% of the Council of Governors at a meeting;

2.1.10 NHSE has exercised its powers to remove them as a Governor of the Trust or has suspended them from office or has disqualified them from holding office as a Governor of the Trust for a specified period or NHSE has exercised any of those powers in relation to them on any other occasion whether in relation to the Trust or some other NHS Foundation Trust;

2.1.11 has within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

2.1.12 their term of office is terminated pursuant to paragraph 3 below;

2.1.13 is a Member of a Staff Class and any professional registration relevant to his eligibility to be a Member of that Staff Class has been suspended for a continuous period of more than six months;

2.1.14 the relevant organisation which they represents ceases to exist;

2.1.15 is a member of the UK Parliament;

2.1.16 is a Director of the Trust.

2.2 Where a person has been elected or appointed to be a Governor and they become disqualified from that appointment they shall notify the Trust Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of first becoming aware of those matters which rendered them disqualified.

2.3 If it comes to the notice of the Trust that a Governor is disqualified, the Trust shall immediately declare them disqualified and shall give them notice in writing to that effect as soon as practicable.

2.4 Upon the giving of notice under paragraphs 2.2 and 2.3 above, that person's tenure of office as a Governor shall thereupon be terminated and they shall cease to be a Governor and their name shall be removed from the Register of Governors.

2.5 If a complaint is received against a member of the Council of Governors, it shall be referred to the Chair who will address the complaint appropriately based on a case by case basis in liaison with the Trust Secretary and/or Director of People as necessary.

2.5.1 the Chair upon receipt of the complaint may carry out an investigation and may suspend the Governor from duties. If the outcome of the investigation is to terminate the Governor, the process is set out under paragraph 3. [Note: the investigation will be determined on a case by case basis].

3. Council of Governors: Termination of Office

3.1 A governor shall immediately cease to hold office if:

3.1.1 they resign by notice in writing to the Trust Secretary;

3.1.2 they fail to attend half of the council meetings in any financial year, unless the other governors are satisfied that:

(a) the absences were due to a reasonable cause and

(b) they will start attending council meetings within such a period as the governors consider reasonable.

3.1.3 in the case of an elected governor, they cease to be a member of the constituency by whom they were elected.

3.1.4 in the case of an appointed governor, the appointing organisation withdraws its sponsorship or terminates the appointment.

3.1.5 without good reason the governor has failed to undertake any training required by the Council of Governors and/or fails to engage with the development review process for governors as agreed by the Council of Governors.

3.1.6 they have failed to sign and deliver to the Chair a statement in the form required by the Council of Governors confirming acceptance of the code of conduct and/or complete the Disclosure and Barring Service process within the specified time period.

3.1.7 they refuse to sign a declaration, in the form specified by the Council of Governors, that they are a member of one of the public constituencies or one of the classes of staff constituency as the case might be and are not prevented from being a member of the Council of Governors.

3.1.8 they are removed from the Council of Governors by a resolution, approved by a two-thirds majority of the remaining governors, that:

(a) they have committed a serious breach of the code of conduct;

(b) he or she has acted in a manner detrimental to the interests of the Trust,

(c) the Council of Governors considers that it is not in the best interests of the Trust for that person to continue as governor.

3.1.9 where there is any disagreement as to whether the proposal for removal of a governor is justified, an independent assessor agreeable to both parties shall be requested to consider the evidence and conclude whether the proposed removal is reasonable or otherwise.

3.1.10 upon a Governor resigning under paragraph 3.1.1 above or upon the Council of Governors resolving to terminate a Governor's tenure of office in accordance with the above provisions, that Governor shall cease to be a Governor and their name shall be forthwith removed from the Register of Governors.

3.1.11 the Standing Orders adopted by the Council of Governors may contain provisions governing its procedure for termination under these provisions and for a Governor to appeal against the decision terminating his tenure of office, except in the case of 3.1.8a above.

3.1.12 a Governor who resigns or whose tenure of office is terminated under this paragraph 3 shall not be eligible to stand for re-election for a period of three years from the date of their resignation or removal from office or the date upon which any appeal against their removal from office is disposed of whichever is the later except by resolution carried by a majority of the Council of Governors present and voting at a general meeting. Any re-election would take into account time served as a Governor so that a maximum term would not exceed nine years.

3.1.13 where a Governor's membership of the Council of Governors ceases for one of the reasons set out in paragraph 2 or paragraph 3, Elected Governors shall be replaced in accordance with paragraphs 4.1 to 4.2 below and, in the case of Appointed Governors, the Trust shall invite the relevant appointing body to appoint a new Governor to hold office for the remainder of the term of office in accordance with the processes referred to in Annex 3 within 30 days of the vacancy having arisen.

4. Council of Governors: Vacancies – Elected Governors

4.1 In the event of an appointed stakeholder governor not serving out their full term of office the Council of Governors shall require the organisation concerned to appoint a replacement at the earliest opportunity.

4.2 In the event of an elected governor not serving out their full term of office the Chair may, where the unexpired term is less than twelve months, choose to leave the seat vacant until the next scheduled election unless the vacancy is in a public constituency and the vacancy means that the governors elected by the public constituencies no longer constitute more than half the members of the Council of Governors. In that event and in all other cases save as provided for in this paragraph the Chair shall be at liberty either:

4.2.1 to call an election within three months to fill the seat for the remainder of that term of office, or

4.2.2 to invite the next highest polling candidate for that seat at the most recent election to fill the seat and be co-opted onto the Council of Governors until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office. At the annual election, it shall be the last candidate elected to the constituency involved who will serve the unexpired period of the term of office for that constituency.

5. Council of Governors: Role

5.1 The Council of Governors and each Governor shall act in the best interests of the Trust at all times and with proper regard to the provisions of the NHS Foundation Trust Code of Governance and any code of conduct for the Council of Governors.

5.2 Subject to the requirement specified in paragraph 5.1 above, each Governor shall exercise their own skill and judgement in their conduct of the Trust's affairs and shall in their stewardship of the Trust's affairs bring as appropriate the perspective of the constituency or organisation by which s/he was elected or appointed, as the case may be. Public governors are expected to represent all members and the public, and not to promote a single issue or cause.

5.3 Subject to the further provisions of this Constitution and without in any way derogating from them, the Council of Governors shall;

5.3.1 hold the Non-Executive Directors to account in assisting the Trust Board of Directors in setting the strategic direction of the Trust and targets for the Trust's performance and in monitoring the Trust's performance in terms of achieving those strategic aims and targets which have been set; and

5.3.2 observe the activities of the Trust with the view to ensuring that they are being conducted in a manner consistent with this Constitution.

6. Council of Governors: Meetings

6.1 The Council of Governors shall hold not less than four general meetings each financial year. However, in extremis (see paragraph 16 of the Trust Constitution), the Chair may decide to suspend Council of Governors' meetings.

6.2 The Council of Governors may appoint committees or sub-committees, consisting of its members, which are relevant and proportionate, to advise and assist it in the discharge of its functions. The outcomes of such committees will be in the form of recommendations to be presented to the Council of

Governors. Recommendations presented to the Council of Governors therefore provide a second layer of oversight on a particular matter of interest by governor peers.

7. Council of Governors: Declarations

7.1 A Member of a Public Constituency standing for election as Governor must make a declaration for the purposes of Section 60 of the 2006 Act in the form specified below stating the particulars of their qualification to vote as a Member and that they are not prevented from being a member of the Council of Governors by virtue of any provisions of this Constitution.

7.2 The specified form of declaration shall be set out on the Nomination Form referred to in the Election Scheme.

8. Council of Governors: Lead Governor

8.1 No person may serve as the Lead Governor for more than a total of six years.

8.2 A person elected as the Lead Governor shall cease to be eligible to continue serving as the Lead Governor if they cease to be a Governor or Member and the Lead Governor's term of office may be terminated by a majority of not less than 75% of the Governors present and voting at a meeting of the Council of Governors.

8.3 Further provisions can be found in the Council of Governors Standing Orders.

ANNEX 6 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

General Overview and Introduction to the Council of Governors

1.1 The Council of Governors shall be constituted in accordance with the requirements of the constitution.

1.2 Provisions concerning the nomination and election to the Council of Governors are set out in the Constitution and the election rules. A member may not be nominated as a candidate for election to the Council of Governors unless he or she conforms to the requirements set out in the Constitution.

1.3 Governors shall comply with the code of conduct set out in Standing Order 4.

1.4 A member of the Council of Governors shall be disqualified from taking up office, or if in office shall vacate the office, in the circumstances set out in the Constitution. A governor shall cease to hold office when required to do so by the Council of Governors.

1.5 In accordance with the Constitution the Chair will chair the Council of Governors.

1.6 Standing Orders, including those concerning agenda, quorum, voting and the taking of minutes at Council of Governors meetings are set out in Standing Order 2 and in the Constitution.

1.7 Members of the Council of Governors shall not be remunerated but may receive expenses e.g. travel expenses in accordance with the relevant Trust polices and guidance.

1.8 Functions and Responsibilities of the Council of Governors

1.8.1 The function of the Council of Governors is to exercise the rights set out in the Constitution and the powers (if any) delegated from time to time by the Trust Board and to act in accordance with these procedures. The Council's roles and responsibilities are set out in Standing Order 3 and the trust shall provide sufficient resources to enable the Council of Governors to discharge its responsibilities.

1.9 Lead Governor

1.9.1 The Council of Governors shall select a public governor to undertake the role of Lead Governor of the Northern Lincolnshire and Goole NHS Foundation Trust. The Lead Governor shall be chosen by the Council of Governors, which will also approve the process for the appointment.

1.9.1 The process for the selection and appointment of the Lead Governor shall be as follows:

- The Lead Governor shall be elected by their peers at the last general meeting of the Council of Governors prior to expiry of the incumbent Lead Governor's term of office. Where there is to be a change of incumbent, the newly elected Lead Governor shall hold office as shadow Lead Governor whilst the incumbent Lead Governor completed their term in office. Where a ballot is required, all Governors present shall be entitled to vote. The Chair (or Vice Chair if presiding as Chair of the Council of Governors meeting in question) shall not participate in the ballot but shall have a casting vote in the event of a tie.
- At least one calendar month before the date of the meeting of the Council of Governors, the Trust Secretary shall contact all Governors by e-mail inviting nominations together with a short election statement in support of their nomination.
- Where more than one nomination is received, ballot papers showing the names of all the nominated candidates shall be distributed with the papers for the meeting and a secret ballot shall be conducted at the meeting. The Trust Secretary, or their nominee, shall act as returning officer and shall announce the results of the election before the close of the meeting when completed ballot papers will be made available for scrutiny by Governors as required. Where there is only one nomination, the Council of Governors shall be asked to ratify the appointment.
- Once elected, the shadow Lead Governor's terms as Lead Governor shall commence upon the expiry of the incumbent Lead Governor's term of office.

1.9.2 The appointment as Lead Governor shall be for a period of three years or until:

- the end of that Governor's current term of office whichever is the sooner; or
- they resign the position of Lead Governor by giving notice to the Chair in writing; or
- they are removed from the position of Lead Governor by a resolution passed by a two thirds majority of the remaining governors at a general meeting of the Council of Governors;
- with the option of re-election after that period if that governor is re-elected on to the Council of Governors. Continuation in the role will not be automatic on re-election to the Council.

1.9.3 The Trust Secretary shall be responsible for notifying NHSE of a change of Lead Governor.

1.9.4 The responsibilities of the Lead Governor shall be:

- To lead the Council of Governors in circumstances where it may not be considered appropriate for the Chair or another one of the Non-

Executive Directors to lead (e.g. chairing a meeting to discuss the appointment of a new chair) and to act as the point of contact with the independent panel referred to in the Trust Constitution Section 18, where a question is referred to that panel in accordance with that paragraph;

- To chair the Membership and Public Engagement & Assurance Group and Appointments and Remuneration Committee;
- On behalf of the Council of Governors, to attend monthly meetings with the Chair and the Trust Secretary;
- On behalf of the Council of Governors, to raise issues for discussion at the Trust Board;
- To assist the Chair in facilitating the flow of information between the Trust Board and the Council of Governors.
- To work with the Trust Chair to draft the Council of Governors commentary for inclusion in the Quality Report.

1.9.5 Further details on the role of the Lead Governor including the role criteria and desirable personal qualities can be found in the Trust document 'Criteria & Process for the Appointment of a Lead Governor".

1.10 Appointment of Deputy Lead Governor

1.10.1 The process for the appointment of the Deputy Lead Governor shall follow the rules outlined in Section 1.9.2.

1.10.2 The responsibilities of the Deputy Lead Governor are in line with the Lead Governor role.

1.11 Trust Secretary

1.11.1 The functions of Trust Secretary; most particularly monitoring of the trust's compliance with the law, Standing Orders and the regulatory framework, are a corporate responsibility shared by the directors but with the lead role being assumed by the Trust Secretary. The Trust Secretary has a significant role to play in the administration of corporate governance. In accordance with the Trust Board Standing Orders at Annex 7 the Chief Executive and the Chief Financial Officer have responsibility for advising the Chair on the interpretation of Standing Orders and the Standing Financial Instructions. The specific duties and responsibilities of the Trust Secretary are outlined below.

1.11.2 Acts as 'Company Secretary' to the Council of Governors and Trust Board of Directors:

- ensuring good information flows within the Trust Board and its committees and between senior management, Non-Executive Directors and the governors;
- ensuring that meetings of the Trust Board, Council of Governors and committees thereof run efficiently and effectively, that they are properly recorded and that Directors and Governors receive appropriate support and timely information;
- ensure that board procedures of both the Trust Board and the Council

of Governors are complied with;

- advise the Trust Board and the Council of Governors (through the chairperson) on all corporate governance matters;
- in conjunction with Executive and Non-Executive Directors, ensure that the Trust complies with all relevant legislation and the Terms of its Provider Licence';
- be available to give advice and support to individual directors, particularly in relation to the induction of new directors and assistance with professional development;
- in conjunction with the Chair and Lead Governor ensuring the ongoing development of the Council of Governors;
- responsible for the management of the membership office;
- as / if required, provide a source of advice and support independent of the Executive on any matters of concern relating to the governance of the organisation.

1.11.3 All directors and governors have access to the advice and services of the Trust Secretary. Both the appointment and removal of the Trust Secretary is a matter for the Chief Executive and Chair jointly.

1.12 Disputes

1.12.1 The Chair shall, in the first instance, arbitrate in any dispute concerning the interpretation of or arising out of these procedures. The Chair shall enforce any code of conduct approved by the Trust Board. Any unresolved dispute shall be determined in accordance with the Constitution as if references to any dispute in relation to the Constitution include any dispute in relation to these procedures.

1.13 Validity of Procedures

1.13.1 The procedures set out in this document are made in accordance with the Constitution. They shall only be altered on a recommendation of the Council of Governors and with the approval of the Trust Board. Changes to these procedures shall not be recommended that would make them inconsistent with the Constitution or the 2006 Act. Where there is any inconsistency between these procedures and the Constitution, the Constitution shall prevail.

2 Standing Orders for Council of Governors Meetings

2.1 Calling Meetings

2.1.1 The Council of Governors is to meet at least three times in each financial year (excluding the annual members meeting) at such times and places as the Council of Governors may determine.

2.1.2 Meetings of the Council of Governors may be called by the Chair, or by six governors including not less than three public governors who give written notice to the Chair specifying the business to be carried out.

2.2 Admission of the Public

All meetings of the Council of Governors are to be general meetings open to members of the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chair may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

2.3 Notice of Meetings

2.3.1 Save in the case of emergencies or the need to conduct urgent business, the Chair's office will give at least 14 days written notice of the date and place of every meeting of the Council of Governors to all governors. Notice will also be published on the trust's website.

2.3.2 After the receipt of a request to call a meeting the Chair's office shall send written notice to all governors, specifying the business to be carried out, as soon as possible after the receipt of such a request. The Chair shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Chair fails to call such a meeting then four governors may call such a meeting.

2.3.3 The notice of the meeting shall be delivered to every governor by email so as to be available to the governor at least five clear days before the meeting.

2.3.4 In the case of a meeting called by the governors in default of the Chair, those governors shall sign the notice and no business shall be transacted at the meeting other than that specified in the notice.

2.3.5 Failure to serve such a notice on more than 25 governors will invalidate the meeting.

2.4 Setting the Agenda

2.4.1 The Trust may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted.

2.4.2 In accordance with the Constitution every agenda for meetings of the Council of Governors will draw to the attention of the elected governors the declaration governors are required to make in Standing Order 5 stating that they are qualified to vote as a member of the trust and that they are not prevented from being a member of the Council of Governors An elected governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the meeting of the Council of Governors.

2.4.3 Any governor wishing to submit an agenda item must notify the Trust Secretary in writing at least ten clear working days prior to the meeting at which it is to be considered. Requests made less than ten clear days before a meeting may be included on the agenda at the discretion of the Group Chair.

2.5 Chair of the Meeting

2.5.1 The Group Chair or, in the absence of the Group Chair, the Vice Chair or, in the absence of the Vice Chair, one of the other Non-Executive Directors is to preside at meetings of the Council of Governors.

2.5.2 If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed then the governors present will choose one of their number to chair that part of the meeting.

2.5.3 If a vote concerns matters relating to the Chair and / or Non-Executive Directors, neither the Chair nor any other Non-Executive Director should preside over the meeting. In this instance, the governors present will choose **one of their number to chair the meeting and to have the casting vote.**

2.6 Annual Members Meeting

2.6.1 The trust will publicise and hold an annual members meeting in accordance with the Constitution.

2.6.2 The following documents shall be presented to the members of the trust at the annual members' meeting by at least one member of the Trust Board:

(a) the annual accounts;

(b) any report of the auditor on the annual accounts; and

(c) the annual report.

2.6.3 The trust may combine a meeting of the Council of Governors convened for the purposes of being presented with the documents in sub-paragraph 2.6.2 with the annual members' meeting.

2.6.4 Members (Executive or suitable Deputy, Non-Executive Directors and Associate Non-Executive Directors) of the Trust Board shall attend the Annual Members' Meeting unless agreed in advance with the Trust Chair.

2.7 Motions

2.7.1 Motions may only be submitted by a governor and must be received by the Chair's office in writing at least one week prior to the meeting at which they are to be considered.

2.7.2 Emergency motions may only be submitted by a governor and must be received by the Chair before the commencement of the meeting. Acceptance of such motions for inclusion on the agenda will be at the discretion of the Chair.

2.7.3 Any other business should be notified to the Chair at the commencement of the meeting. Acceptance of such items of business for inclusion on the agenda will be at the discretion of the Chair.

2.7.4 Notice of a motion to rescind a previous minute must be received by the Chair's office at least 21 days before the meeting and must be signed by a majority of members. Such a motion should not be taken until at least 30 minutes after the start of the meeting.

2.7.5 An amendment that does not directly negate a resolution may be moved by any member. No further amendments may be moved until the first amendment is disposed of. If an amendment is passed it shall become part of the substantive motion and subject to further amendment.

2.7.6 The mover of a motion under Standing Order 2.7.1 or 2.7.2 above shall have a maximum of five minutes to move and three minutes to reply. Once a motion has been moved no member shall speak more than once or for more than three minutes.

2.8 Chair's Ruling

2.8.1 Statements of governors made at meetings of the trust shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

2.9 Voting

2.9.1 An elected governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, a declaration has been made in the form specified by the Council of Governors of particulars of their qualification to vote as a member of the trust, and that they are not prevented from being a member of the Council of Governors. An elected governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of elected governors.

2.9.2 Subject to the Constitution, questions arising at a meeting shall be determined by a majority of the votes of the governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

2.9.3 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the governors present so request.

2.9.4 In no circumstances may an absent governor vote by proxy. Absence is defined as being absent at the time of the vote.

2.9.5 No resolution of the Council of Governors shall be passed if the public governors present unanimously oppose it.

2.10 Attendance

2.10.1 Governors who are unable to attend the Council of Governors meeting should advise the Chair's office in advance of the meeting so that their apologies may be submitted.

2.10.2 The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

2.10.3 The Council of Governors may invite the Chief Executive or any other member or members of the Trust Board, or a representative of the trust's auditors or other advisors to attend a meeting of the Council of Governors.

2.10.4 The Council of Governors may require one or more directors to attend a meeting of the Council of Governors for the purpose of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the trust's or directors' performance).

2.11 Minutes

2.11.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting. The person presiding at it will sign them.

2.11.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

2.11.3 Minutes shall be circulated in accordance with the governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

2.12 Record of Attendance

2.12.1 The names of the governors present at the meeting shall be recorded in the minutes.

2.13 Suspension of Standing Orders

2.13.1 Except where this would contravene any statutory provision, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council of Governors members are present, and that a majority of those present vote in favour of suspension.

2.13.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

2.13.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the governors.

2.13.4 No formal business may be transacted while Standing Orders are suspended.

2.14 Variation and Amendment of Standing Orders

2.14.1 These Standing Orders shall be amended only if the requirements provided for in the Constitution for variation of the Constitution have been met and if:

(a) a majority of the governors voting at a quorate meeting of the Council of Governors agrees to the amendment;

(b) the amendment has been authorised by a majority of directors voting at a quorate meeting of the Trust Board;

(c) the variation proposed does not contravene a statutory provision.

Any amendments to these Standing Orders shall be reported to NHSE.

2.14.2 Where an amendment is made in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust) at least one member of the Council of Governors must attend the next annual members' meeting and present the amendment and the trust must give the members an opportunity to vote on whether they approve the amendment.

2.14.3 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

2.15 Quorum

2.15.1 Nine governors including not less than five public governors shall form a quorum.

2.15.2 Any governor who has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest shall no longer count towards the quorum. If a quorum is then not available for the discussion and / or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

2.15.3 In accordance with the Constitution, if at any meeting there is no quorum within an appropriate period of time (to be determined by the Chair of the meeting) from the start of the meeting it shall stand adjourned for six clear days and written notice of the date, place and time of the adjourned meeting shall be given to all governors. Upon reconvening, those present shall constitute a quorum.

2.16 Appointment of Committees

2.16.1 The Council of Governors may establish such committees as it requires to conduct its business. Membership of these committees shall be open to all governors.

2.16.2 Each committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the council) as the Council of Governors shall decide. Such terms of reference shall be read in conjunction with these Standing Orders.

2.16.3 As and when vacancies arise on each committee, governors shall be invited to express an interest in standing for appointment. Where elections are

required, they shall be held at the first meeting of the Council of Governors after the vacancy has arisen. Governor members will be elected by the Council of Governors until the end of their term of office as a governor although will be entitled to express an interest in standing for re-appointment if they are re-elected as a governor.

3 Governors – Roles and Responsibilities

3.1 In addition to those duties specified in the constitution, it is the role of the Council of Governors and of each governor:

3.1.1 To act at all times in the best interests of the Trust.

3.1.2 To represent the interests of the membership and partner organisations.

3.1.3 To feedback information about the trust to the membership and partner organisations.

3.1.4 To use their best endeavours to ensure Northern Lincolnshire and Goole NHS Foundation Trust remains a leading acute trust.

3.1.5 To ensure the Council of Governor meetings are held in accordance with policy and Standing Orders.

3.1.6 To comply with and implement the code of conduct for the Council of Governors as set out in Standing Order 4.

3.2 To be consulted on and make recommendations to the Trust Board on the development of the membership strategy.

3.3 To respond as appropriate when consulted by the Trust Board in accordance with the Constitution.

3.4 To undertake such functions as the Trust Board shall from time to time request.

3.5 To consider the annual accounts, any report of the auditor on them and the annual report.

3.6 To set up committees and working groups; for example, membership strategy, assurance, quality.

3.7 To attend regular Council of Governor meetings.

3.8 To attend the annual members meeting.

3.9 The specific duties of governors are:

3.9.1 amending the constitution;

3.9.2 approving the appointment of the Chief Executive;

3.9.3 appointing and removing the Chair and other Non-Executive Directors;

3.9.4 appointing and removing the NHS foundation trust's external auditor;

3.9.5 receiving the NHS foundation trust's annual accounts and annual report;

3.9.6 receiving the Trust's forward (operational) plan;

3.9.7 taking decisions on 'significant transactions';

3.9.8 taking decisions on non-NHS income.

4 Code of Conduct for the Council of Governors and the Nolan Principles

4.1 Introduction

4.1.1 This code seeks to outline appropriate conduct for governors, and addresses both the requirements of office and their personal behaviour. Ideally any penalties for non-compliance would never need to be applied. However, a code is considered an essential guide for governors, particularly those who are newly elected.

4.1.2 The code seeks to expand on or complement the Constitution. Copies will be made available for the information of all governors and for those considering seeking election to the trust's Council of Governors.

4.1.3 Members seeking election to the Council of Governors should sign a declaration to confirm that they will comply with the code in all respects and that, in particular, they support the Trust's objectives.

4.2 Qualifications for Office

4.2.1 Members of the Council of Governors must continue to comply with the qualifications required to hold elected office throughout their period of tenure as defined in the Constitution. The Chair should be advised of any changes in circumstances, which disqualify the governor from continuing in office. An example of this would be a public governor becoming an employee of the trust.

4.3 Code of Conduct Role and Functions

4.3.1 In addition to their duties set out in the Constitution, and specifically in relation to matters of conduct, governors should:

4.3.1.1 adhere to the Trust's rules and policies and support its objectives, in particular those of retaining foundation status and developing a successful organisation;

4.3.1.2 act in the best interests of the Trust at all times;

4.3.1.3 contribute to the workings of the Council of Governors in order for it to fulfil its role and functions as defined in the Constitution;

4.3.1.4 recognise that their role is a collective one. They exercise collective decision making in the meeting room, which is recorded in the minutes. Outside the meeting room a governor has no more rights and privileges than any other member;

4.3.1.5 note that the functions allotted to the Council of Governors are not of a managerial nature.

4.4 Confidentiality

4.4.1 All governors are required to respect the confidentiality of the information they are made privy to as a result of their membership of the Council of Governors.

4.5 Conflict of Interests

4.5.1 Governors should act with the utmost integrity and objectivity and in the best interests of the trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment. Any governor who has a material interest in a matter as defined by the Constitution, shall declare such interest to the Council of Governors and:

- shall not vote on any such matters;
- shall not be present except with the permission of the Council of Governors in any discussion of the matter.

4.5.2 If in any doubt the governor should seek advice from the Chair and / or Trust Secretary. It is important that conflicts of interest are addressed and are seen to be actioned in the interests of the trust and all individuals concerned.

4.5.3 Any governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining governors.

4.5.4 The Register of Governors Interests will feature as a standing item on the agenda of each meeting of the Council of Governors.

4.6 Council of Governors Meetings

4.6.1 Governors have a responsibility to attend meetings of the Council of Governors. When this is not possible they should submit an apology to the Chair's office in advance of the meeting stating the reason for non-attendance. The reason for non-attendance will be recorded in the minutes of the meeting.

4.6.2 In accordance with the Constitution, absence from the Council of Governor meetings without good reason established to the satisfaction of the Council of Governors is grounds for disqualification. If a governor fails to attend half of the meetings of the Council of Governors in any financial year his or her tenure of office is to be immediately terminated unless the other governors are satisfied that the absence was due to a reasonable cause and he or she will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

4.6.3 Governors are expected to attend for the duration of the meeting.

4.7 Personal Conduct

4.7.1 Governors are required to adhere to the highest standards of conduct in the performance of their duties. In respect of their interaction with others, they are required to:

4.7.1.1 adhere to good practice in respect of the conduct of meetings and respect the views of their fellow elected members;

4.7.1.2 be mindful of conduct which could be deemed to be unfair or discriminatory;

4.7.1.3 treat the Trust's executives and other employees with respect and in accordance with the Trust's policy in this respect;

4.7.1.4 recognise that the Council of Governors and management have a common purpose, i.e. the success of the Trust and adopt a team approach;

4.7.1.5 conduct themselves in such a manner as to reflect positively on the Trust. When attending external meetings or any other events at which they are present, it is important for governors to be ambassadors for the trust.

4.8 Accountability

4.8.1 Governors are accountable to the membership and should demonstrate this by attending members' meetings and other key events, which provide opportunities to interface with their electorate in order to understand their views.

4.9 Induction and Development

4.9.1 Training is essential for governors, in respect of the effective performance of their current role. Governors are required to adhere to the Trust's policy in all respects.

4.10 Visits to Trust Premises

4.10.1 Where governors wish to visit the premises of the Trust in a formal capacity as opposed to individuals in a personal capacity, the Council of Governors should liaise with the Membership Office to make the necessary arrangements.

4.11 Non-Compliance with the Code of Conduct

4.11.1 Non-compliance with the code may result in action being taken as follows:

- Where misconduct takes place, the Chair shall be authorised to take such action as may be immediately required, including the exclusion of the person concerned from a meeting.
- Where such misconduct is alleged, it shall be open to the Council of Governors to decide, by simple majority of those in attendance, to lay a formal charge of misconduct:

- notifying the governor in writing of the charge/s, detailing the specific behaviour, which is considered to be detrimental to the Trust, and inviting and considering their response within a defined timescale.
- inviting the governor to address the Council of Governors in person if the matter cannot be resolved satisfactorily through correspondence;
- deciding, by simple majority of those present and voting, whether to uphold the charge of conduct detrimental to the trust;
- imposing such sanctions as shall be deemed appropriate. Such sanctions will range from the issuing of a written warning as to the member's future conduct and consequences, non-payment of expenses to the removal of the governor from office.

4.11.2 A governor may be removed from the Council of Governors by a resolution approved by not less than two-thirds of the remaining governors present and voting at a general meeting of the Council of Governors.

4.11.3 This code of conduct does not limit or invalidate the right of the governor or the trust to act under the Constitution.

4.12 Nolan Principles – the seven principles of public life

4.12.1 Governors should act in accordance with the Nolan Principles, namely:

Selflessness: Holders of public office should take decisions solely in terms of the public interest. They should not do so to gain financial or other material benefit for themselves, their family or their friends.

Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity: In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choice on merit.

Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness: Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership: Holders of public office should promote and support these principles by leadership and example.

5 Declarations of Interests and Register of Interests

5.1 Declarations

5.1.1 In accordance with the Constitution and the 2006 Act and in recognition of the codes of conduct and accountability issued by the Department of Health and Social Care the trust is required to maintain a register of interests of governors. The governors must declare any relevant and material interest, whether direct or indirect, in any contract, proposed contract or other matter which is under consideration by the Council of Governors.

5.1.2 Interests, which should be regarded as 'relevant and material' are:

- Directorships, including non-executive Directorships held in private companies or PLCs (with the exception of those of dormant companies) likely or possibly seeking to do business with the NHS.

- Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
- Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or voluntary organisation in the field of health or social care.
- Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.
- Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the trust, including but not limited to, lenders or banks.

5.1.3 The Trust will interpret the phrase 'relevant and material' in accordance with guidance issued from time to time by the Independent Regulator.

5.1.4 If governors have any doubt about the relevance of an interest, this should be discussed with the Chair.

5.1.5 The exceptions, which shall not be treated as material interests are as follows:

- shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange.
- an employment contract held by staff governors.
- an employment contract with the Humber and North Yorkshire Integrated Care Board or an organisation in membership of a Place Health and Care Partnership held by a Place Partnership governor.
- an employment contract with a local authority held by a local authority governor.
- an employment contract with a partnership organisation held by a partnership governor.

5.2 Register of Interests

5.2.1 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of governors. In particular the register will include details of all directorships and other relevant and material interests, which governors have declared.

5.2.2 These details will be kept up to date and governors must disclose any relevant and material interest as soon as they are aware of it.

5.2.3 The register will be available for inspection by members of the public free of charge.

5.3 Disclosure

5.3.1 Any governor who has a material interest as defined above shall declare such interest to the Council of Governors and:

- shall not be present except with the permission of the Council of Governors in any discussion with relevance to the interest;
- shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE TRUST BOARD

1 Introduction

1.1. The Northern Lincolnshire and Goole NHS Foundation Trust (the Trust) is a public benefit corporation authorised by the Independent Regulator of NHS foundation Trusts under the National Health Service Act 2006.

1.2. The principal purpose of the Trust is set out in the 2012 and 2022 Act, and the Trust Constitution.

1.3. The Trust is required to adopt Standing Orders for the regulation of its proceedings and business.

1.4. The powers of the Trust are set out in section 3 of the Trust Constitution.

1.5. The Trust has specific powers to contract in its own name and to act as a corporate Trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to NHSE. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

2 Delegation of Powers

2.1 The Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session. These powers and decisions are set out in the Scheme of Delegation.

2.2 Under the Standing Orders 7.2 relating to the Arrangements for the Exercise of Functions the Trust Board may exercise its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of Standing Order 8 or by an Executive Director, in each case subject to such restrictions and conditions as the Trust Board thinks fit or as NHSE may direct.

2.3 Delegated powers are covered in the Scheme of Delegation, which has effect as if incorporated into the Standing Orders.

3 Interpretation and Scope

3.1 Interpretation

3.1.1 Save as permitted by law, and subject to the Constitution, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders on which they shall be advised by the Chief Executive and in the case of Standing Financial Instructions by the Chief Financial Officer.

3.1.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

"Accounting Officer" shall be the officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Trust" means the Northern Lincolnshire and Goole NHS Foundation Trust.

"Board" shall mean the Chair, Non-Executive Directors, and the Executive Directors.

"Budget" shall mean a resource, expressed in financial terms, proposed by the board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"Chair" is the person appointed by the Council of Governors to lead the board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"Chief Executive" shall mean the chief executive officer of the Trust.

"Chief Financial Officer" shall mean the chief financial officer of the Trust.

"Committee" shall mean a committee appointed by the Trust.

"Committee Members" shall be persons formally appointed by the Trust to sit on or to chair specific committees.

"Director" shall mean a person appointed as a director in accordance with the Constitution and includes the Chair.

"Funds Held On Trust" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept. Such funds may or may not be charitable.

"Motion" means a formal proposition to be discussed and voted on during the course of a meeting.

"Non-Executive Director" means a director, including the Chair, who does not hold an executive office of the Trust.

"Nominated Officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Officer" means an employee of the Trust.

"Senior Independent Director" means the Non-Executive Director appointed as an alternative point of contact for governors and directors when they have concerns that have not been resolved through the normal channels of Chair, Chief Executive, Chief Financial Officer or Trust Secretary or for which such contact is inappropriate.

"Vice Chair" means the Non-Executive Director appointed by the Trust to take on the Chair's duties if the Chair is absent for any reason

3.2 Scope

3.2.1 All business shall be conducted using these Standing Orders in the name of the Trust.

3.2.2 All funds received in Trust shall be in the name of the Trust as corporate Trustee. In relation to funds held on Trust, powers exercised by the Trust as corporate Trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

3.2.3 The Trust has resolved that certain powers and decisions may only be exercised by the board in formal session. These powers and decisions are set out in the "Reservation of Powers to the Board" and have effect as if incorporated into the standing orders.

4 Appointment to the Board

4.1 Composition of the Trust Board

4.1.1 In accordance with the NHS 2006 Act and the Trust Constitution the composition of the board of the Trust shall comprise a Chair, five Non-Executive Directors, and five Executive Directors including the Chief Executive, Chief Financial Officer, a registered medical practitioner and a registered nurse or midwife.

4.1.2 The Trust, on occasion, may seek to appoint Associate Non-Executive Directors to address specific identified skills gaps or allow succession planning. Associate Non-Executive Directors are non-voting members of the Trust Board.

4.2 Appointment of the Chair and Non-Executive Directors

4.2.1 The Trust has resolved that certain powers and decisions may only be exercised by the board in formal session. These powers and decisions are set out in the "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

4.2.2 In accordance with the Trust Constitution, the appointment and removal of the Chair and the other Non-Executive Directors is the prerogative of the Council of Governors. Where a Non-Executive Director vacancy arises, the Appointment & Remuneration Committee, on behalf of the Council of Governors, with the Joint Chair and / or Vice Chair, will assess and seek opinion from the Trust Board on the skills and experience required.

4.2.3 For the appointment of a Chair the Trust shall appoint a nominations panel (of the Appointments & Remuneration Committee for Non-Executive Directors) which will include the Senior Independent Director (or another Non-Executive Director in the case of a conflict of interests) and at least three governors to interview applicants and make a recommendation to the Council of Governors.

4.2.4 In the case of other Non-Executive Directors, the Trust shall appoint a nominations panel which will include the Chair, and at least three governors to interview applicants and to make a recommendation to the Council of Governors.

4.3 Appointment of an Associate Non-Executive Director

4.3.1 In accordance with the Trust Constitution, the appointment and removal of an Associate Non-Executive Director is the prerogative of the Council of Governors. Where an Associate Non-Executive Director vacancy arises, the Appointment & Remuneration Committee, on behalf of the Council of Governors, with the Joint Chair and / or Vice Chair, will assess and seek opinion from the Trust Board on the skills and experience required.

4.3.2 For the appointment of an Associate Non-Executive Director the Trust shall appoint a nominations panel (of the Appointments & Remuneration Committee for Non-Executive Directors) which will include the Senior Independent Director (or another Non-Executive Director in the case of a conflict of interests) and at least three governors to interview applicants and make a recommendation to the Council of Governors.

4.4

4.4Terms of Office of the Chair and Non-Executive Directors4.4.1Unless the Council of Governors decides otherwise from time to time the Chair and the Non-Executive Directors are to be appointed for a term of three years and will be eligible for reappointment for two further terms of three years. Any proposed term beyond nine years (e.g. three three-year terms) for a Non-Executive Director shall be subject to annual re-appointment, rigorous review, and shall take into account the need for progressive refreshing of the board.

4.5Terms of Office of an Associate Non-Executive Director

4.5.1Unless the Council of Governors decides otherwise from time to time Associate Non-Executive Directors are to be appointed for a term of one year and may be eligible for reappointment for an additional two, one-year terms.

4.5.2Associate Non-Executive Directors are a non-voting members of the Trust Board.

4.6Performance Appraisal of the Group Chair

4.6.1`The Non-Executive Directors shall meet without the Group Chair at least annually to evaluate the Group Chair's performance as part of a process of appraisal which has been agreed with the Council of Governors.

4.7Appointment of Vice Chair

4.7.1`For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Group Chair, the Council of Governors will appoint a Non-Executive Director to be Vice Chair for such a period, not exceeding the remainder of the term as Non-Executive Director of the Trust, as it may specify on making the appointment. If the Group Chair is unable to discharge the office of Group Chair of the Trust/Group, the Vice Chair shall be Acting Chair of the Trust.

4.7.2Any Non-Executive Director so elected may at any time resign from the office of Vice Chair by giving notice in writing to the Group Chair and the Council of Governors may thereupon appoint another Non-Executive Director as Vice Chair.

4.8Powers of Vice Chair

4.8.1Where the Chair of the Trust has died or has otherwise ceased to hold office or where they have been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform their duties, be taken to include references to the Vice Chair.

4.9Appointment of Senior Independent Director

4.9.1The NHS Foundation Trust Code of Governance recommends that the Board of Directors should appoint a Non-Executive Director as the Senior Independent Director as an alternative point of contact for governors and directors when they have concerns that have not been resolved through the normal channels of Chair, Chief Executive, Chief Financial Officer or Trust Secretary or for which such contact is inappropriate.

4.9.2The criteria and process for the appointment of a Senior Independent Director is set out in Appendix A of the Terms of Reference and Membership of the Appointments & Remuneration Committee for Non-Executive Directors.

4.10Executive Directors – Additional Appointments

4.10.1 With the approval of the Trust Board, a Group Executive Director may accept not more than one appointment as a Non-Executive Director of another NHS foundation Trust or an organisation of comparable size and complexity.

4.10.2 An Executive Director may not accept an appointment as Chair of another NHS Foundation Trust or an organisation of comparable size and complexity, except in the case of a Trust which is the subject of a Memorandum of Understanding.

5 Executive Directors – Joint Appointments

5.1 The Trust recognises that as partnership and collaborative working is further developed with partners, opportunities may arise to introduce joint executive roles. Such opportunities are managed in accordance with section 7 ('Joint Roles with Other Trusts') of the 'Principles Framework for Determining the Remuneration & Terms of Service for the Chief Executive and Executive Directors' document (managed by the Remuneration and Terms of Service Committee).

6 Practice and Procedure of Meetings

6.0.1 All business meetings of the Trust Board shall be conducted in the name of the Trust.

6.1 Annual Members' Meeting

6.1.1 In accordance with the Trust Constitution the Trust will hold a members meeting (the "annual members' meeting") within nine months of the end of the financial year.

6.2 Calling Meetings / Extraordinary Meetings

6.2.1 The Chair may call a meeting of the Trust Board at any time. The Chair shall send a written notice to all directors as soon as possible after the receipt of such a request. The Chief Executive or four directors may request the Chair to call a meeting giving written notice of the business to be carried out. If the Chair fails to call such a meeting then the Chief Executive, or four directors, whichever is the case, may forthwith call a meeting.

6.2.2 The ordinary meetings of the Trust Board shall, unless otherwise be determined, be held on a nominated day each month or at such other times as the board may determine and at such places as the board may determine.

6.2.3 Meetings of the Trust Board shall be open to the public, unless and to the extent that the Trust Board has resolved that members of the public should be excluded from a meeting due to special reasons.

6.2.4 The Chair (Vice Chair in the absence of the Chair) shall give such directions as the Chair thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust Board's business shall be conducted without interruption and disruption.

6.2.5 Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make an oral report of proceedings as they take place without the prior agreement of the Trust Board.

6.3 Notice of Meetings

6.3.1 Save in the case of emergencies or the need to conduct urgent business, the Chairman's office shall give to all directors at least fourteen days written notice of the date and place of every meeting of the Trust Board.

6.3.2 Before each meeting of the Trust Board, a notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every director, or sent by post to the usual place of residence of such director, so as to be available to every director at least three clear days before the meeting.

6.3.3 Lack of service of the notice on any director shall not affect the validity of a meeting.

6.3.4 In the case of a meeting called by directors or the Chair, in default of the Chief Executive, the notice shall be signed by those directors or the Chair and no business shall be transacted at the meeting other than that specified in the notice.

6.3.5 Failure to serve such a notice on more than two directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

6.4 Notice of Agenda Items

6.4.1 The Trust may determine that certain matters shall appear on every agenda for a meeting of the Trust Board and shall be addressed prior to any other business being conducted, which will have effect as though incorporated into the Standing Orders.

6.4.2 A director wishing to propose an agenda item or motion should send written notice eight clear days before the meeting to the Chair who shall insert the item or motion in the agenda for the meeting. Requests made less than eight days before a meeting may be included on the agenda at the discretion of the Chair.

6.4.3 Notwithstanding the intent of the previous paragraph urgent business may be raised at a meeting of the board provided the director wishing to raise such business has given notice to the Chair not later than the day preceding the meeting or in exceptional circumstances not later than one hour before the meeting. In either case, the Chair (or in their absence the Vice Chair) shall determine in consultation with the Chief Executive, the urgency of the proposed business and whether it should be discussed, deferred to the next meeting, or dealt with by the Chief Executive.

6.4.4 Before holding a meeting, the Trust Board shall send a copy of the agenda to the Council of Governors.

6.5 Chair of Meeting

6.5.1 At any meeting of the Trust Board, the Chair, if present, shall preside.

6.5.2 If the Chair is absent from the meeting the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent such Non-Executive Directors as the directors' present shall choose shall preside.

6.5.3 If the Chair is absent from the meeting temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If Chair and Vice Chair are absent, or are disqualified from participating, such Non-Executive Directors as the directors' present shall choose shall preside.

6.6 Motions

6.6.1 A director of the Trust wishing to propose an agenda item, or move or amend a motion shall send a written notice thereof at least eight clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to Standing Order 6.5.

6.6.2 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

6.6.3 Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director(s) who gives it and also the signature of four other directors. When any such motion has been disposed of by the Trust, it shall not be competent for any director other than the Group Chair to propose a motion to the same effect within six months.

6.6.4 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

6.6.4.1 An amendment to the motion.

6.6.4.2 The adjournment of the discussion or the meeting.

6.6.4.3 That the meeting proceed to the next business. (*)

6.6.4.4 The appointment of an ad hoc committee to deal with a specific item of business.

6.6.4.5 That the motion be now put to a vote. (*)

In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate and who is eligible to vote.

6.6.5 No amendment to the motion shall be admitted if, in the opinion of the chairman of the meeting, the amendment negates the substance of the motion.

6.6.6 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

6.7 Group Chair's Ruling

6.7.1 Statements of directors made at meetings of the board shall be relevant to the matter under discussion at the material time. The decision of the Group Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders, shall be final. In this interpretation they shall be advised by the Executive and in the case of Standing Financial Instructions by the Chief Financial Officer.

6.8 Voting

6.8.1 Every question at a meeting can be determined by a majority of the votes of the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

6.8.2 All questions put to the vote shall, at the discretion of the Group Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

6.8.3 If at least one-third of the directors' present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

6.8.4 If a director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

6.8.5 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

6.8.6 Any director or member of a committee of the directors may participate in a meeting of the Trust Board or such committee by means of a conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.

6.8.7 A resolution in writing signed by all of the directors entitled to receive notice of a meeting of the Trust Board shall be as valid and effectual as if it had been passed at a meeting of the board of directors duly convened and held and may consist of several documents in the like form each signed by one or more directors.

6.8.8 A resolution in electronic form sent to all of the directors entitled to receive notice of a meeting of the board of directors by electronic communication (for the purposes of this provision "electronic communication" means a communication transmitted (whether from one person to another, from one device to another or from a person to a device or vice versa) (a) by means of an electronic communications network; or (b) by other means but while in an electronic form) to the electronic addresses notified to the Trust by each of the directors, shall be as valid and effectual as if it had been passed at a meeting of the Trust Board duly convened and held provided that each and every director entitled to receive a notice of a meeting of the Trust Board responds by electronic communication to the electronic address from which the resolution in electronic form was transmitted from, confirming their acceptance of the resolution.

6.8.9 An acting director who has been appointed formally by the appropriate appointments committee in accordance with the Constitution to carry out a vacant director's duties during a period of temporary incapacity, shall be entitled to exercise the voting rights of the director.

6.8.10 An officer attending the board to represent an executive director during a period of incapacity or temporary absence without being formally appointed to the board may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

6.9 Minutes

6.9.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

6.9.2 The names of the directors' present at the meeting shall be recorded in the minutes. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

6.9.3 It is the responsibility of each individual director to ensure that, where they have concerns which cannot be resolved about the running of the foundation Trust or a proposed action, those concerns are recorded in the board minutes.

6.9.4 Minutes shall be circulated in accordance with directors' wishes.

6.9.5 A copy of the minutes shall be provided by the Trust Board to the Council of Governors as soon as practicable after the meeting to which they relate.

6.10 Quorum

6.10.1 No business shall be transacted at a meeting of the Trust Board unless at least six of the directors are present including not less than three executive directors (one of whom must be the Chief Executive or Chief Financial Officer) and three Non-Executive Directors.

6.10.2 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

6.10.3 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Orders 10 and 11) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least three executive directors to form part of the quorum shall not apply where the executive directors are excluded from a meeting (for example when the board considers the recommendations of the Remuneration and Terms of Service Committee).

6.10.4 Directors can participate in meetings by telephone or through the use of video conferencing facilities, where such facilities are available. Participation in a meeting through any of these methods shall be deemed to constitute presence in person at the meeting.

6.11 Personal Conduct (part of Standards of Business Conduct Policy section)

6.11.1 Directors are required to adhere to the highest standards of conduct in the performance of their duties. In respect of their interaction with others, they are required to:

- adhere to good practice in respect of the conduct of meetings and respect the views of their colleagues;
- be mindful of conduct which could be deemed to be unfair or discriminatory;

- treat the Trust's Council of Governors and Trust employees with respect and in accordance with the Trust's policy;

- recognise that the Trust Board and the Council of Governors have a common purpose, i.e. the success of the Trust, and adopt a team approach;

- conduct themselves in such a manner as to reflect positively on the Trust. When attending external meetings or any other events at which they are present, it is important for directors to be ambassadors for the Trust.

7 Suspension of Standing Orders

7.1 Except where this would contravene any statutory provision, Standing Orders may be suspended at any meeting, provided that:

7.1.1 at least two thirds of the board are present including one executive director and one Non-Executive Director,

7.1.2 a majority of those present vote in favour of a suspension;

7.1.3 the variation proposed does not contravene any statutory provision or direction made by NHSE.

7.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

7.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and should be available to the directors.

7.4 No formal business shall be transacted while Standing Orders are suspended.

7.5 The Audit, Risk and Governance Committee shall review every decision to suspend Standing Orders.

8 Reservation of Powers and Delegation of Functions

8.1 Reservation of Powers

8.1.1 The Trust has resolved that certain powers and decisions may only be exercised by the Board in formal session, held in accordance with Standing Order 6. These powers and decisions are set out in the "Reservation of Powers to the Board and Delegation of Powers" and have effect as if incorporated into the Standing Orders.

8.2 Arrangements for the Exercise of Functions by Delegation

8.2.1 The Trust Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of Standing Order 9.5 below or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the board thinks fit.

8.3 Emergency Powers

8.3.1 The powers which the Trust Board has retained to itself within these Standing Order 8.1 may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors.

8.3.2 The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the board for ratification.

8.4 Delegation to Committees

8.4.1 The Trust Board shall agree from time to time to the delegation of executive powers to be exercised by executive committees or assurance sub-committees of the Trust Board, which it has formally constituted.

8.4.2 The Constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Trust Board.

8.5 Delegation to Officers

8.5.1 Those functions of the Trust which have not been retained as reserved by the Trust Board or delegated to a committee or committee of the Trust Board shall be exercised on behalf of the Trust Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust Board.

8.5.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered for approval by the Trust Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered for approval by the Trust Board as indicated above.

8.5.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the board of the Chief Financial Officer or other executive director to provide information and advise the Trust Board in accordance with any statutory requirements or the requirements of the Independent Regulator.

8.5.4 The arrangements made by the Trust Board as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

9 Committees

9.1 Appointment of Committees and Sub-Committees

9.1.1 Subject to Standing Order 8.4 and such directions as may be given by the Constitution, the Trust may appoint committees of the Trust, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust.

9.1.2 A committee appointed under Standing Order 8.4 may, subject to such directions as may be given by the Trust, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the Trust committee (whether or not they include directors of the Trust).

9.1.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration agreed by the Trust Board to meetings of any committees or sub-committee established by the Trust.

9.1.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the board), as the board shall decide.

9.1.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the board.

9.1.6 The Board Committees will be made up of Non-Executive Directors and Executive Directors as core members and other staff as deemed appropriate being 'in attendance'. Except the Audit, Risk and Governance Committee and Remuneration and Terms of Service Committee must only have Non-Executive Directors as core members.

9.1.7 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the independent regulator, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with applicable statute and regulations and with guidance issued by the independent regulator.

9.1.8 The following committees shall be established:

(a) Audit Committee
The Trust Board shall establish an Audit Committee to be known as the Audit, Risk and Governance Committees-in-Common which shall meet at least quarterly and be answerable to, and report to, the Trust Boards-in-Common. The terms of reference of the Committee have effect as if incorporated into these Standing Orders.

(b) Remuneration Committee
The board shall establish a Remuneration Committee, to be known as the Remuneration Committees-in-Common which shall meet at least quarterly and be answerable to, and report to, the Trust Boards-in-Common. The terms of reference of the Committee have effect as if incorporated into the Standing Orders.

(c) Charitable Funds Committee
The Trust Board shall establish a Charitable Funds Committee which shall meet at least quarterly and be answerable to, and report to, the Trust Boards-in-Common. The terms of reference of the Committee have effect as if incorporated into the Standing Orders.

(d) Finance Committee
The Trust Board shall establish a Finance Committee to be known as the Performance, Estates and Finance Committees-in-Common which shall meet at least quarterly and be answerable to, and report to, the Trust Boards-in-Common. The terms of reference of the Committee have effect as if incorporated into these Standing Orders.

(e) Quality & Safety Committee
The Trust Board shall establish a Quality & Safety Committee to be known as the Group Quality and Safety Committees-in-Common which shall meet at least quarterly and be answerable to, and report to, the Trust Boards-in-Common. The terms of reference of the Committee have effect as if incorporated into the Standing Orders.

(f) Workforce Committee

The Trust Board shall establish a Workforce Committee to be known as the Group Workforce, Education and Culture Committees-in-Common which shall meet at least quarterly and be answerable to, and report to, the Trust Boards-in-Common The terms of reference of the Committee have effect as if incorporated into the Standing Orders.

(g) Committees In Common

The Trust Board shall establish any other joint permanent or ad-hoc committee in common as may be required. It is not necessarily a requirement that these other committees report directly to the Trust Boards-in-Common, but in all cases the reporting arrangements will be defined in their terms of reference.

(h) Other Committees

The Trust Board shall establish any other permanent or ad-hoc committees as may be required. It is not necessarily a requirement that these other committees report directly to the Trust Board, but in all cases the reporting arrangements will be defined in their terms of reference.

9.2 Confidentiality

9.2.1 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the board or shall otherwise have concluded on that matter.

9.2.2 A director of the Trust or a member of a committee shall not disclose any matter reported to the board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the board or committee shall resolve that it is confidential.

10 Declaration of Interests and Register of Interests

10.1 Pursuant to Section 20 of Schedule 7 of the 2006 Act, a register of Directors' interests must be kept by the Trust.

10.2 Pursuant to Section 152 of the 2012 Act, Directors have a duty:

10.2.1 to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

10.2.2 not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

10.3 Declarations of Interests

10.3.1 Trust Board directors are required to declare relevant and material interests. Any directors appointed subsequently should do so on appointment.

10.3.2 Interests which should be regarded as "relevant and material" are:

10.3.2.1 Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies) likely or possibly seeking to do business with the NHS.

10.3.2.2 Ownership, part-ownership or directorates of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

10.3.2.3 Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

10.3.2.4 A position of authority in a charity or voluntary organisation in the field of health and social care;

10.3.2.5 Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services;

10.3.2.6 Any connection with an organisation, entity or company considering entering into a financial arrangement with the Trust, including, but not limited to, lenders or banks.

10.3.3 If Trust Board directors have any doubt about the relevance of an interest, this should be discussed with the Chair.

10.3.4 At the time board directors' interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next Trust Board meeting following the change occurring.

10.3.5 Trust Board directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

10.3.6 During the course of a Trust Board meeting, if a conflict of interest is established, the board director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

10.3.7 There is no requirement for the interests of board directors' spouses or partners to be declared. (Note, however, that Standing Order 11 requires that the interest of directors' spouses, if living together, in contracts should be declared).

10.3.8 It is the obligation of the director to inform the Trust Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest. The secretary will amend the register upon receipt within three working days.

10.4 Authorisation of Conflict of Interest

10.4.1 Where a director has a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust (in contravention of the duty outlined at Standing Order 10), this may be authorised if a majority of directors vote in favour of authorisation.

10.4.2 If there is a dispute as to whether a conflict or potential conflict of interest exists, majority will resolve the issue with the Chair having the casting vote.

10.4.3 If a director has a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust that is not authorised by the Trust Board, the director in question will be deemed to be in breach of the statutory duty.

10.5 Register of Interests

10.5.1 In accordance with the Constitution the Trust Secretary will ensure that a Register of Interests is established to record formally declarations of interests of directors. In particular the register will include details of all directorships and other relevant and material interests which have been declared by both executive and non-executive board directors.

10.5.2 These details will be kept up to date by means of an annual review of the register in which any changes to interests declared during the preceding twelve months will be incorporated and reviewed by the Trust Board.

10.5.3 The register will be available to the public and the Chair will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

11 Exclusion of Directors from Proceedings on Account of Pecuniary Interest

11.1 Subject to the following provisions of this Standing Order, if a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

11.2 The Trust shall exclude a director from a meeting of the Trust while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration.

11.3 For the purpose of this Standing Order, any remuneration, compensation or allowances payable to a director by virtue of paragraph 9 of Schedule 2 to the NHS & Community Care Act 1990, relating to payments of travelling expenses and other allowances as determined by the Secretary of State with the approval of the Treasury, shall not be treated as a pecuniary interest.

11.4 For the purpose of this Standing Order the Chair or a director shall be treated, subject to Standing Order 11.2, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

11.4.1 they, or their nominee, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

11.4.2 they are a partner of, or in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of persons living together as partners the interest of one or other shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

11.5 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

11.5.1 of their membership of a company or other body, if the director has no beneficial interest in any securities of that company or other body;

11.5.2 of an interest in any company, body or person with which the director is connected as mentioned in Standing Order 11.2 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

11.6 Where a director:

11.6.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

11.6.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

11.6.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which the director has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class.

11.6.4 This Standing Order shall not prohibit the director from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to their duty to disclose their interest.

11.7 Standing Order 11 applies to a committee or sub-committee of the Trust as it applies to the Trust and applies to any member of any such committee or sub-committee (whether or not they is also a director of the Trust) as it applies to a director of the Trust.

12 Standards of Business Conduct

12.1 Policy

12.1.1 Directors shall act in accordance with the Nolan Principles Governing Conduct of Public Office Holders at all times.

12.1.2 Staff must comply with the Trust's guidance contained in Standards of Business Conduct Policy. The following provisions should be read in conjunction with that document.

12.2 Interest of Officers in Contracts

12.2.1 If it comes to the knowledge of a director or an officer of the Trust that a contract in which they have any pecuniary interest, not being a contract to which they are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact that they are interested therein. In the case of married persons, or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

12.2.2 An officer or employee must also declare to the Chief Executive any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the

interests of the Trust. A register of declared interests shall be kept and maintained by means of an annual review.

12.3 Canvassing of, and Recommendations by Directors in Relation to Appointments

12.3.1 Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

12.3.2 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment. This does not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust for reference purposes.

12.3.3 Informal discussions which take place with potential candidates outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

12.4 Relatives of Directors of Officers

12.4.1 Candidates for any staff appointment shall, when making application, be required to disclose in writing whether they have a close relationship or are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

12.4.2 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

12.4.3 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

12.4.4 Where the relationship of an officer or another director to a director of the Trust is disclosed, Standing Order 11.2 shall apply.

12.4.5 All managers must comply with the Trust's Standards of Business Conduct Policy.

13 Tendering and Contracting Procedures

Details relating to Tendering and Contracting Procedures can be found in the **Standing Financial Instructions document reference DCM076.**

14 Miscellaneous

14.1 Standing Orders to be Given to Directors and Officers

14.1.1 It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions.

14.1.2 Updated copies shall be available to all staff via the Trust intranet.

14.1.3 New officers designated by the Chief Executive shall be informed in writing of the location and means of accessing Standing Orders.

14.2 Trust Policies

14.2.1 All Trust policies will be prepared, consulted upon and assessed for equality impact in accordance with the Trust document control policy and supporting procedures.

14.2.2 Draft policies presented to the board or the Trust Executive Team for approval must be accompanied by evidence of compliance with the proper procedures for consultation and equality impact assessment.

14.3 Documents Having the Standing of Standing Orders

14.3.1 Standing Financial Instructions, Reservation of Powers to the Trust Board and Delegation of Powers including the Trust's Devolution Policy, shall have the effect as if incorporated into Standing Orders.

14.4 Signature of Documents

14.4.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the board shall have given the necessary authority to some other person for the purpose of such proceedings.

14.4.2 The Chief Executive or nominated officers shall be authorised, by resolution of the board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the board or committee or sub-committee to which the board has delegated appropriate authority.

14.5 Seal and Sealing of Documents

14.5.1 Custody of Seal

14.5.2 The Common Seal of the Trust shall be kept securely by the Trust Secretary as delegated by the Chief Executive. The seal will only be affixed to a document in accordance with these Standing Orders.

14.5.3 Sealing of Documents

14.5.3.1 The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the board in accordance with these Standing Orders. The seal of the Trust must be used in order to execute a deed, when required to do so by law, normally the conveyancing of land.

14.5.3.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Financial Officer and authorised and countersigned by the Chief Executive (or an officer nominated by the Chief Executive who shall not be within the originating directorate).

14.5.4 Register of Sealing

14.5.4.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall

have approved and authorised the document and those who attested the Seal.

14.5.4.2 A report of all sealing shall be made to the Trust at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

14.6 Review of Standing Orders

14.6.1 Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

14.7 Variation of Standing Orders

14.7.1 These Standing Orders shall be amended only if: the requirements provided for in the Constitution for variation of the Constitution have been met and if:

14.7.2 a notice of motion under Standing Order 6.7 has been given; and

14.7.3 no fewer than half the total of the Trust's Non-Executive Directors vote in favour of amendment; and

14.7.4 at least two-thirds of the directors are present; and

14.7.5 the variation proposed does not contravene a statutory provision; and

14.7.6 the proposed amendment has been reported to NHSE.

ANNEX 8 – FURTHER PROVISIONS

1. Application for Membership

1.1 An individual may become a member by application to the Trust in accordance with this Constitution or, where so provided for in this Constitution, by being invited by the Trust to become a member of a staff class of the staff constituency in accordance with paragraph 7.5 of the Trust Constitution.

1.2 Where an individual wishes to apply to become a member of the Trust, the following procedure shall apply:

1.2.1 the Trust shall upon request supply the individual with a form of application for membership in a form determined by the Trust;

1.2.2 upon receipt of the said form of application duly completed or upon application in person or via the telephone, the Trust will complete the actions described in paragraph 1.2.3;

1.2.3 unless the applicant is ineligible for membership or is disqualified from membership, the Trust shall cause their name to be entered forthwith on the Trust's Register of Members and shall give notice in writing to the applicant of that fact;

1.2.4 upon the applicant's name being entered on the Trust's Register of Members the individual shall thereupon become a member;

1.2.5 the information to be included in the Trust's Register of Members shall include the following details relating to that member:

- full name and title;
- the constituency of which they are a member.

1.3 Where an individual is to be invited by the Trust to become a member, the following procedure shall apply:

1.3.1 the Trust shall take all reasonable steps to satisfy itself that the individual is eligible to become a member of the staff constituency before issuing an invitation to become a member of the Trust and that it has all the information needed to administer that person's membership, as may be defined by the Trust from time to time;

1.3.2 the Trust having so satisfied itself, it shall thereupon invite that individual to become a member pursuant to paragraph 7.5 of the Constitution and if necessary shall request the individual to provide such further information, if any, as it may need to administer his or her membership;

1.3.3 unless the individual has within 14 days of the date upon which the Trust dispatches its invitation to him or her to become a member advised the Trust that they do not wish to become a member, the Trust shall thereupon enter that individual's name on the Register of Members and they shall thereupon become a member provided that the Trust has been provided with the information, if any, requested pursuant to paragraph 1.3.2 above to enable it to administer the membership;

1.3.4 if the individual has failed to provide the information requested by the Trust within 14 days of being invited by the Trust to provide it in accordance with paragraph 1.3.2 above, the Trust shall give notice in writing to the applicant that the information has not been provided and that unless and until the information is provided that individual's name shall not be entered on the Register of Members.

1.4 No individual who is ineligible or disqualified from membership shall be entered or remain on the Register of Members.

1.5 For the avoidance of doubt, an individual shall become a member on the date upon which their name is entered on the Trust's Register of Members and shall cease to be a member upon the date on which their name is removed from the Register of Members as provided for in this Constitution.

2. Additional Grounds for Eligibility or Disqualification of Members

2.1 In addition to satisfying those grounds of eligibility otherwise provided for in the Constitution, the Trust reserves the right to exclude persons from membership of the Trust if they are:

- Persons under 16 years of age.
- Vexatious complainants, as defined by the Trust Policy and Procedure for the Management of Feedback from Complaints, Concerns, Comments and Compliments (DCP071) from time to time.
- Former members of the staff of the Trust who were dismissed due to misconduct in the course of their employment.
- Patients of the Trust who have been excluded from treatment by the Trust in accordance with the Trust's policy from time to time for the management of violent and aggressive behaviour towards Trust staff.
- Persons who, within the preceding five years, have committed an act of violence against any of the Trust's employees or registered volunteers in association with their employment, as defined in the Trust's policy from time to time for the management of violent and aggressive behaviour, or who have wilfully damaged Trust property or facilities.

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)101

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	4 November 2026
Director Lead	Keith Haynes, Interim Board Secretary
Contact Officer/Author	Keith Haynes, Interim Board Secretary
Title of the Report	**Governors, Executive Directors, Non-Executive Directors and Other Directors Register of Interests**
Executive Summary	The report provides the current Register of Interests for Governors, Executive Directors, Non-Executive Directors and Other Directors as of October 2026.
Background Information and/or Supporting Document(s) (if applicable)	Standards of Business Conduct Policy (DCP120) and Conflicts of Interest Policy for Governors (DCP228)
Prior Approval Process	Register of Interest (ROI) system
Financial implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

REGISTER OF GOVERNORS' INTERESTS
Nov 2026 (v1.4)

GOVERNOR NAME	INTERESTS	DATE
PUBLIC GOVERNORS – EAST & WEST LINDSEY		
Dr Gorajala Vijay	➢ None	08.12.2025
Vacancy		
Vacancy		
PUBLIC GOVERNORS – GOOLE & HOWDENSHIRE		
Dietmar Harteveld	➢ None	16.12.2025
Brent Huntington	➢ Trustee Friends of Oakhill, Goole ➢ Member of Montague Practice PPG ➢ Board member Goole & Airmyn IDB	08.12.2025
Clare Woodard	➢ Deputy Chief Executive Officer for HEY Smile Foundation	12.01.2026
PUBLIC GOVERNORS – NORTH LINCOLNSHIRE		
Kevin Allen	➢ Volunteer worker at SGH ➢ Local Authority Governor at Scunthorpe C E Primary School ➢ Local Authority Governor at Enderby Road Infants School	15.12.2025
Paula Ashcroft	➢ Persons Voice Co-ordinator for North Lincolnshire Council	15.12.2025
Marian Davison	➢ None	16.12.2025
Wendy Lawtey	➢ Care Quality Commission (CQC) Inspector Adult Social Care (from 12 January 2026)	31.12.2025
Caroline Ridgway	➢ Employed by City Health Care Partnership (CHCP) as a Podiatrist	03.12.2025
PUBLIC GOVERNORS – NORTH EAST LINCOLNSHIRE		
Michael Bateson	➢ Board member/Trustee of local charity Friendship at Home and Niece employed as a Midwife by NLaG	29.10.2026
Cheryl George	➢ None	16.12.2025
David James	➢ Military Care Navigator for Lincolnshire Maternity and Neonatal Programme (Better Births Team)	15.12.2025
Ian Reekie	➢ Director of Lincs Inspire Venues & Enterprises and Member of the Board of Trustees at Lincs Inspire	23.04.2026
Vacancy		

STAKEHOLDER GOVERNORS		
Cllr Anne Handley – East Riding of Yorkshire Council	➢ Leader of East Riding of Yorkshire Council (Conservative Group) ➢ Trustee of Two Rivers Community Pantry, Goole	02.04.2026
Vacancy – North East Lincolnshire Place		
Vacancy – North Lincolnshire Place		
Vacancy – North East Lincolnshire Council		
Vacancy – North Lincolnshire Council		
Vacancy – Lincolnshire Council		

STAFF GOVERNORS		
Ahmed Aftab	➢ Director of Sazin Eyecare Limited and Director of Sazin Estates Limited ➢ Consultant Ophthalmologist - St Hugh's Hospital, Grimsby: Spamedica, Bolton: Lindsey Suite and Inspire Health, Scunthorpe ➢ Member of British Medical Association (BMA) with different local, regional and national roles ➢ Staff Governor	28.04.2026 09.12.2025
Corrin Manaley	➢ Staff Governor	08.12.2025
Dr Sandeep Saxena	➢ Staff Governor ➢ Member of Local Negotiating Committee (LNC) for NLaG	08.12.2025 08.07.2026
Jackie Weavill	➢ Staff Governor	27.11.2025

Register of Interests

Name and position	Interests
Executive and Other Directors	
Kieran Baker, Group Chief Digital Officer	None.
Hilda Gwilliams, Group Chief Patient Safety Officer	None.
Keith Haynes, Interim Board Secretary	None.
Myles Howell, Group Director of Communications	Wife works as Divisional General Manager in the UEC Care Group.
Jo Ledger, Acting Group Chief Nurse	Daughter and niece work at the Trust
Helen Marks, Group Chief People Officer	TBC
Tom Myers, Group Director of Estates	None.
Therese Patten, Interim Trust Chief Executive	TBC
Sam Peate, Group Chief Delivery Officer	Wife is a Healthcare Assistant employed by York and Scarborough Teaching Hospitals NHS Foundation Trust
Emma Sayner, Group Chief Financial Officer	Director of Hull Citycare Ltd (Representing the NHS shareholding interest), Partner in Burton Lodge Guest House (no link to NHS), Board member on Care 2 Independence (Social Enterprise).
Dr Peter Sedman, Group Deputy Chief Medical Officer	Owns shares in The Spire Healthcare Group PLC. Choose and book work with local Spire Hospital
Lyn Simpson, Group Chief Executive Officer	Trustee for Tyneside and Newcastle MIND. Justice of the Peace at Teesside Magistrates.
Rob Stones, Group Director of Performance	TBC

Group Non-Executive Directors	
Julie Beilby, Group Non-Executive Director	South Cockerington Parish Councillor.
Alan Downey, Group Chair	Trustee of Nurtureuk, education charity Wife works for Price Waterhouse Coopers

Dr Paul Edmondson-Jones, Group Associate Non-Executive Director	TBC
Dr Ekta Elston, Group Associate Non-Executive Director	TBC
Jo Gander, Group Non-Executive Director	Trustee of Lincolnshire Humber Federation of WI Non-Executive Director at Doncaster and Bassetlaw Teaching Hospitals Trust
Jane Hawkard, Group Non-Executive Director	Director of JJJ+L Holdings Ltd (July 2020).
Murray Macdonald, Interim Trust Chair	Trustee Manby Scout Group – 2009. Trustee with Lincolnshire Refugee Doctors Project
Dr David Sulch, Group Non-Executive Director	Medicolegal reports on patients in the fields of stroke, geriatric or general medicine (split roughly 80:20 between defendant and claimant work). I have reported on the care of patients treated at HUTH and NLaG previously but do not do so now. Consultant Stroke Physician at Dartford and Gravesham NHS Trust. Medical Examiner at Medway NHS Foundation Trust.

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)102

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	4 November 2026
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer/Author	Philippa Russell, Deputy Group Chief Finance Officer Brian Shipley, Operational Director of Finance
Title of the Report	**Finance Report – Month 6**
Executive Summary	This report summarises the reported financial position as at Month 6 of the 2026/27 reporting period.
Background Information and/or Supporting Document(s) (if applicable)	Report attached
Prior Approval Process	Performance, Estates and Finance Committee in Common
Financial implication(s) (if applicable)	Contained within the report
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:



NHS
Humber Health
Partnership

Finance Report Month 6
September – 2026/27

Finance Overview

In-month I&E Performance – page 3 to 8

(£4.5m) The Group reported an in-month deficit for month 6 of (£10.1m), (£4.5m) adverse to plan.

Year to Date I&E Performance – page 3 to 8

(£20.8m) The Group reported a year-to-date deficit of (£60.6m), (£20.8m) adverse to plan. The position includes (£1.5m) of expenditure relating to Industrial Action cover.

I&E Forecast Outturn & Risk – page 9 to 11

(£43.1m) The Group is formally forecasting a plan compliant position. However, an adjusted straight-line projection would give a deficit of (£136. 0m). Mitigating actions reduce the deficit leaving an unidentified gap of (£43.1m).

YTD Cost Improvement Plan – page 12 to 13

(£26.7m) The Group has delivered £24.0m in CIP against a YTD target of £50.7m, (£26.7m) behind target.The Group are forecasting CIP delivery of £71.5m, (£47.7m) adverse to plan.

Underlying I&E – page 14

(£152.3m) The Group's underlying position is estimated at a deficit of circa (£152.3m). In year recurrent CIP delivery will be the key driver of its underlying financial position.

System Performance – page 15

(£54.3m) The ICS reported a YTD deficit of (£96.5m), (£54.3m) adverse to plan at month 6. The ICS is forecasting a (£63.1m) deficit for the year in line with plan.(*Values are including DSF)

Capital Expenditure – page 16

(£20.9m) The Group has spent £11.0m on capital expenditure against a plan of £31.9m, (£20.9m) behind plan.

Balance Sheet & Cash – pages 17 to 18

£44.9m The Group's cash balance at the end of month 6 was £44.9m. The Group continues to require additional external cash support. At the end of month 6 the Group has drawn down £30.0m in additional cash support.

Variable Pay – pages 19 to 25

£6.6m The Group has spent £47.1m on variable pay, £6.6m 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 6 with a year-to-date (YTD) deficit of (£60.6m), (£20.8m) adverse to plan.

£million	HUTH £m						NLAG £m						HHP £m					
	CM			YTD			CM			YTD			CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income																		
Clinical Income	75.8	75.2	(0.6)	454.8	457.2	2.4	47.2	47.2	(0.0)	282.0	280.6	(1.5)	123.0	122.4	(0.6)	736.9	737.8	0.9
Other Income	6.3	7.2	0.9	36.9	38.8	1.8	4.8	4.7	(0.1)	27.3	27.9	0.6	11.1	12.0	0.9	64.2	66.7	2.4
Total Operating Income	**82.1**	**82.5**	**0.3**	**491.8**	**496.0**	**4.2**	**52.0**	**51.9**	**(0.1)**	**309.3**	**308.5**	**(0.9)**	**134.1**	**134.4**	**0.3**	**801.1**	**804.5**	**3.4**
Pay Costs																		
Clinical Pay	(41.3)	(43.2)	(1.9)	(249.0)	(256.5)	(7.5)	(30.1)	(29.7)	0.4	(179.4)	(176.6)	2.8	(71.4)	(72.9)	(1.5)	(428.4)	(433.1)	(4.7)
Other Pay	(8.4)	(8.6)	(0.2)	(51.9)	(52.0)	(0.1)	(7.3)	(7.4)	(0.1)	(43.5)	(43.7)	(0.2)	(15.7)	(16.0)	(0.3)	(95.4)	(95.8)	(0.3)
Total Pay Costs	**(49.7)**	**(51.9)**	**(2.1)**	**(300.9)**	**(308.5)**	**(7.6)**	**(37.4)**	**(37.1)**	**0.3**	**(223.0)**	**(220.4)**	**2.6**	**(87.1)**	**(88.9)**	**(1.8)**	**(523.9)**	**(528.9)**	**(5.0)**
Clinical Non Pay	(19.6)	(20.6)	(1.0)	(119.0)	(124.5)	(5.5)	(8.1)	(8.4)	(0.3)	(48.9)	(50.3)	(1.5)	(27.8)	(29.1)	(1.3)	(167.8)	(174.8)	(7.0)
Other Non Pay	(11.6)	(13.4)	(1.7)	(71.2)	(81.3)	(10.1)	(6.0)	(6.4)	(0.4)	(35.3)	(40.7)	(5.4)	(17.6)	(19.8)	(2.1)	(106.5)	(122.0)	(15.6)
Total Non Pay Costs	**(31.3)**	**(34.0)**	**(2.8)**	**(190.2)**	**(205.8)**	**(15.7)**	**(14.1)**	**(14.8)**	**(0.7)**	**(84.1)**	**(91.0)**	**(6.9)**	**(45.4)**	**(48.9)**	**(3.5)**	**(274.3)**	**(296.8)**	**(22.6)**
Total Operating Expenditure	**(81.0)**	**(85.9)**	**(4.9)**	**(491.0)**	**(514.3)**	**(23.3)**	**(51.6)**	**(51.9)**	**(0.4)**	**(307.1)**	**(311.4)**	**(4.3)**	**(132.5)**	**(137.8)**	**(5.3)**	**(798.1)**	**(825.7)**	**(27.6)**
EBITDA	**1.2**	**(3.4)**	**(4.6)**	**0.7**	**(18.3)**	**(19.0)**	**0.4**	**(0.0)**	**(0.4)**	**2.2**	**(2.9)**	**(5.2)**	**1.6**	**(3.4)**	**(5.0)**	**3.0**	**(21.2)**	**(24.2)**
Depreciation	(2.7)	(2.7)	0.0	(16.1)	(16.0)	0.2	(2.4)	(2.0)	0.4	(14.1)	(10.9)	3.2	(5.0)	(4.7)	0.4	(30.2)	(26.8)	3.4
Non Operating Items	(1.5)	(1.5)	0.0	(9.2)	(8.9)	0.3	(0.7)	(0.5)	0.1	(4.1)	(3.4)	0.6	(2.2)	(2.0)	0.2	(13.3)	(12.3)	0.9
Surplus/(Deficit)	**(3.1)**	**(7.6)**	**(4.5)**	**(24.6)**	**(43.1)**	**(18.5)**	**(2.6)**	**(2.5)**	**0.1**	**(15.9)**	**(17.2)**	**(1.3)**	**(5.7)**	**(10.1)**	**(4.4)**	**(40.5)**	**(60.4)**	**(19.9)**
NHSE Allowable Adjustments	(0.1)	(0.1)	0.1	(0.1)	(0.6)	(0.5)	0.1	0.1	(0.1)	0.9	0.4	(0.5)	(0.0)	(0.0)	(0.0)	0.8	(0.2)	(1.0)
Adjusted Surplus / (Deficit)	**(3.2)**	**(7.7)**	**(4.5)**	**(24.8)**	**(43.8)**	**(19.0)**	**(2.5)**	**(2.5)**	**0.0**	**(15.0)**	**(16.8)**	**(1.8)**	**(5.7)**	**(10.1)**	**(4.5)**	**(39.7)**	**(60.6)**	**(20.8)**

- **The Group reported a (£10.1m) deficit in month, (£4.5m) adverse to plan. The Group has incurred (£1.5m) to cover Industrial Action in April.**
- The Group is behind on its CIP programme by (£26.7m). This is only partly mitigated through vacancy factors and other underspends.
- The Group cash balance decreased by £6.2m in month to £44.9m (£19.9m HUTH / £25.0m NLAG), but the majority of the available cash is linked to capital creditors and slippage on the capital programme. £30.0m of additional external cash support (Revenue Support Public Dividend Capital (PDC)) has been drawn down at the end of Month 6. The Group requested £12.5m of cash support for October and had £10.0m approved. HUTH October drawdown requirement was £6.34m (£1.16m lower than allocated) due to an expected improvement in the aged Debtor position and higher than forecast Education income paid in advance. However, the majority of this improvement is a timing difference with £11.8m requested for November that is still awaiting NHSE approval.

See Appendix A on Page 18 to 19 for Detailed I&E Position

Financial Performance Summary: By Care Group

Directorate	Directorate 2	Care Group	YTD Budget	YTD Actual	YTD Variance	In Month Variance	% Overspend	% CIP Identified (Forecast)	Escalate	% Overspend movement M6
			£000's	£000's	£000's	£'000's				
Central Income			752,936	748,932	(4,004)	(762)	-0.5%			→
Corporate Directorates			(129,288)	(130,981)	(1,693)	(800)	-1.3%	55.0%		↓
Finance Technical			(44,665)	(39,687)	4,977	130				
Operations	Operations North	Acute And Emergency Medicine North	(22,715)	(24,997)	(2,281)	(270)	-10.0%	46.5%	Y	↑
		Cancer Network	(4,510)	(4,454)	56	42	1.2%	20.3%	N	↑
		Cardiovascular	(26,441)	(27,814)	(1,373)	(197)	-5.2%	111.5%	Monitor	↑
		Chief Delivery Officer	(422)	(651)	(230)	(10)	-54.5%	0.0%	Monitor	↑
		Digestive Diseases	(35,017)	(38,672)	(3,655)	(554)	-10.4%	49.0%	Y	↑
		Head & Neck	(29,266)	(29,101)	165	(68)	0.6%	84.9%	N	↓
		Patient Services	(22,907)	(23,164)	(257)	74	-1.1%	31.7%	Monitor	↑
		Specialist Cancer And Support Services	(146,065)	(150,257)	(4,192)	(825)	-2.9%	47.3%	Y	↓
		Theatres, Anaesthetics And Critical Care	(65,102)	(67,668)	(2,567)	(636)	-3.9%	54.3%	Y	↓
	Operations North Total		**(352,444)**	**(366,778)**	**(14,334)**	**(2,444)**	-4.1%			
	Operations South	Acute And Emergency Medicine South	(34,667)	(35,885)	(1,218)	(247)	-3.5%	73.6%	N	↓
		Chief Delivery Officer	(446)	(414)	32	29	7.1%	0.0%	N	↑
		Community, Frailty & Therapy	(45,221)	(47,520)	(2,299)	(267)	-5.1%	39.0%	Y	↑
		Family Services	(59,636)	(61,453)	(1,816)	(387)	-3.0%	43.6%	Y	↓
		Neuroscience	(19,783)	(20,866)	(1,082)	(331)	-5.5%	48.2%	Y	↓
		Pathology Network Group	(26,163)	(26,292)	(129)	(15)	-0.5%	75.8%	N	↓
		Site Management & Discharge Teams	(3,742)	(3,853)	(110)	(15)	-3.0%	37.2%	Monitor	↑
		Specialist Medicine	(37,833)	(39,371)	(1,538)	(177)	-4.1%	28.0%	Y	↑
		Specialist Surgery	(34,473)	(35,792)	(1,319)	(94)	-3.8%	60.5%	Monitor	↑
	Operations South Total		**(261,965)**	**(271,444)**	**(9,480)**	**(1,504)**	-3.6%			
Operations Total			**(614,408)**	**(638,222)**	**(23,814)**	**(3,947)**	-3.9%			
Reserves			(5,100)	(425)	4,676	933				
Grand Total			**(40,525)**	**(60,383)**	**(19,857)**	**(4,447)**				
Adjusted Financial Performance			776	(206)	(982)	(8)				
Adjusted Financial Performance (surplus / (deficit)			**(39,749)**	**(60,589)**	(20,839)	(4,455)				

Financial Performance – Forecast Outturn (FOT)

The Group is forecasting a deficit of (£121.2m) 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 (£43.1m) 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 £58.6m, a gap of £60.5m. This is an improvement of £1.6m vs M5.
- A straight-line forecast based on the YTD deficit position would leave the group with a £121.2m deficit by year end. When adjusted for seasonality, expenditure that has not yet started and non recurrent slippage in the year-to-date position, this deficit increases to £136.0m, no significant improvement since M5.
- Forecast CIP delivery has reduced in total since reporting M5, but the risk adjusted value has increased. Undeveloped opportunities included in the forecast have reduced from £15m to £10m as schemes have been progressed. Forecast assumes improved efficiency of at least £23.5m.
- Unidentified mitigation has increased by £3.6m to £43.1m which is the level of further improvement required to close the remaining efficiency gap.
- The forecast also assumes a level of mitigation through additional non recurrent income and non recurrent flexibility

	Current Month			Previous Month			Movement		
Forecast Bridge (Group)	HUTH £'m	NLAG £'m	HHP £'m	HUTH £'m	NLAG £'m	HHP £'m	HUTH £'m	NLAG £'m	HHP £'m
YTD deficit (M6)	(43.8)	(16.8)	(60.6)	(36.1)	(14.3)	(50.5)	(7.7)	(2.5)	(10.1)
Straight line forecast	**(87.6)**	**(33.6)**	**(121.2)**	**(86.7)**	**(34.4)**	**(121.1)**	**(0.9)**	**0.8**	**(0.1)**
Seasonality	(1.2)	(1.5)	(2.7)	(1.3)	(1.5)	(2.8)	0.1	-	0.1
Industrial Action	1.1	0.3	1.5	1.6	0.5	2.0	(0.4)	(0.1)	(0.6)
Investment Expenditure Profile	(2.6)	(1.9)	(4.5)	(3.3)	(2.4)	(5.7)	0.7	0.5	1.2
Expected changes to run-rate	(3.8)	(3.6)	(7.3)	(4.0)	(3.1)	(7.0)	0.2	(0.5)	(0.3)
Depreciation, Interest Received & PDC	-	(1.8)	(1.8)	-	(1.8)	(1.8)	-	0.0	0.0
Adjusted Run Rate	**(94.0)**	**(42.0)**	**(136.0)**	**(93.8)**	**(42.7)**	**(136.4)**	**(0.3)**	**0.7**	**0.5**
Forecast CIP delivery (improvement in run-rate)	14.6	8.8	23.5	21.4	7.1	28.5	(6.8)	1.8	(5.0)
Non recurrent mitigation	0.5	3.4	3.9		3.0	3.0	0.5	0.4	0.9
Additional Non Recurrent (Technical)			-			-	-	-	-
Additional Non Recurrent Income	2.4		2.4	2.4		2.4	-	-	-
Forecast deficit	**(76.5)**	**(29.7)**	**(106.2)**	**(69.9)**	**(32.6)**	**(102.6)**	**(6.5)**	**2.9**	**(3.6)**
Plan	**(39.4)**	**(23.7)**	**(63.1)**	**(39.4)**	**(23.7)**	**(63.1)**	**-**	**-**	**-**
Unmitigated Variance	**(37.1)**	**(6.1)**	**(43.1)**	**(30.5)**	**(9.0)**	**(39.5)**	**(6.5)**	**2.9**	**(3.6)**

Financial Performance – Forecast Scenarios

The Group has a significant amount of risk to its core Best Case forecast deficit of £106.2m, particularly CIP forecast delivery.

Forecast Bridge (Group)	HUTH £'m	NLAG £'m	Group £'m
Best Case			
Reported Forecast (as per Plan)	(39.40)	(23.7)	(63.1)
Less Unidentified Mitigation	(37.08)	(6.06)	(43.1)
Forecast deficit	**(76.5)**	**(29.7)**	**(106.2)**
Variance	**(37.1)**	**(6.1)**	**(43.1)**
Mid Case			
Reported Forecast (as per Plan)	(39.40)	(23.67)	(63.1)
Less Unidentified Mitigation	(37.08)	(6.06)	(43.1)
CIP adjusted to reflect current risk adjusted forecast	(8.37)	(4.4)	(12.8)
Forecast deficit	**(84.9)**	**(34.1)**	**(119.0)**
Variance	**(45.5)**	**(10.5)**	**(55.9)**
Worst Case			
Reported Forecast (as per Plan)	(39.40)	(23.67)	(63.1)
Less Unidentified Mitigation	(37.08)	(6.06)	(43.1)
No further improvement in CIP delivery vs run-rate	(14.65)	(8.8)	(23.5)
Variable Income Risk	(2.90)	(1.3)	(4.2)
RTT / 52 week recovery	(5.23)	(2.7)	(7.9)
Winter Pressures / Growth Risk	(0.60)	(0.4)	(1.0)
Inflationary Risks	(0.40)	(0.5)	(0.9)
Other risks			0.0
Forecast deficit	**(100.3)**	**(43.4)**	**(143.6)**
Variance	**(60.9)**	**(19.7)**	**(80.6)**

This analysis matches the scenarios included in the Provider Assurance Model (PAM).

Best case assumes all identified CIP, including opportunities that have not yet been worked up are delivered and aligns with the forecast assumptions described in the forecast bridge.

Mid case reflects the risk adjusted CIP forecast at M6.

Worst case assumes no further CIP is delivered (over and above the level already assumed in the YTD position) plus some additional risks to delivery including potential additional costs required to deliver required RTT improvement.

Financial Performance – Recovery Plan

A new Financial Recovery Programme (FRP) started at the beginning of September with a fortnightly FRP Board meeting, chaired by the CEO and a fortnightly FRP Delivery Group chaired by the Financial Improvement Director. The Delivery Group is providing structured check and challenge with Care Groups and Corporate areas, reviewing progress against financial recovery and Cost Improvement Programme (CIP) plans and agreeing the actions required to close identified gaps.

- Agreed a targeted 30% / £30m reduction in variable pay with associated Care Group targets – the majority of Care Groups have developed plans to achieve this target, but further work required to deliver with c. 10% reduction YTD.
- Introduced weekly tracking of a range of metrics including CIP progress, variable pay and vacancy approvals alongside increased visibility and scrutiny of run rates.
- Full vacancy pause was implemented on the 6th of July and now that that has come to an end, a revised vacancy approval process has been implemented with separate Medical, Clinical and Non-Clinical panels to scrutinise all vacancies and all temporary staffing requests with a further Executive Team sign off requirement for all approved requests.
- Recovery Action Plan's escalated to Performance & Finance Committee for the Care Groups' of greatest concern.
- Business Case in-development for Voluntary Redundancy programme.
- Alignment with clinical priorities through the Integrated Recovery Plan – action plans signed off 30th June 2026.
- Strengthened CIP development & support delivery - Appointment of Grant Thornton & Keith Pringle - Financial Improvement Director. Grant Thornton are directly supporting the 8 most challenged Care Groups to deliver their CIP and financial plans.
- New Non-Pay Panel in place to review all non-clinical orders over £500. This new panel has a much wider remit than the Discretionary Spend Panel, with full oversight of non-pay governance and efficiency opportunities.
- The Business Case approval process has been significantly strengthened over the last 12 months, and a full post implementation review of all cases approved over the last 12 months is under way.

Financial Performance – CIP Delivery

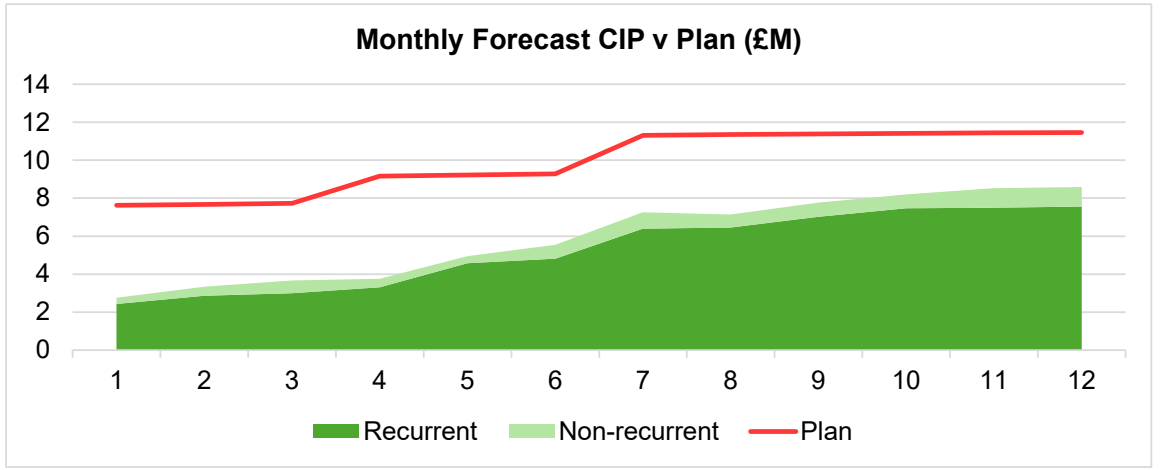
The Group has delivered £24.0m CIP year-to-date against a target of £50.7m, (£26.7m) adverse. The Group is forecasting CIP delivery of £71.5m (£47.7m) adverse to plan.

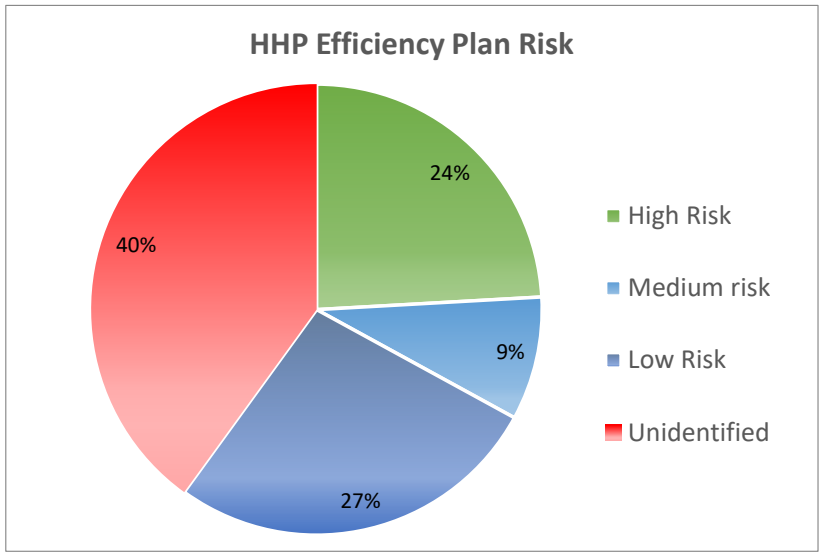
		HUTH						NLAG						HHP					
		Year to Date			Forecast Year-end			Year to Date			Forecast Year-end			Year to Date			Forecast Year-end		
£000		Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Operations	Acute and Emergency Medicine North	1,386	261	(1,125)	2,771	1,288	(1,483)	0	0	0	0	0	0	1,386	261	(1,125)	2,771	1,288	(1,483)
	Acute and Emergency Medicine South	0	0	0	0	0	0	2,582	1,535	(1,046)	5,163	3,799	(1,364)	2,582	1,535	(1,046)	5,163	3,799	(1,364)
	Cancer Network	102	20	(82)	205	47	(158)	66	7	(59)	133	21	(111)	169	27	(142)	337	68	(269)
	Cardiovascular	1,061	176	(885)	2,122	2,633	511	269	150	(119)	538	331	(207)	1,330	326	(1,004)	2,661	2,964	304
	Chief Delivery Officer	27	0	(27)	54	0	(54)	29	0	(29)	58	0	(58)	56	0	(56)	112	0	(112)
	Community, Frailty & Therapy	1,082	339	(743)	2,163	1,095	(1,068)	1,293	239	(1,054)	2,586	753	(1,833)	2,374	578	(1,797)	4,749	1,848	(2,901)
	Digestive Diseases	898	341	(557)	1,796	956	(840)	909	341	(567)	1,818	811	(1,006)	1,807	682	(1,124)	3,614	1,767	(1,847)
	Family Services	1,508	485	(1,023)	3,017	1,536	(1,481)	1,529	674	(855)	3,060	1,111	(1,949)	3,037	1,159	(1,878)	6,076	2,647	(3,430)
	Head & Neck	990	782	(209)	1,981	1,662	(319)	640	516	(124)	1,279	1,105	(175)	1,630	1,298	(332)	3,260	2,767	(493)
	Major Trauma Network	80	21	(60)	161	43	(118)	0	0	0	0	0	0	80	21	(60)	161	43	(118)
	Neuroscience	665	353	(312)	1,331	668	(663)	314	84	(229)	628	274	(354)	979	437	(542)	1,958	941	(1,017)
	Pathology Network Group	317	331	14	635	666	31	1,024	435	(589)	2,048	1,369	(679)	1,342	767	(575)	2,683	2,034	(649)
	Patient Services	570	179	(391)	1,140	483	(656)	486	47	(439)	972	187	(786)	1,056	226	(830)	2,112	670	(1,442)
	Site Management & Discharge Teams	84	20	(65)	169	65	(103)	109	28	(81)	218	79	(140)	193	47	(146)	387	144	(243)
	Specialist Cancer And Support Services	2,760	536	(2,224)	5,521	1,801	(3,720)	1,937	507	(1,430)	3,875	2,638	(1,237)	4,698	1,043	(3,654)	9,396	4,439	(4,957)
	Specialist Medicine	868	87	(781)	1,736	191	(1,545)	641	286	(356)	1,283	654	(629)	1,509	372	(1,137)	3,019	845	(2,174)
	Specialist Surgery	1,062	282	(780)	2,123	888	(1,235)	726	564	(162)	1,452	1,271	(181)	1,788	846	(942)	3,575	2,159	(1,416)
	Theatres, Anaesthetics And Critical Care	1,935	387	(1,548)	3,871	1,926	(1,944)	1,334	443	(891)	2,668	1,627	(1,040)	3,269	831	(2,439)	6,539	3,554	(2,985)
Total Operations		**15,397**	**4,599**	**(10,798)**	**30,795**	**15,948**	**(14,846)**	**13,888**	**5,857**	**(8,031)**	**27,777**	**16,029**	**(11,749)**	**29,285**	**10,456**	**(18,829)**	**58,572**	**31,977**	**(26,595)**
Corporate	Chief Executive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Chief Medical Officer	361	100	(261)	721	200	(521)	101	0	(101)	201	0	(201)	461	100	(361)	922	200	(722)
	Chief Nurse	301	56	(245)	602	311	(291)	282	98	(184)	565	508	(57)	583	154	(429)	1,166	819	(347)
	Director Of Assurance	13	0	(13)	25	48	23	27	18	(9)	53	79	26	39	18	(21)	78	127	49
	Director Of People	382	0	(382)	764	316	(447)	319	0	(319)	638	375	(263)	701	0	(701)	1,402	692	(710)
	Finance - E&F	2,640	1,870	(770)	5,280	4,201	(1,078)	1,601	203	(1,399)	3,203	1,132	(2,071)	4,241	2,072	(2,169)	8,482	5,333	(3,150)
	Finance - Finance	144	110	(34)	289	220	(69)	119	81	(39)	239	152	(86)	264	191	(72)	527	372	(155)
	Finance - Procurement	62	0	(62)	124	0	(124)	44	0	(44)	87	0	(87)	106	0	(106)	212	0	(212)
	Finance - S & P	198	0	(198)	397	151	(246)	117	62	(55)	233	246	12	315	62	(253)	630	397	(234)
	Strategy, Partnerships and Digital	431	8	(423)	862	52	(810)	359	102	(257)	718	324	(394)	790	111	(679)	1,580	376	(1,204)
Total Corporate		**4,531**	**2,145**	**(2,387)**	**9,063**	**5,500**	**(3,563)**	**2,968**	**564**	**(2,405)**	**5,937**	**2,816**	**(3,121)**	**7,500**	**2,708**	**(4,791)**	**15,000**	**8,315**	**(6,684)**
Total Allocated CIP Core Programme		**19,929**	**6,744**	**(13,185)**	**39,857**	**21,448**	**(18,409)**	**16,856**	**6,421**	**(10,435)**	**33,714**	**18,844**	**(14,870)**	**36,785**	**13,165**	**(23,620)**	**73,572**	**40,292**	**(33,279)**
Trustwide	Reserves	0	1,647	1,647	0	2,400	2,400	0	2,152	2,152	0	3,903	3,903	0	3,799	3,799	0	6,303	6,303
	Technical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Unallocated	6,464	0	(6,464)	22,043	7,582	(14,461)	457	0	(457)	9,486	3,270	(6,215)	6,921	0	(6,921)	31,528	10,852	(20,676)
	Full Year Effects	5,491	5,496	6	10,981	10,981	0	1,512	1,509	(3)	3,023	3,023	0	7,002	7,005	3	14,004	14,004	0
Total Technical & Unallocated		**11,954**	**7,143**	**(4,811)**	**33,024**	**20,963**	**(12,061)**	**1,969**	**3,661**	**1,692**	**12,509**	**10,196**	**(2,312)**	**13,923**	**10,804**	**(3,119)**	**45,532**	**31,159**	**(14,374)**
TOTAL		**31,883**	**13,887**	**(17,996)**	**72,881**	**42,411**	**(30,470)**	**18,825**	**10,082**	**(8,743)**	**46,223**	**29,041**	**(17,182)**	**50,708**	**23,969**	**(26,739)**	**119,104**	**71,451**	**(47,653)**

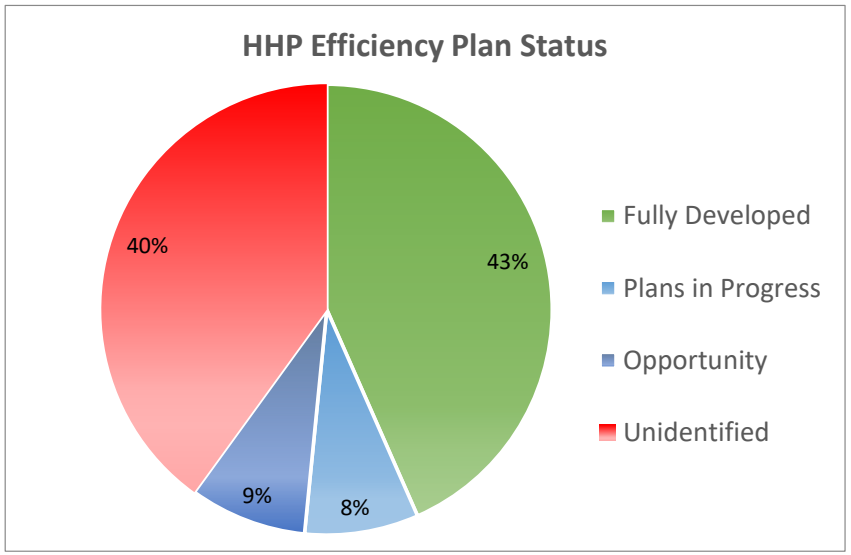
Financial Performance – CIP

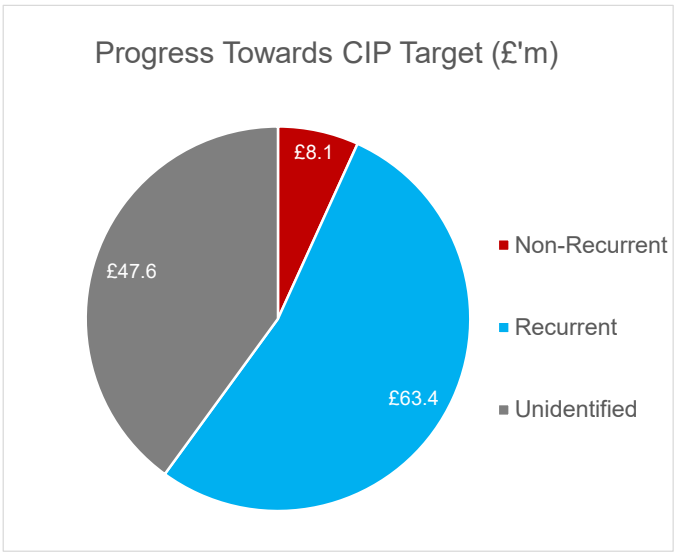
Efficiency Forecast Risk	HUTH	NLAG	HHP
High Risk	10,218	18,494	28,711
Medium risk	4,452	6,097	10,549
Low Risk	27,741	4,450	32,191
Unidentified	30,470	17,182	47,652
TOTAL	**72,881**	**46,223**	**119,103**

Efficiency Forecast Status	HUTH	NLAG	HHP
Fully Developed	29,576	22,117	51,693
Plans in Progress	5,995	3,743	9,738
Opportunity	6,839	3,180	10,019
Unidentified	30,470	17,182	47,652
TOTAL	**72,881**	**46,223**	**119,103**









Underlying Position

The Group's underlying financial position is estimated at a deficit of (£152.3m), a deterioration of (£13.5m) from month 5.

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 (£71.0m).
3. The in year CIP schemes have a potential FYE of £4.5m 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 £6.3m 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)	(19.4)	(51.6)	(71.0)
FYE 26/27 CIP (Risk Adjusted)	2.5	2.0	4.5
NR Industrial Action	0.3	1.1	1.5
FYE 26/27 Investments	(3.0)	(5.4)	(8.5)
NR Technical & Other	(4.9)	(1.3)	(6.3)
Underlying Deficit	**(46.9)**	**(105.4)**	**(152.3)**

System Financial Performance – Month 6, September 2026

The ICS reported a YTD deficit of (£96.5m), (£54.3m) adverse to plan. The ICS is forecasting a (£63.1m) plan compliant deficit at the year end. (Headline values include Deficit Support Funding)

			Surplus / (Deficit) Including DSF						Surplus / (Deficit) Excluding DSF					
Code	Name	ICB / Provider	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s
Humber and North Yorkshire														
QOQ	NHS Humber and North Yorkshire ICB	ICB	0	0	0	0	0	0	(5,442)	(5,442)	0	(10,883)	(10,883)	0
RCD	Harrogate and District NHS Foundation Trust	Provider	(2,553)	(22,177)	(19,624)	0	0	0	(9,303)	(22,177)	(12,874)	(13,500)	(13,500)	0
RWA	Hull University Teaching Hospitals NHS Trust	Provider	(24,780)	(43,794)	(19,014)	(39,400)	(39,400)	0	(24,780)	(43,794)	(19,014)	(39,400)	(39,400)	0
RV9	Humber Teaching NHS Foundation Trust	Provider	0	0	0	0	0	0	0	0	0	0	0	0
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Provider	(14,968)	(16,793)	(1,825)	(23,665)	(23,665)	0	(14,968)	(16,793)	(1,825)	(23,665)	(23,665)	0
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Provider	82	(13,742)	(13,824)	0	0	0	(9,166)	(18,367)	(9,201)	(18,500)	(18,500)	0
Humber and North Yorkshire Provider Total		**QOQ**	**(42,219)**	**(96,506)**	**(54,287)**	**(63,065)**	**(63,065)**	**0**	**(58,217)**	**(101,131)**	**(42,914)**	**(95,065)**	**(95,065)**	**0**
Humber and North Yorkshire Total		**QOQ**	**(42,219)**	**(96,506)**	**(54,287)**	**(63,065)**	**(63,065)**	**0**	**(63,659)**	**(106,573)**	**(42,914)**	**(105,948)**	**(105,948)**	**0**

			Total Efficiencies					
Code	Name	ICB / Provider	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s
Humber and North Yorkshire								
QOQ	NHS Humber and North Yorkshire ICB	ICB	36,795	36,768	(27)	81,468	81,468	0
RCD	Harrogate and District NHS Foundation Trust	Provider	14,661	6,618	(8,043)	32,000	32,000	0
RWA	Hull University Teaching Hospitals NHS Trust	Provider	31,883	13,887	(17,996)	72,881	72,881	(0)
RV9	Humber Teaching NHS Foundation Trust	Provider	7,446	7,451	5	14,353	14,353	0
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Provider	18,826	10,082	(8,744)	46,223	46,223	(0)
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Provider	31,796	24,748	(7,048)	65,787	65,786	(1)
Humber and North Yorkshire Provider Total		**QOQ**	**104,612**	**62,786**	**(41,825)**	**231,244**	**231,242**	**(2)**
Humber and North Yorkshire Total		**QOQ**	**141,407**	**99,554**	**(41,853)**	**312,712**	**312,710**	**(1)**

Note - The ICS plan has been updated following formal agreement of revised financial plans for Harrogate & York Trusts.

Capital Expenditure

The Group has spent £11.0m year to date on capital expenditure against a plan of £31.9m plan, (£20.9m) 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	3.0	0.0	(3.0)	0.0	0.0	0.0	3.0	0.0	(3.0)
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	0.2	0.4	0.2	0.2	0.0	(0.2)	0.4	0.4	0.1
HRI Tower Block	0.0	0.0	0.0	6.0	0.1	(5.9)	6.0	0.1	(5.9)
SDEC	0.0	0.0	0.0	5.0	0.3	(4.7)	5.0	0.3	(4.7)
Total Estates Major Schemes	**3.2**	**0.6**	**(2.6)**	**11.2**	**0.4**	**(10.8)**	**14.4**	**0.9**	**(13.4)**
Other Estates Schemes	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.1	0.0
IM&T Programme	1.0	0.4	(0.6)	0.3	0.5	0.2	1.3	0.9	(0.4)
EPR	3.8	2.2	(1.7)	2.1	2.4	0.3	6.0	4.6	(1.4)
Equipment Renewal	1.0	0.1	(0.9)	3.2	0.5	(2.7)	4.2	0.6	(3.6)
Facilities Maintenance	1.2	0.3	(0.8)	0.7	0.8	0.1	1.8	1.1	(0.7)
Other Capital Expenditure	0.8	0.4	(0.4)	3.5	2.5	(1.0)	4.2	2.8	(1.4)
Total Capital Programme	**11.0**	**4.0**	**(7.0)**	**20.9**	**7.0**	**(13.9)**	**31.9**	**11.0**	**(20.9)**
Funded By:									
Internally Generated	8.0	3.1	(4.9)	9.6	6.6	(3.0)	17.6	9.7	(7.9)
PDC Funded	2.2	0.5	(1.7)	11.2	0.0	(11.2)	13.4	0.5	(12.9)
Donated	0.1	0.0	(0.0)	0.2	0.2	0.0	0.2	0.2	0.0
IFRS16	0.7	0.3	(0.4)	0.0	0.3	0.3	0.7	0.6	(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	**11.0**	**4.0**	**(7.0)**	**20.9**	**7.0**	**(13.9)**	**31.9**	**11.0**	**(20.9)**

Key areas of slippage in Month 6 continue to relate to HRI: the reconfiguration required to facilitate SDEC and the Tower Block improvements. Expected internal slippage on SDEC has now been agreed (£5.4m) with mitigating items already in the planned capital programme for 2027/2028 brought forward to 2026/2027, including theatre improvements at HRI and CHH and additional backlog maintenance.

The revised profile and cost for the Tower Block scheme has been agreed and £10.1m has been slipped to 2027/2028. The associated PDC funding will also be drawn down in 2027/2028.

ITU at DPoW continues to be behind plan, internal slippage has now been agreed at £2.2m, with actions now in place to bring forward schemes from 2027/28 into this year. Schemes agreed to be brought forward include Goole Fire Alarms phase 2, SGH lifts and other backlog maintenance schemes.

The NLAG have has also approved to defer external funding for the Gamma Camera to 2027/28.

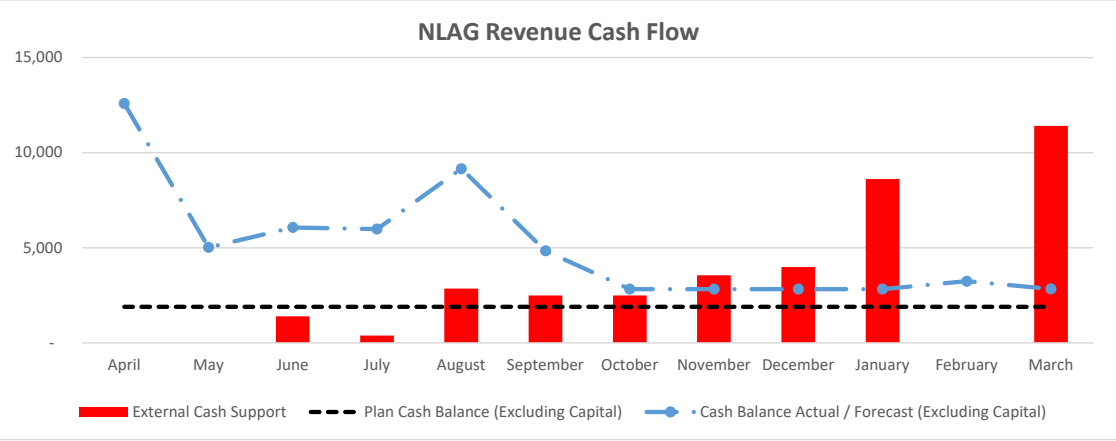
Ward C6 at DPoW is expected to be completed at the end of October.

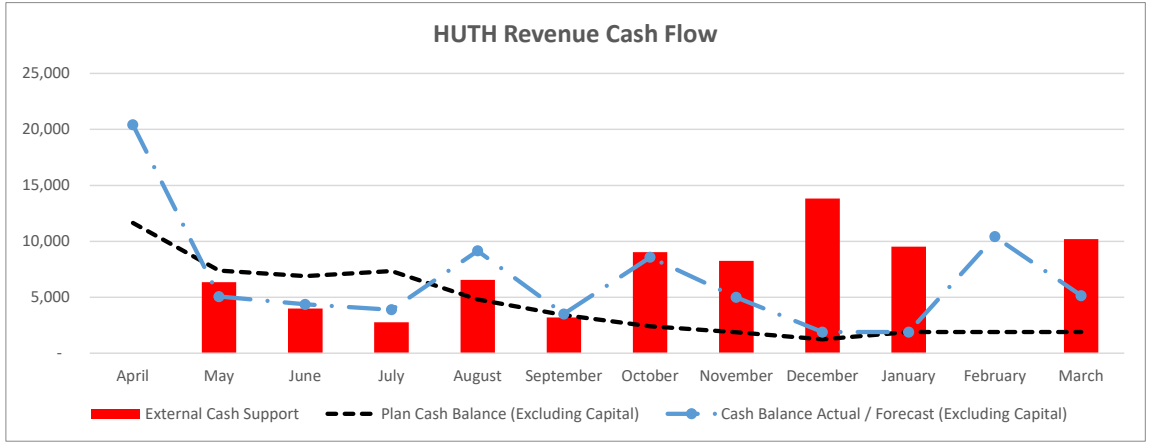
Balance Sheet

£ million	NLAG			HUTH			HHP		
	Actual	Actual	In month	Actual	Actual	In month	Actual	Actual	In month
	31-Aug-26	30-Sep-26	movement	31-Aug-26	30-Sep-26	movement	31-Aug-26	30-Sep-26	movement
Fixed Assets	307.2	305.9	(1.2)	539.0	537.4	(1.6)	846.2	843.3	(2.8)
Other Investments	0.0	0.0	0.0	0.6	0.6	0.0	0.6	0.6	0.0
Current Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Inventories	5.1	5.3	0.2	20.4	20.6	0.2	25.5	25.8	0.4
Trade and Other Debtors	19.3	19.2	(0.2)	45.4	41.4	(4.0)	64.7	60.5	(4.2)
Cash	31.1	25.0	(6.1)	20.0	19.9	(0.1)	51.1	44.9	(6.2)
Total Current Assets	**55.5**	**49.4**	**(6.1)**	**85.8**	**81.8**	**(4.0)**	**141.3**	**131.2**	**(10.0)**
Current Liabilities									
Trade and Other Creditors	(64.3)	(62.1)	2.2	(81.3)	(76.9)	4.4	(145.7)	(139.0)	6.6
Accruals	(27.9)	(25.3)	2.6	(42.9)	(52.1)	(9.2)	(70.8)	(77.5)	(6.7)
Other Current Liabilities	(9.9)	(7.3)	2.7	(26.1)	(21.2)	5.0	(36.1)	(28.5)	7.6
Total Current Liabilities	**(102.2)**	**(94.7)**	**7.5**	**(150.4)**	**(150.2)**	**0.1**	**(252.5)**	**(245.0)**	**7.6**
Net Current Liabilities	**(46.7)**	**(45.3)**	**1.4**	**(64.6)**	**(68.4)**	**(3.9)**	**(111.2)**	**(113.7)**	**(2.5)**
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)	(2.5)	0.6	(6.0)	(5.4)	0.6
Finance Lease Obligations > 1 Year	(6.3)	(6.5)	(0.2)	(68.6)	(68.2)	0.5	(74.9)	(74.6)	0.3
Provisions - Non Current	(3.3)	(3.3)	0.0	(2.2)	(2.2)	0.0	(5.5)	(5.5)	0.0
Total Assets/(Liabilities)	**248.7**	**248.7**	**(0.0)**	**403.0**	**398.7**	**(4.4)**	**651.7**	**647.3**	**(4.4)**
TOTAL CAPITAL & RESERVES	**248.7**	**248.7**	**(0.0)**	**403.0**	**398.7**	**(4.4)**	**651.7**	**647.3**	**(4.4)**

Cash Flow

The Group's cash balance at the end of month 6 was £44.9m. The Group continues to require additional external cash support. At the end of month 6 the Group has drawn down £30.0m in additional cash support.





£m		AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09	AP10	AP11	AP12	YTD
HUTH	Planned Drawdown	0.00	6.89	5.07	0.00	7.14	3.03	0.00	2.15	4.59	3.59	0.00	8.69	**22.13**
	Requested Drawdown	0.00	6.35	6.68	6.80	9.01	15.61	9.03	8.26	13.83	9.53	0.00	10.20	**53.48**
	Confirmed Drawdown	0.00	6.35	4.00	2.78	6.56	3.20	6.34						**29.23**
£m		AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09	AP10	AP11	AP12	TOTAL
NLAG	Planned Drawdown	0.00	0.00	1.40	0.39	1.84	5.12	0.00	1.89	3.56	0.00	2.65	6.45	**8.75**
	Requested Drawdown	0.00	0.00	1.40	3.11	2.85	5.98	3.48	3.55	3.99	8.61	0.00	11.40	**16.82**
	Confirmed Drawdown	0.00	0.00	1.40	0.39	2.85	2.50	2.50						**9.64**

2026-27 Combined ICB and Provider Summary
Month 5
BPPC Summary

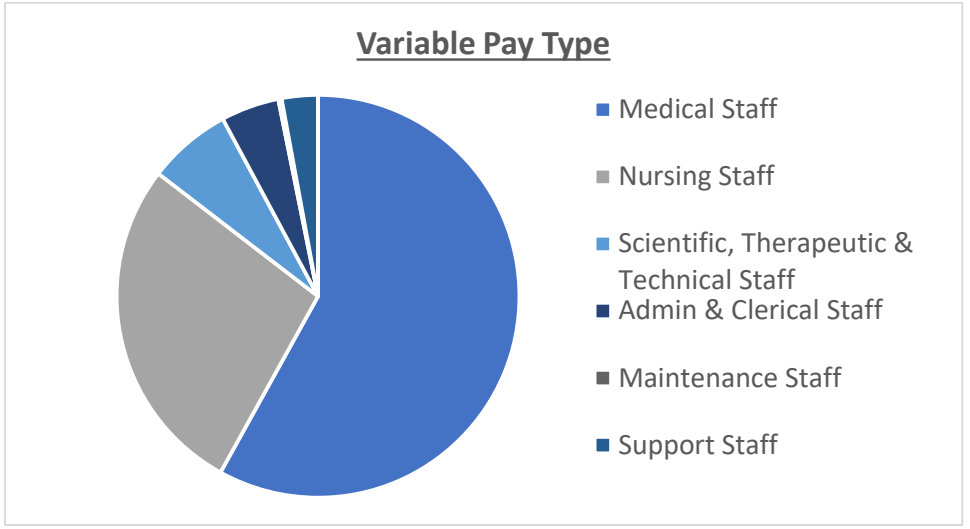
			YTD					
			Percentage of bills paid within target			Percentage of bills paid within target		
			Current YTD by Number			Current YTD by Value £000s		
Code	Name	Provider Type	Non NHS %	NHS %	Total %	Non NHS %	NHS %	Total %
Humber and North Yorkshire								
RCD	Harrogate and District NHS Foundation Trust	Acute	14.9%	17.1%	15.0%	36.5%	7.2%	33.8%
RWA	Hull University Teaching Hospitals NHS Trust	Acute	69.5%	70.7%	69.6%	59.7%	75.6%	62.5%
RV9	Humber Teaching NHS Foundation Trust	Mental Health	98.8%	89.1%	98.2%	96.3%	99.5%	97.2%
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Acute	59.1%	62.2%	59.2%	77.8%	68.9%	76.7%
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Acute	86.3%	64.5%	85.7%	87.8%	64.5%	84.7%

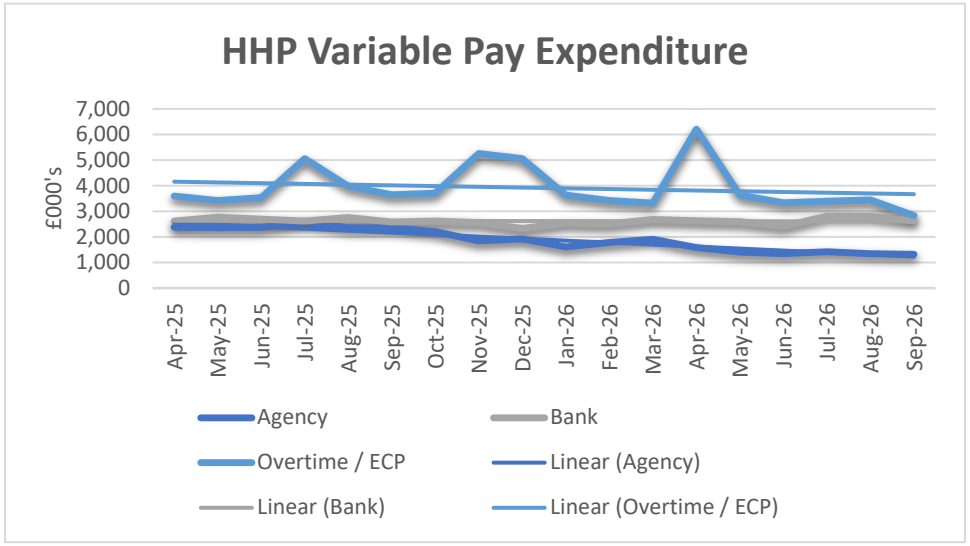
Variable Pay Summary

The Group has spent £47.1m on variable pay YTD. This is £6.6m 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	4,421	2,458	1,963	6,533	4,275	2,257	10,954	6,733	4,220
	Nursing Staff	720	643	77	1,699	413	1,285	2,419	1,057	1,362
	Scientific, Therapeutic & Technical Staff	120	107	13	861	511	350	981	618	363
	Admin & Clerical Staff	18	11	8	26	0	26	45	11	34
	Maintenance Staff	0	0	0	0	1	(1)	0	1	(1)
	Support Staff	0	0	0	0	0	0	0	0	0
	Other Staff	22	0	22	2	3	(1)	24	3	21
Agency Total		**5,301**	**3,219**	**2,082**	**9,121**	**5,203**	**3,918**	**14,423**	**8,423**	**6,000**
Bank	Medical Staff	2,277	2,394	(117)	1,148	1,039	109	3,425	3,433	(8)
	Nursing Staff	2,196	2,176	20	6,218	6,690	(472)	8,414	8,866	(452)
	Scientific, Therapeutic & Technical Staff	365	229	135	793	611	183	1,158	840	318
	Admin & Clerical Staff	475	535	(60)	1,038	1,113	(75)	1,513	1,647	(135)
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	82	87	(5)	1,479	996	483	1,560	1,083	477
	Other Staff	0	0	0	0	0	0	0	0	0
Bank Total		**5,394**	**5,421**	**(26)**	**10,676**	**10,448**	**227**	**16,070**	**15,869**	**201**
Overtime / ECP's	Medical Staff	8,632	9,311	(680)	7,499	7,879	(380)	16,130	17,190	(1,060)
	Nursing Staff	2,934	2,462	471	967	517	450	3,901	2,979	921
	Scientific, Therapeutic & Technical Staff	1,152	1,065	87	773	648	125	1,925	1,713	212
	Admin & Clerical Staff	588	421	168	157	121	36	746	542	203
	Maintenance Staff	99	94	6	29	33	(4)	129	127	2
	Support Staff	320	238	82	77	44	33	397	282	115
	Other Staff	0	0	0	0	0	0	0	0	0
Overtime / ECP's Total		**13,724**	**13,590**	**134**	**9,503**	**9,244**	**259**	**23,228**	**22,834**	**394**
Grand Total		**24,420**	**22,230**	**2,190**	**29,300**	**24,896**	**4,404**	**53,720**	**47,126**	**6,594**

	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	15,329	14,163	1,166	15,180	13,194	1,986	30,509	27,357	3,152
Nursing Staff	5,850	5,281	569	8,883	7,620	1,263	14,734	12,902	1,832
Scientific, Therapeutic & Technical Staff	1,636	1,401	235	2,427	1,770	657	4,064	3,171	892
Admin & Clerical Staff	1,082	966	116	1,221	1,234	(13)	2,303	2,200	103
Maintenance Staff	99	94	6	29	34	(5)	129	128	1
Support Staff	402	325	77	1,556	1,040	516	1,958	1,365	593
Other Staff	22	0	22	2	3	(1)	24	3	21
Grand Total	**24,420**	**22,230**	**2,190**	**29,300**	**24,896**	**4,404**	**53,720**	**47,126**	**6,594**





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 (£19.7m) higher than target.

Directorate / Care Group	Annual Target	Monthly Target	September	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	574	(95)	2,877	4,164	(1,287)	8,329	(2,575)
Acute And Emergency Medicine South	10,912	909	1,049	(140)	5,456	6,901	(1,445)	13,802	(2,890)
Cancer Network	126	10	6	5	63	36	27	73	53
Cardiovascular	2,068	172	174	(2)	1,034	1,611	(577)	3,222	(1,154)
Chief Delivery Officer	0	0	3	(3)	0	25	(25)	50	(50)
Community, Frailty & Therapy	5,468	456	518	(62)	2,734	3,531	(797)	7,063	(1,595)
Digestive Diseases	4,395	366	410	(44)	2,198	3,076	(879)	6,153	(1,757)
Family Services	7,552	629	929	(300)	3,776	5,587	(1,811)	11,174	(3,622)
Head & Neck	4,262	355	306	49	2,131	2,055	77	4,109	153
Neuroscience	2,222	185	204	(18)	1,111	1,299	(188)	2,598	(377)
Pathology Network Group	1,060	88	48	41	530	465	65	931	130
Patient Services	1,583	132	193	(62)	791	1,309	(517)	2,617	(1,034)
Site Management & Discharge Teams	633	53	38	15	317	284	33	568	65
Specialist Cancer And Support Services	6,621	552	628	(76)	3,311	4,326	(1,015)	8,651	(2,030)
Specialist Medicine	3,211	268	360	(92)	1,606	1,956	(350)	3,912	(701)
Specialist Surgery	3,571	298	308	(10)	1,785	2,055	(270)	4,110	(539)
Theatres, Anaesthetics And Critical Care	7,665	639	705	(66)	3,832	4,618	(786)	9,236	(1,571)
Sub Total Operations	**67,103**	**5,592**	**6,451**	**(859)**	**33,552**	**43,299**	**(9,747)**	**86,598**	**(19,495)**
Chief Executive	13	1	15	(14)	7	42	(35)	83	(70)
Chief Medical Officer	20	2	0	2	10	31	(21)	62	(42)
Chief Nurse Office	181	15	15	1	90	115	(25)	230	(50)
Director of Assurance	0	0	-	0	0	-	0	-	0
Director of People	227	19	7	12	113	87	27	173	54
Director of Finance, Estates & Facilities	3,038	253	274	(21)	1,519	1,555	(35)	3,109	(71)
Strategy and Partnerships	133	11	8	3	67	103	(36)	206	(72)
Sub Total Operations	**3,613**	**301**	**319**	**(18)**	**1,806**	**1,932**	**(125)**	**3,864**	**(251)**
TOTAL	**70,716**	**5,893**	**6,770**	**(877)**	**35,358**	**45,231**	**(9,873)**	**90,462**	**(19,745)**

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	75.8	75.2	(0.6)	454.8	457.2	2.4	47.2	47.2	(0.0)	282.0	280.6	(1.5)	123.0	122.4	(0.6)	736.9	737.8	0.9
Other Income	6.3	7.2	0.9	36.9	38.8	1.8	4.8	4.7	(0.1)	27.3	27.9	0.6	11.1	12.0	0.9	64.2	66.7	2.4
Total Operating Income	**82.1**	**82.5**	**0.3**	**491.8**	**496.0**	**4.2**	**52.0**	**51.9**	**(0.1)**	**309.3**	**308.5**	**(0.9)**	**134.1**	**134.4**	**0.3**	**801.1**	**804.5**	**3.4**
Pay Costs																		
Medical Staff	(17.8)	(19.3)	(1.5)	(105.9)	(113.7)	(7.9)	(11.0)	(10.9)	0.1	(64.4)	(64.5)	(0.2)	(28.7)	(30.2)	(1.5)	(170.2)	(178.3)	(8.1)
Nursing Staff	(16.4)	(16.6)	(0.3)	(98.1)	(99.0)	(0.8)	(13.5)	(13.3)	0.2	(81.5)	(79.5)	2.1	(29.9)	(30.0)	(0.1)	(179.7)	(178.5)	1.2
Scientific Therapeutic & Technical Staff	(7.2)	(7.3)	(0.1)	(45.0)	(43.7)	1.3	(5.6)	(5.5)	0.2	(33.5)	(32.6)	0.9	(12.8)	(12.8)	0.1	(78.5)	(76.3)	2.2
Total Clinical Pay	**(41.3)**	**(43.2)**	**(1.9)**	**(249.0)**	**(256.5)**	**(7.5)**	**(30.1)**	**(29.7)**	**0.4**	**(179.4)**	**(176.6)**	**2.8**	**(71.4)**	**(72.9)**	**(1.5)**	**(428.4)**	**(433.1)**	**(4.7)**
Admin & Clerical Staff	(6.4)	(6.4)	0.1	(39.0)	(38.8)	0.3	(5.5)	(5.4)	0.2	(32.5)	(31.8)	0.7	(12.0)	(11.7)	0.2	(71.6)	(70.6)	1.0
Maintenance Staff	(0.3)	(0.3)	0.0	(1.9)	(1.9)	0.0	(0.2)	(0.2)	0.0	(1.0)	(1.0)	0.0	(0.5)	(0.5)	0.0	(3.0)	(2.9)	0.1
Support Staff	(1.5)	(1.7)	(0.3)	(9.9)	(10.1)	(0.2)	(1.5)	(1.7)	(0.2)	(9.0)	(9.9)	(0.9)	(2.9)	(3.4)	(0.5)	(18.9)	(20.1)	(1.2)
Other Staff	(0.0)	(0.0)	0.0	(0.1)	(0.0)	0.1	0.0	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)	(0.1)	0.0
Apprentice Levy	(0.2)	(0.2)	(0.0)	(1.0)	(1.2)	(0.2)	(0.1)	(0.1)	(0.0)	(0.9)	(0.9)	(0.0)	(0.3)	(0.3)	(0.0)	(1.8)	(2.1)	(0.2)
Total Other Pay	**(8.4)**	**(8.6)**	**(0.2)**	**(51.9)**	**(52.0)**	**(0.1)**	**(7.3)**	**(7.4)**	**(0.1)**	**(43.5)**	**(43.7)**	**(0.2)**	**(15.7)**	**(16.0)**	**(0.3)**	**(95.4)**	**(95.8)**	**(0.3)**
Total Pay Costs	**(49.7)**	**(51.9)**	**(2.1)**	**(300.9)**	**(308.5)**	**(7.6)**	**(37.4)**	**(37.1)**	**0.3**	**(223.0)**	**(220.4)**	**2.6**	**(87.1)**	**(88.9)**	**(1.8)**	**(523.9)**	**(528.9)**	**(5.0)**
Drugs	(11.3)	(10.8)	0.5	(68.0)	(72.0)	(3.9)	(3.4)	(3.5)	(0.1)	(20.3)	(21.0)	(0.7)	(14.7)	(14.3)	0.4	(88.3)	(93.0)	(4.7)
Clinical Supplies & Services	(8.3)	(9.8)	(1.5)	(50.9)	(52.5)	(1.6)	(4.8)	(5.0)	(0.2)	(28.6)	(29.3)	(0.7)	(13.1)	(14.8)	(1.7)	(79.5)	(81.8)	(2.3)
Total Clinical Non Pay	**(19.6)**	**(20.6)**	**(1.0)**	**(119.0)**	**(124.5)**	**(5.5)**	**(8.1)**	**(8.4)**	**(0.3)**	**(48.9)**	**(50.3)**	**(1.5)**	**(27.8)**	**(29.1)**	**(1.3)**	**(167.8)**	**(174.8)**	**(7.0)**
Admin & Clerical Staff - Non Execs	(0.0)	(0.0)	0.0	(0.1)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.2)	(0.1)	0.1
General Supplies & Services	(1.8)	(2.0)	(0.2)	(11.3)	(12.5)	(1.2)	(0.9)	(0.7)	0.2	(4.3)	(4.2)	0.0	(2.7)	(2.7)	(0.0)	(15.6)	(16.7)	(1.1)
Establishment Expenses	(0.3)	(0.5)	(0.2)	(1.8)	(2.5)	(0.7)	(0.4)	(0.4)	0.0	(2.2)	(2.2)	(0.0)	(0.7)	(0.9)	(0.2)	(4.0)	(4.7)	(0.7)
Establishment Expenses Op Lease	0.0	0.0	0.0	0.0	0.0	0.0	(0.1)	(0.0)	0.0	(0.4)	(0.4)	(0.0)	(0.1)	(0.0)	0.0	(0.4)	(0.4)	(0.0)
Establishment Expenses Transport	(0.2)	(0.2)	(0.0)	(1.0)	(1.4)	(0.3)	(0.3)	(0.2)	0.1	(1.5)	(1.5)	0.0	(0.4)	(0.4)	0.0	(2.6)	(2.9)	(0.3)
Other Establishment Costs	(0.2)	(0.8)	(0.7)	(1.1)	(2.5)	(1.4)	(0.1)	(0.0)	0.1	(0.6)	(0.7)	(0.2)	(0.3)	(0.9)	(0.6)	(1.7)	(3.3)	(1.6)
Other Establishment Costs Clinical Negligence	(2.5)	(2.5)	(0.0)	(14.8)	(14.3)	0.4	(1.6)	(1.5)	0.0	(9.4)	(9.3)	0.1	(4.0)	(4.0)	0.0	(24.2)	(23.6)	0.5
Premises and Fixed Plant	(3.0)	(2.3)	0.7	(18.3)	(16.6)	1.7	(1.6)	(1.4)	0.2	(10.8)	(10.5)	0.3	(4.6)	(3.7)	0.9	(29.1)	(27.1)	2.1
Premises and Fixed Plant - Rates	(0.4)	(0.4)	(0.1)	(2.3)	(2.6)	(0.3)	(0.2)	(0.3)	(0.0)	(1.5)	(1.6)	(0.1)	(0.6)	(0.7)	(0.1)	(3.8)	(4.2)	(0.5)
Purchase of Healthcare Services NHS and other DHSC bodies	(1.9)	(2.1)	(0.2)	(11.3)	(12.4)	(1.1)	(0.3)	(0.3)	(0.0)	(1.9)	(1.6)	0.3	(2.2)	(2.4)	(0.2)	(13.2)	(14.0)	(0.8)
Purchase of Healthcare Services Non NHS	(0.9)	(1.9)	(1.0)	(5.4)	(11.7)	(6.3)	(0.1)	(1.1)	(1.0)	(0.7)	(6.1)	(5.4)	(1.0)	(3.0)	(1.9)	(6.1)	(17.8)	(11.7)
Miscellaneous Expenditure	(0.1)	(0.0)	0.0	(0.5)	(0.6)	(0.2)	0.0	0.0	0.0	0.0	0.0	0.0	(0.1)	(0.0)	0.0	(0.5)	(0.6)	(0.2)
Miscellaneous Expenditure Statutory Audit	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.1	(0.1)	(0.1)	(0.0)	(0.4)	(0.5)	(0.1)	(0.1)	(0.1)	(0.0)	(0.5)	(0.6)	(0.0)
Education Expenditure	(0.5)	(0.5)	(0.0)	(3.2)	(3.5)	(0.3)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	0.0	(0.5)	(0.6)	(0.0)	(3.3)	(3.6)	(0.3)
Consultancy Expenditure	0.0	(0.1)	(0.1)	0.0	(0.6)	(0.6)	(0.3)	(0.2)	0.1	(1.3)	(1.2)	0.1	(0.3)	(0.3)	(0.1)	(1.3)	(1.8)	(0.5)
Fixed Asset Impairments / Revaluation	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	(0.1)	(0.1)	(0.1)	(0.7)	(0.6)	(0.0)	(0.1)	(0.1)	(0.1)	(0.7)	(0.6)
Total Other Non Pay	**(11.6)**	**(13.4)**	**(1.7)**	**(71.2)**	**(81.3)**	**(10.1)**	**(6.0)**	**(6.4)**	**(0.4)**	**(35.3)**	**(40.7)**	**(5.4)**	**(17.6)**	**(19.8)**	**(2.1)**	**(106.5)**	**(122.0)**	**(15.6)**
Total Non Pay Costs	**(31.3)**	**(34.0)**	**(2.8)**	**(190.2)**	**(205.8)**	**(15.7)**	**(14.1)**	**(14.8)**	**(0.7)**	**(84.1)**	**(91.0)**	**(6.9)**	**(45.4)**	**(48.9)**	**(3.5)**	**(274.3)**	**(296.8)**	**(22.6)**
Total Operating Expenditure	**(81.0)**	**(85.9)**	**(4.9)**	**(491.0)**	**(514.3)**	**(23.3)**	**(51.6)**	**(51.9)**	**(0.4)**	**(307.1)**	**(311.4)**	**(4.3)**	**(132.5)**	**(137.8)**	**(5.3)**	**(798.1)**	**(825.7)**	**(27.6)**
EBITDA	**1.2**	**(3.4)**	**(4.6)**	**0.7**	**(18.3)**	**(19.0)**	**0.4**	**(0.0)**	**(0.4)**	**2.2**	**(2.9)**	**(5.2)**	**1.6**	**(3.4)**	**(5.0)**	**3.0**	**(21.2)**	**(24.2)**
Depreciation	(2.7)	(2.7)	0.0	(16.1)	(16.0)	0.2	(2.4)	(2.0)	0.4	(14.1)	(10.9)	3.2	(5.0)	(4.7)	0.4	(30.2)	(26.8)	3.4
Non Operating Items	(1.5)	(1.5)	0.0	(9.2)	(8.9)	0.3	(0.7)	(0.5)	0.1	(4.1)	(3.4)	0.6	(2.2)	(2.0)	0.2	(13.3)	(12.3)	0.9
Surplus/(Deficit)	**(3.1)**	**(7.6)**	**(4.5)**	**(24.6)**	**(43.1)**	**(18.5)**	**(2.6)**	**(2.5)**	**0.1**	**(15.9)**	**(17.2)**	**(1.3)**	**(5.7)**	**(10.1)**	**(4.4)**	**(40.5)**	**(60.4)**	**(19.9)**
NHSE Allowable Adjustments	(0.1)	(0.1)	0.1	(0.1)	(0.6)	(0.5)	0.1	0.1	(0.1)	0.9	0.4	(0.5)	(0.0)	(0.0)	(0.0)	0.8	(0.2)	(1.0)
Adjusted Surplus / (Deficit)	**(3.2)**	**(7.7)**	**(4.5)**	**(24.8)**	**(43.8)**	**(19.0)**	**(2.5)**	**(2.5)**	**0.0**	**(15.0)**	**(16.8)**	**(1.8)**	**(5.7)**	**(10.1)**	**(4.5)**	**(39.7)**	**(60.6)**	**(20.8)**

Appendix A – Trust I&E & Divisional Budgetary Performance

		HUTH (£m)						NLAG (£m)						HHP (£m)					
		CM			YTD			CM			YTD			CM			YTD		
Directorate	Care Group	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operations	Acute and Emergency Medicine (North)	(3.8)	(4.1)	(0.3)	(22.7)	(25.0)	(2.3)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(3.8)	(4.1)	(0.3)	(22.7)	(25.0)	(2.3)
	Acute and Emergency Medicine (South)	0.0	0.0	0.0	0.0	0.0	0.0	(5.8)	(6.1)	(0.2)	(34.7)	(35.9)	(1.2)	(5.8)	(6.1)	(0.2)	(34.7)	(35.9)	(1.2)
	Cancer Network	(0.5)	(0.5)	(0.0)	(2.9)	(2.9)	(0.0)	(0.3)	(0.2)	0.0	(1.6)	(1.5)	0.1	(0.8)	(0.7)	0.0	(4.5)	(4.5)	0.1
	Cardiovascular	(3.5)	(3.7)	(0.2)	(21.1)	(22.4)	(1.3)	(0.9)	(0.9)	0.0	(5.3)	(5.4)	(0.1)	(4.4)	(4.6)	(0.2)	(26.4)	(27.8)	(1.4)
	Chief Delivery Officer	(0.0)	(0.0)	(0.0)	(0.4)	(0.7)	(0.2)	(0.1)	(0.0)	0.0	(0.4)	(0.4)	0.0	(0.1)	(0.1)	0.0	(0.9)	(1.1)	(0.2)
	Community, Frailty & Therapy	(3.6)	(3.8)	(0.2)	(21.2)	(22.9)	(1.7)	(4.0)	(4.1)	(0.1)	(24.0)	(24.6)	(0.6)	(7.6)	(7.9)	(0.3)	(45.2)	(47.5)	(2.3)
	Digestive Diseases	(3.2)	(3.8)	(0.7)	(18.8)	(22.4)	(3.6)	(2.8)	(2.7)	0.1	(16.2)	(16.3)	(0.1)	(6.0)	(6.5)	(0.6)	(35.0)	(38.7)	(3.7)
	Family Services	(5.2)	(5.6)	(0.4)	(30.9)	(33.0)	(2.1)	(4.8)	(4.8)	(0.0)	(28.7)	(28.5)	0.2	(10.0)	(10.4)	(0.4)	(59.6)	(61.5)	(1.8)
	Head & Neck	(3.4)	(3.5)	(0.1)	(20.6)	(20.6)	0.0	(1.6)	(1.5)	0.1	(8.7)	(8.5)	0.2	(5.0)	(5.1)	(0.1)	(29.3)	(29.1)	0.2
	Neuroscience	(2.4)	(2.7)	(0.3)	(14.4)	(15.3)	(0.8)	(0.9)	(1.0)	(0.1)	(5.3)	(5.6)	(0.3)	(3.3)	(3.6)	(0.3)	(19.8)	(20.9)	(1.1)
	Pathology Network Group	(2.1)	(2.2)	(0.1)	(12.5)	(12.8)	(0.3)	(2.3)	(2.3)	0.0	(13.7)	(13.5)	0.2	(4.4)	(4.4)	(0.0)	(26.2)	(26.3)	(0.1)
	Patient Services	(2.2)	(2.2)	0.1	(13.2)	(13.4)	(0.2)	(1.6)	(1.6)	0.0	(9.7)	(9.7)	(0.1)	(3.8)	(3.8)	0.1	(22.9)	(23.2)	(0.3)
	Site Management & Discharge teams	(0.3)	(0.3)	(0.0)	(1.6)	(1.7)	(0.0)	(0.3)	(0.4)	(0.0)	(2.1)	(2.2)	(0.1)	(0.6)	(0.6)	(0.0)	(3.7)	(3.9)	(0.1)
	Specialist Cancer and Support Services	(18.5)	(19.3)	(0.7)	(110.9)	(114.8)	(3.9)	(5.9)	(6.0)	(0.1)	(35.2)	(35.5)	(0.2)	(24.4)	(25.3)	(0.8)	(146.1)	(150.3)	(4.2)
	Specialist Medicine	(4.2)	(4.4)	(0.2)	(24.7)	(26.1)	(1.4)	(2.2)	(2.1)	0.0	(13.1)	(13.3)	(0.2)	(6.3)	(6.5)	(0.2)	(37.8)	(39.4)	(1.5)
	Specialist Surgery	(3.8)	(3.9)	(0.1)	(22.4)	(23.3)	(0.9)	(2.4)	(2.4)	(0.0)	(12.0)	(12.5)	(0.4)	(6.2)	(6.3)	(0.1)	(34.5)	(35.8)	(1.3)
	Theatres, Anaesthetics and Critical Care	(7.0)	(7.7)	(0.6)	(42.0)	(44.2)	(2.2)	(3.4)	(3.4)	0.0	(23.1)	(23.5)	(0.4)	(10.5)	(11.1)	(0.6)	(65.1)	(67.7)	(2.6)
Total Operations		**(63.8)**	**(67.6)**	**(3.8)**	**(380.5)**	**(401.4)**	**(20.9)**	**(39.3)**	**(39.5)**	**(0.2)**	**(233.9)**	**(236.8)**	**(2.9)**	**(103.1)**	**(107.1)**	**(3.9)**	**(614.4)**	**(638.2)**	**(23.8)**
Corporate	Chief Executive	(0.1)	(0.2)	(0.1)	(0.7)	(1.2)	(0.5)	(0.1)	(0.2)	(0.1)	(0.6)	(1.1)	(0.5)	(0.2)	(0.4)	(0.2)	(1.4)	(2.3)	(0.9)
	Chief Medical Officer	(0.5)	(0.5)	(0.0)	(2.9)	(3.0)	(0.1)	(0.8)	(0.8)	(0.1)	(4.0)	(4.1)	(0.1)	(1.3)	(1.4)	(0.1)	(7.0)	(7.1)	(0.2)
	Chief Nurse Office	(2.8)	(3.1)	(0.3)	(18.9)	(18.7)	0.2	(2.4)	(2.4)	0.1	(14.5)	(14.3)	0.3	(5.2)	(5.5)	(0.2)	(33.4)	(32.9)	0.5
	Director of Assurance	(0.1)	(0.2)	(0.1)	(0.3)	(0.7)	(0.3)	(0.1)	(0.0)	0.0	(0.4)	(0.4)	0.0	(0.1)	(0.3)	(0.1)	(0.8)	(1.1)	(0.3)
	Director of People	(0.9)	(1.1)	(0.2)	(5.4)	(5.6)	(0.1)	(0.9)	(0.9)	(0.0)	(4.9)	(4.9)	0.0	(1.8)	(2.0)	(0.2)	(10.3)	(10.4)	(0.1)
	Director of Finance, Estates & Facilities	(6.7)	(6.8)	(0.1)	(39.9)	(40.0)	(0.1)	(4.3)	(4.4)	(0.1)	(26.1)	(27.0)	(0.9)	(11.0)	(11.2)	(0.2)	(66.0)	(67.0)	(0.9)
	Strategy and Partnerships	(1.1)	(1.0)	0.1	(5.9)	(5.7)	0.2	(0.8)	(0.6)	0.2	(4.5)	(4.5)	0.0	(1.9)	(1.6)	0.3	(10.4)	(10.2)	0.2
Total Corporate		**(12.2)**	**(13.0)**	**(0.8)**	**(74.1)**	**(74.7)**	**(0.6)**	**(9.4)**	**(9.4)**	**(0.0)**	**(55.2)**	**(56.2)**	**(1.1)**	**(21.5)**	**(22.3)**	**(0.8)**	**(129.3)**	**(131.0)**	**(1.7)**
Central Income, Reserves & Technical	Central Income	77.8	77.3	(0.4)	460.8	459.6	(1.2)	49.0	48.6	(0.3)	292.2	289.3	(2.8)	126.7	126.0	(0.8)	752.9	748.9	(4.0)
	Central Technical	(4.5)	(5.1)	(0.5)	(27.2)	(26.8)	0.5	(2.9)	(2.3)	0.7	(17.5)	(12.9)	4.5	(7.5)	(7.3)	0.1	(44.7)	(39.7)	5.0
	Reserves	(0.3)	0.7	1.0	(3.6)	0.1	3.7	0.0	(0.1)	(0.1)	(1.5)	(0.5)	1.0	(0.3)	0.7	0.9	(5.1)	(0.4)	4.7
Total Central Income, Reserves & Technical		**72.9**	**73.0**	**0.1**	**430.0**	**433.0**	**3.0**	**46.0**	**46.3**	**0.2**	**273.2**	**275.9**	**2.7**	**119.0**	**119.3**	**0.3**	**703.2**	**708.8**	**5.6**
Surplus / (Deficit)		**(3.1)**	**(7.6)**	**(4.5)**	**(24.6)**	**(43.1)**	**(18.5)**	**(2.6)**	**(2.5)**	**0.1**	**(15.9)**	**(17.2)**	**(1.3)**	**(5.7)**	**(10.1)**	**(4.4)**	**(40.5)**	**(60.4)**	**(19.9)**
Adjustments to adjusted financial performance		(0.1)	(0.1)	0.1	(0.1)	(0.6)	(0.5)	0.1	0.1	(0.1)	0.9	0.4	(0.5)	(0.0)	(0.0)	(0.0)	0.8	(0.2)	(1.0)
Adjusted financial performance Surplus / (Deficit)		**(3.2)**	**(7.7)**	**(4.5)**	**(24.8)**	**(43.8)**	**(19.0)**	**(2.5)**	**(2.5)**	**0.0**	**(15.0)**	**(16.8)**	**(1.8)**	**(5.7)**	**(10.1)**	**(4.5)**	**(39.7)**	**(60.6)**	**(20.8)**

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)103

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	4 November 2026
Director Lead	Sam Peate, Group Chief Delivery Officer Emma Sayner, Group Chief Finance Officer
Contact Officer/Author	Rob Stones, Director of Performance, Planning and Business Intelligence Jackie Railton, Deputy Director, Planning and Performance Louise Topliss, Head of Performance
Title of the Report	Group Performance Report
Executive Summary	Key messages: • Significant challenges remain across all constitutional standards • Both HUTH and NLAG remain under Tier one oversight for UEC, Cancer, Diagnostics and RTT • Activity is on plan for HUTH Year to date but off plan at NLAG • RTT activity is seeing material growth in the overall waiting list size and volume of patients waiting beyond 52 weeks • 12 hour UEC performance for HUTH showing as most improved in last 12 months nationally
Background Information and/or Supporting Document(s) (if applicable)	Performance, Estates and Finance Committees-in-Common escalation report included within this paper.
Prior Approval Process	Trust Boards-in-Common, 9th October 2026
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 ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Integrated Performance Report

Reporting Month:
August 2026

United by Compassion:
Driving for Excellence

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

disability confident EMPLOYER

VETERAN AWARE

CiC Oversight Dashboard

Operational Performance

HUTH

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

NLaG

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

Monthly Trend Key

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

Financial Position

Group

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

People

Group

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

Table of Contents

1. **Overview** 7
2. **Regulation and Compliance** 8
3. **HHP Key Metric Oversight Scorecard** 9
4. **HHP Group Executive Summary – Performance** 10

Chief Delivery Officer Update – Performance Overview (June 2026) 11

a. **Hull University Teaching Hospitals Performance AAA Summary** 12
b. **Northern Lincolnshire and Goole Hospitals Performance AAA Summary** 12
c. **Unplanned Care** 13
   i. **Emergency Care Standards – 4-hour Performance** 16
   ii. **Enabler Metric 1: Mean Time to Treatment** 17
   iii. **Enabler Metric 2: Non-Admitted Total Time in Department** 18
   iv. **Enabler Metric 4: A&E Attendances – Type 1 Attendances** 19
   v. **Enabler Metric 5: A&E Attendances – Type 3 Attendances** 20
d. **Planned Care** 21
   a. **Cancer 62 Day First Definitive Treatment** 24
   ii. **Cancer 31-day First Treatment** 25
   iii. **Cancer 28-day Faster Diagnosis Performance** 26
   iv. **Diagnostic 6-Week Standard** 27
   v. **RTT Incomplete Performance** 28
   vi. **RTT 65 week waits** 29
   vii. **RTT 52 week waits** 30
   viii. **Enabler Metric 1: Time to First Appointment (%)** 31
   ix. **Enabler Metric 2: RTT Data Quality** 32

x. Enabler Metric 3: Capped Theatre Utilisation 33
xi. Enabler Metric 4: Outpatient Follow Up Backlog 34
xii. Enabler Metric 5: Cancelled Operations – 28-day Breaches 35
5. HHP Group Executive Summary – Quality 36
Group Chief Patient Safety Officer Update – Quality Overview (June 2026) 37
a. Hull University Teaching Hospital Quality AAA Summary 38
b. Northern Lincolnshire & Goole Hospitals Quality AAA Summary 38
HUTH Scorecard 40
NLAG Scorecard 40
i. PALS Concerns 41
ii. Complaints Received 42
iii. PALS Concerns 43
c. Safety 44
HUTH Scorecard 45
NLAG Scorecard 46
i. Care Hours per Patient Day 47
ii. C.Difficile Cases 48
iii. MRSA Cases 49
iv. E.Coli Cases 50
d. Effectiveness 51
HUTH Scorecard 52
NLAG Scorecard 52
i. VTE Assessment within 14hrs 53
ii. Summary Hospital Mortality Indicator 54
iii. Emergency Readmissions within 30 Days 55

6. HHP Group Executive Summary – Workforce 56
Chief People Officer Update – Workforce Overview (July 2026) 57
a. Hull University Teaching Hospital Workforce AAA Summary 58
b. Northern Lincolnshire & Goole Hospitals Workforce AAA Summary 58
c. Staff Culture & Experience 59
HUTH Scorecard 60
NLAG Scorecard 60
i. Staff Sickness Absence Rate 61
ii. Staff Appraisal Rate (AfC) 62
iii. Staff Mandatory Training – Role Specific 63
d. Recruitment & Retention 64
HUTH Scorecard 65
NLAG Scorecard 65
i. Staff Time to Shortlist 66
ii. Staff Time to Offer 67
iii. Staff Time to Employment Checks 68
Appendices 69
1. Key to Statistical Process Control (SPC) Charts 70
2. National Oversight Framework Definitions 71
3. Using Data Insights to identify Alert, Advise and Assure status 72
4. National Oversight Framework 73
HUTH Overview 73
NLAG Overview 74
Regional Context 75
5. Trust League Tables 80

a. HUTH – Filtered to Teaching Hospitals 80
b. NLAG – Filtered to Medium 81
6. HHP Foundation Scorecards 82

1. Overview

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

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

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

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

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

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

2. Regulation and Compliance

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

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

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

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

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

3. HHP Key Metric Oversight Scorecard

Oversight Framework

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

Oversight | CQC

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

4. HHP Group Executive Summary – Performance

Executive Lead: Sam Peate, Group Chief Delivery Officer

Accountable to: Performance, Estate and Finance Committee

Hull University Teaching Hospitals NHS Trust

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

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

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

Chief Delivery Officer Update – Performance Overview (August 2026)

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

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

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

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

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

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

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

a. Hull University Teaching Hospitals Performance AAA Summary

Count: 12

Alert

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

Count: 3

Advise

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

Count: 5

Assure

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

b. Northern Lincolnshire and Goole Hospitals Performance AAA Summary

Count: 17

Alert

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

Count: 2

Advise

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

Count: 2

Assure

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

c. Unplanned Care

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

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

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

Progress

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

Action

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

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

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

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

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

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

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

i. Emergency Care Standards – 4-hour Performance

A&E - 4 Hour Standard (All)

Progress:

• All-type performance remained below trajectory at both Trusts in August; frailty, UTC, SDEC, paediatric and NCTR work continued.

• HUTH Type 1 performance was 48.6%; handovers remained assured at 98.9% within 45 minutes, but decision-to-admit waits over 12 hours increased to 8.8%.

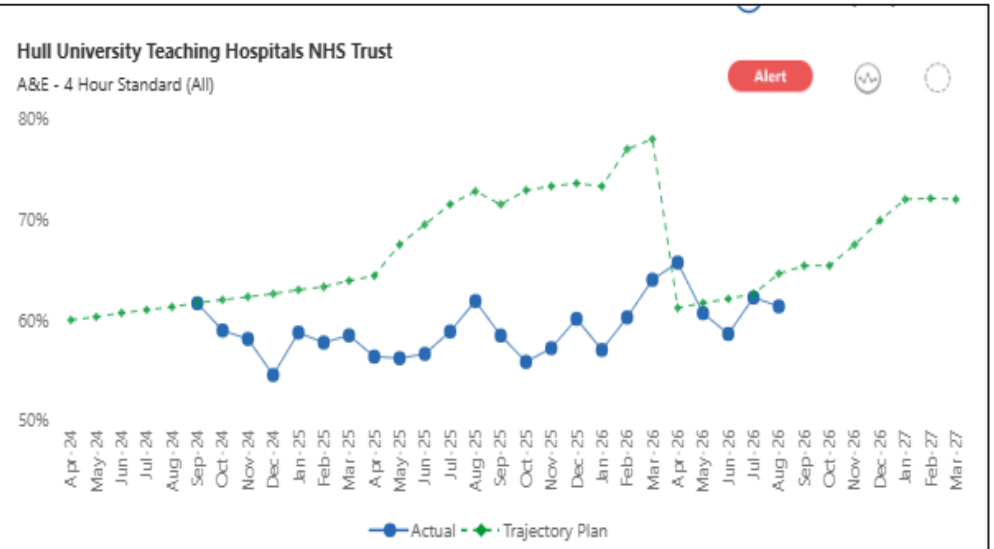
• NLAG Type 1 performance was 50.4%; handovers improved to 74.4% within 45 minutes and decision-to-admit waits over 12 hours reduced to 48.3%, but both remain material risks.

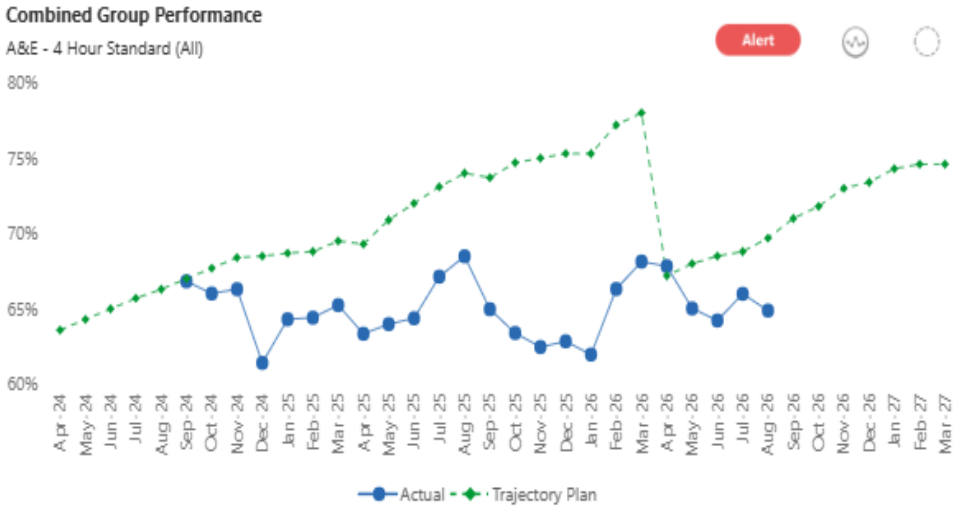
Action:

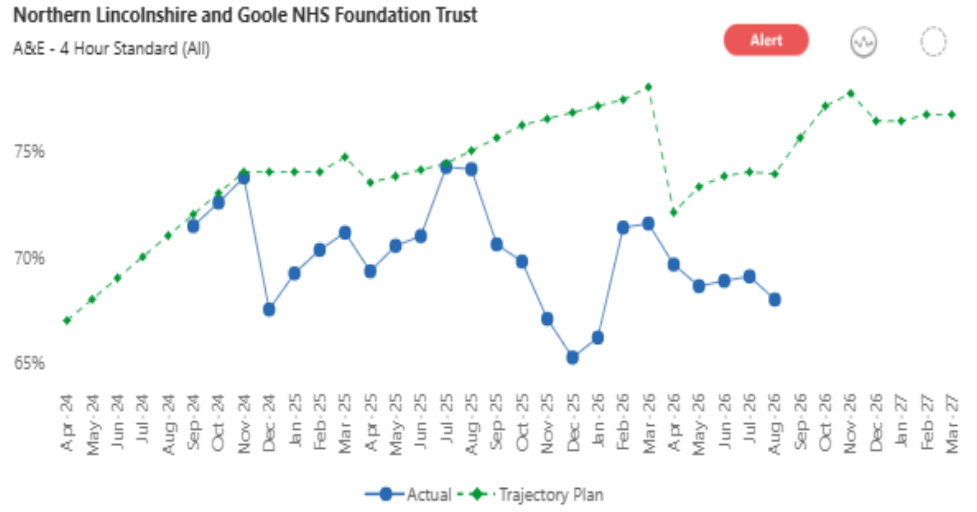
• Recover HUTH UTC and Type 3 performance with CHCP; strengthen frailty, streaming and SDEC. Call before conveying to incorporate consultant at SGH from W/C 14th, DPOW from October.

• Implement front-door frailty SDEC and PAU actions; deliver South Bank flow-out to recover handovers and admitted flow.

• Escalate demand, long-stay, NCTR and discharge constraints daily and align with winter and bed-modelling plans.







ii. Enabler Metric 1: Mean Time to Treatment

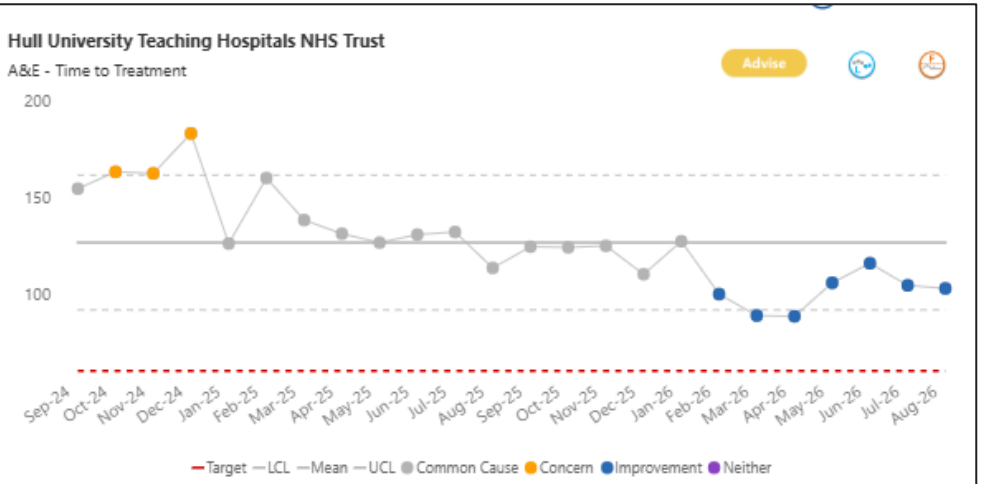
A&E - Time to Treatment

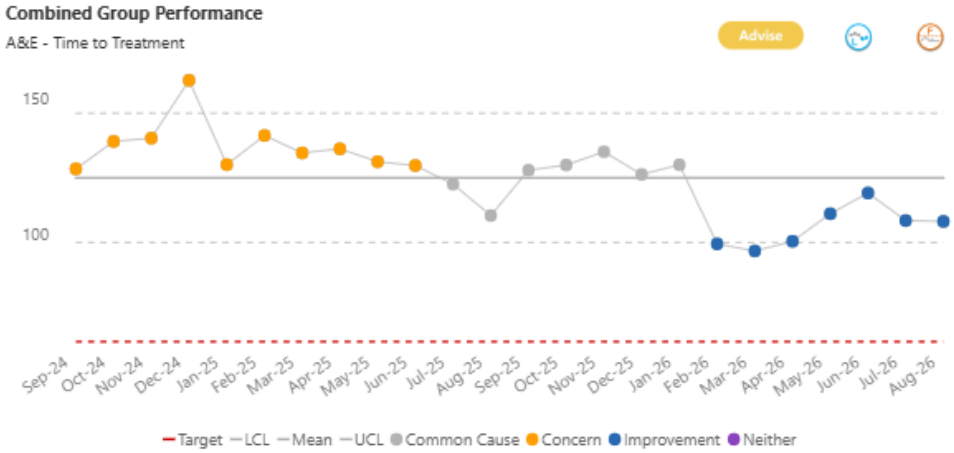
HUTH:

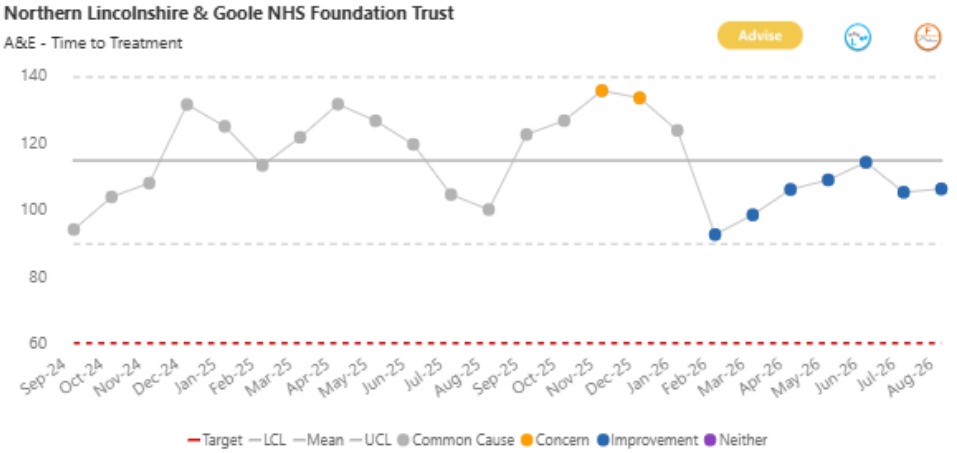
Mean time to treatment improved again in August and remained below the historical mean but was still above 100 minutes and the 60-minute operational target. Early clinical assessment, streaming and rapid decision-making must therefore be sustained at peak times.

NLAG:

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







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

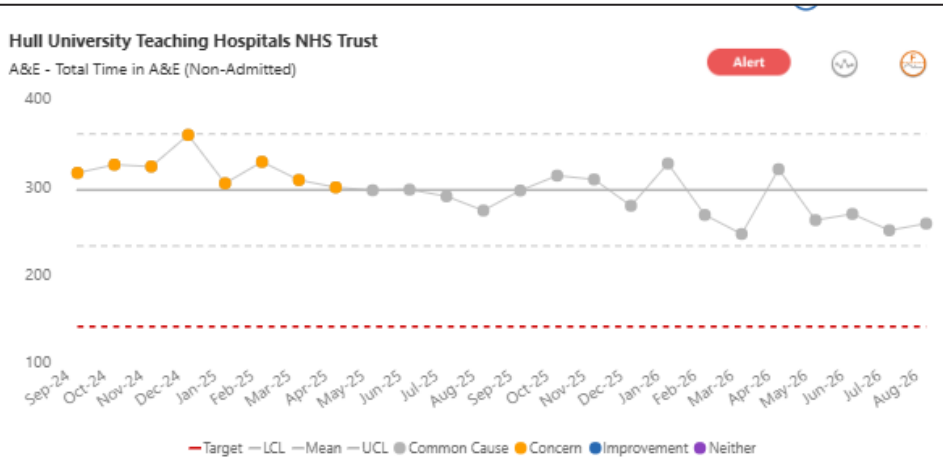
A&E - Total Time in A&E (Non-Admitted)

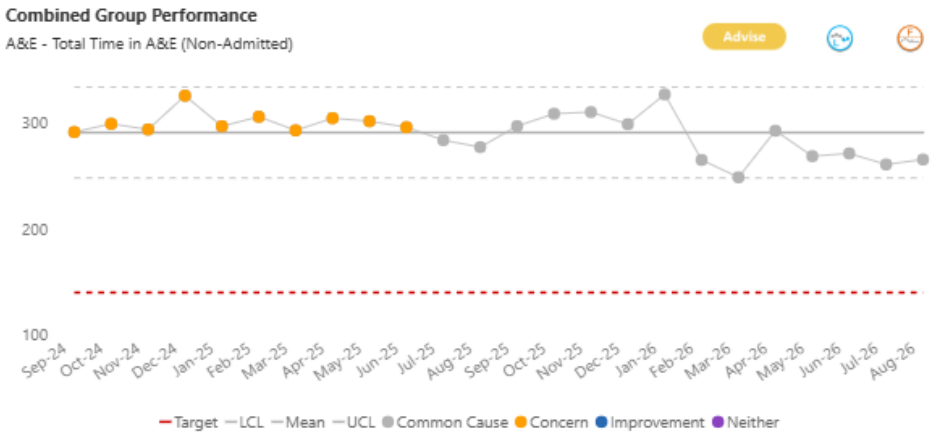
HUTH:

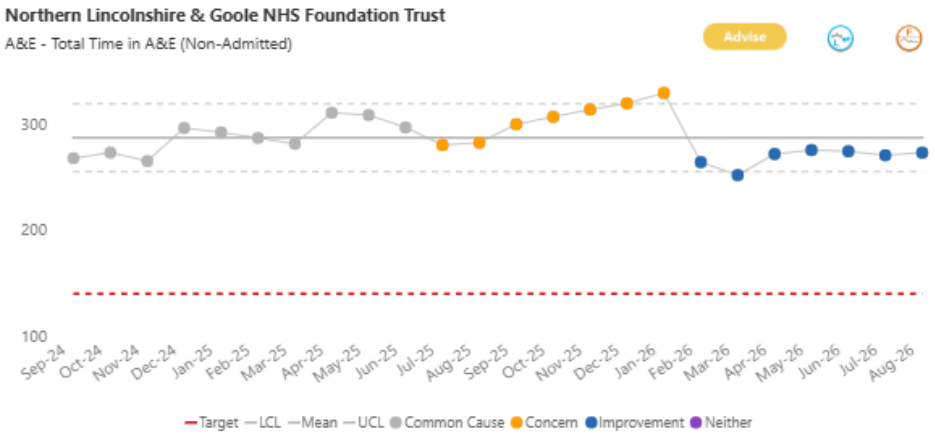
Non-admitted time improved in August but remained substantially above the 140-minute target. The response is to strengthen early streaming, rapid assessment and discharge from ED pathways, with daily review of avoidable waits for patients who do not require admission.

NLAG:

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







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

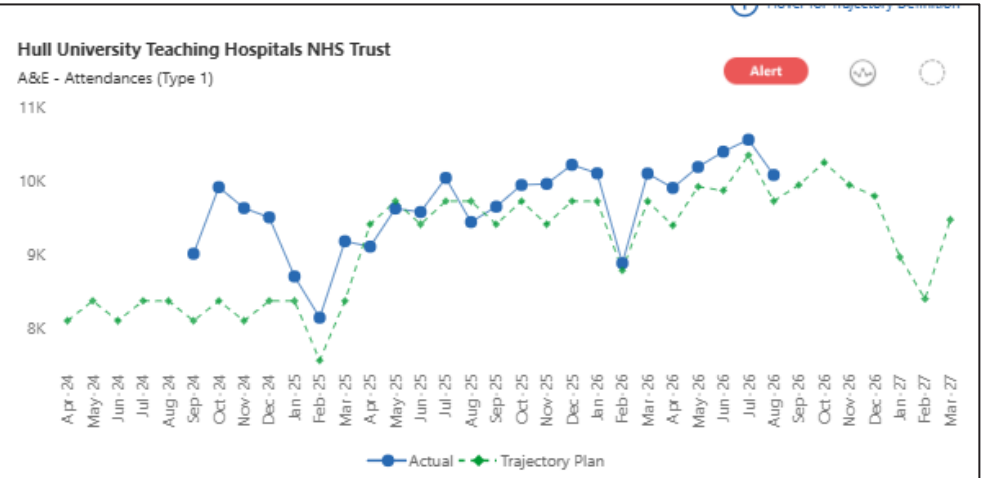
A&E - Attendances (Type 1)

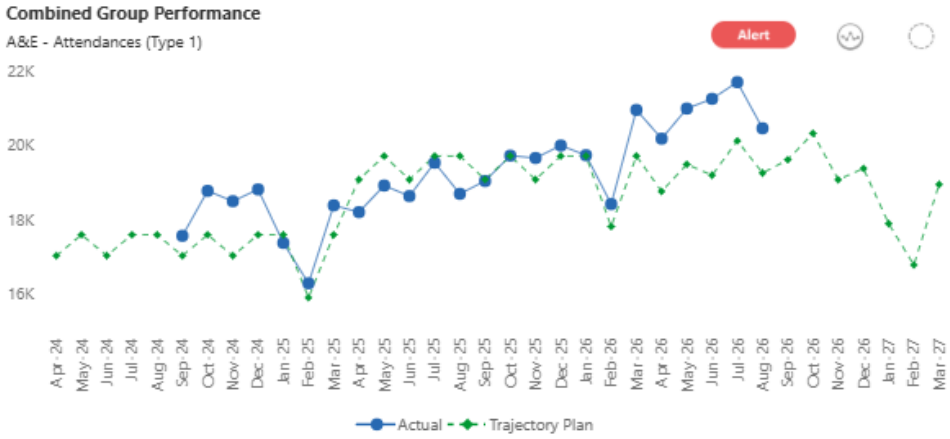
HUTH:

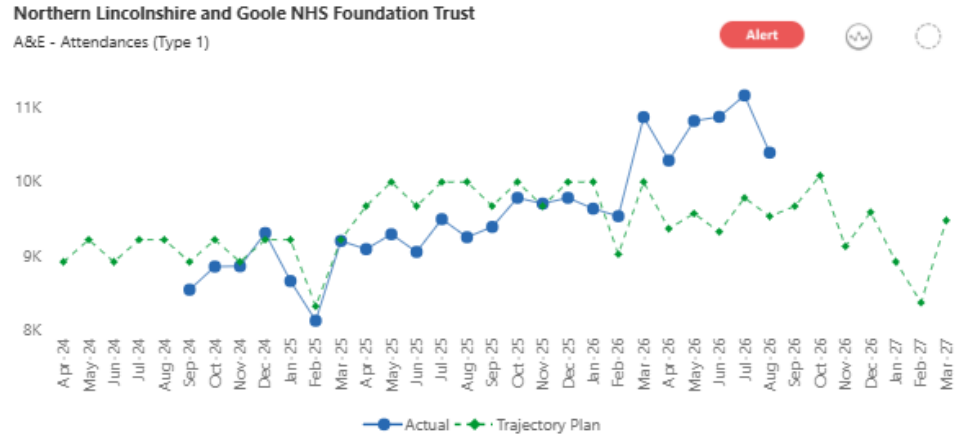
Type 1 attendances reduced from July but remained above trajectory in August, continuing the sustained upward pressure on ED. Action remains focused on streaming, alternatives to ED, SDEC and demand management with system partners.

NLAG:

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







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

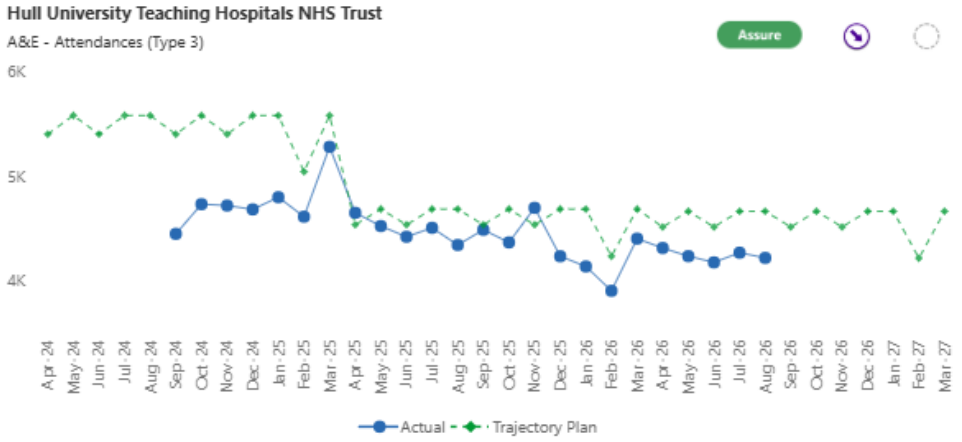
A&E - Attendances (Type 3)

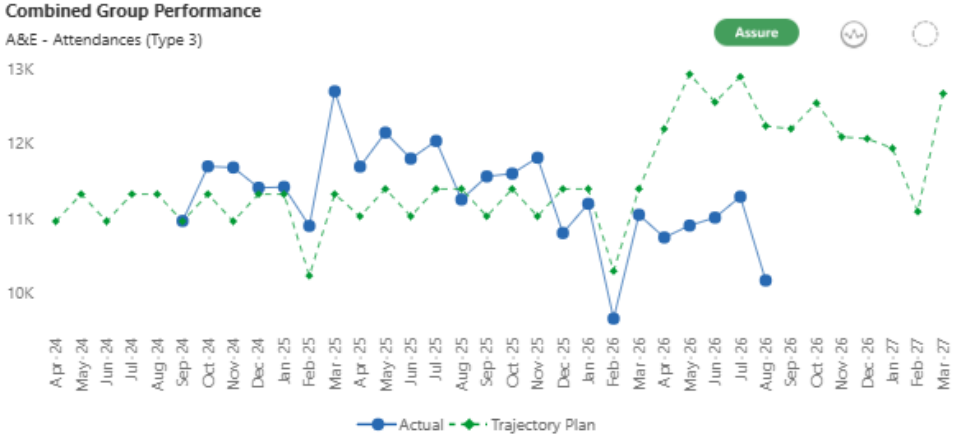
HUTH:

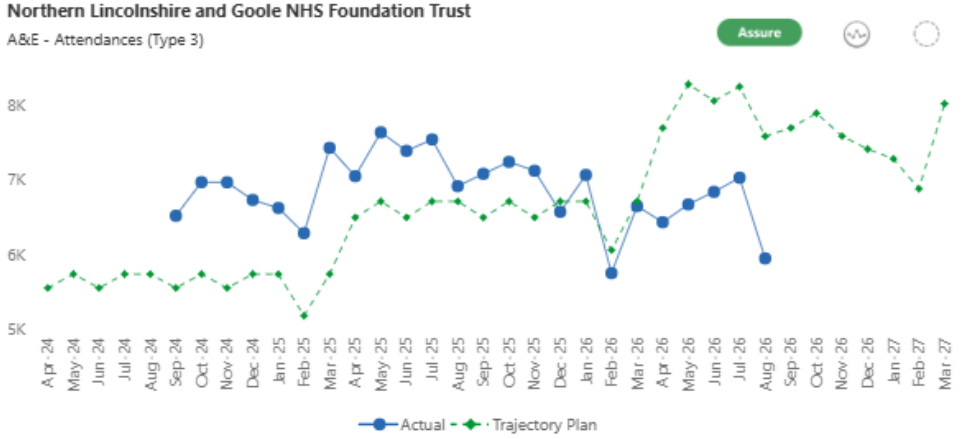
Type 3 attendances remained below trajectory in August while Type 1 demand was above plan. Although the statistical classification is Assure, the demand shift is operationally adverse; UTC access, streaming and redirection pathways require review with system partners.

NLAG:

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







d. Planned Care

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

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

Progress

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

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

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

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

Action

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

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

HUTH

Tier 1 - Foundation Scorecard

Oversight | CQC

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

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

NLAG

Tier 1 - Foundation Scorecard

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

Oversight | CQC

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

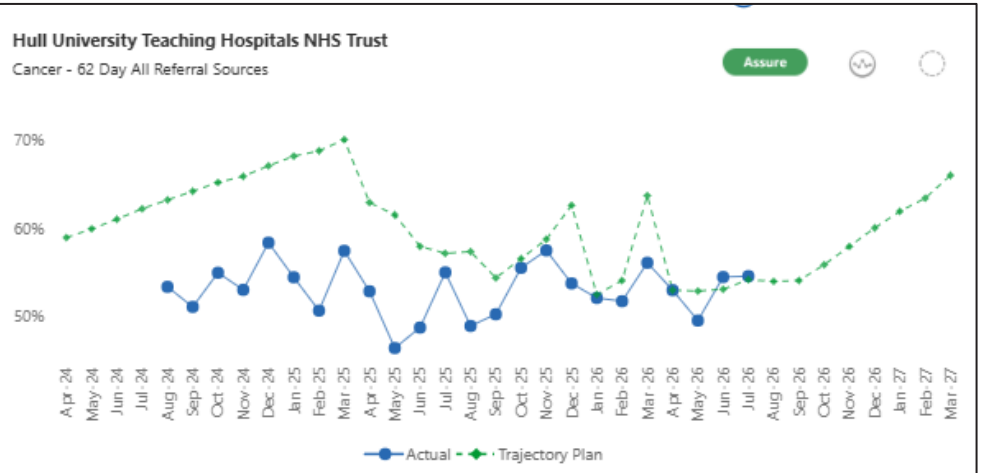
a. Cancer 62 Day First Definitive Treatment

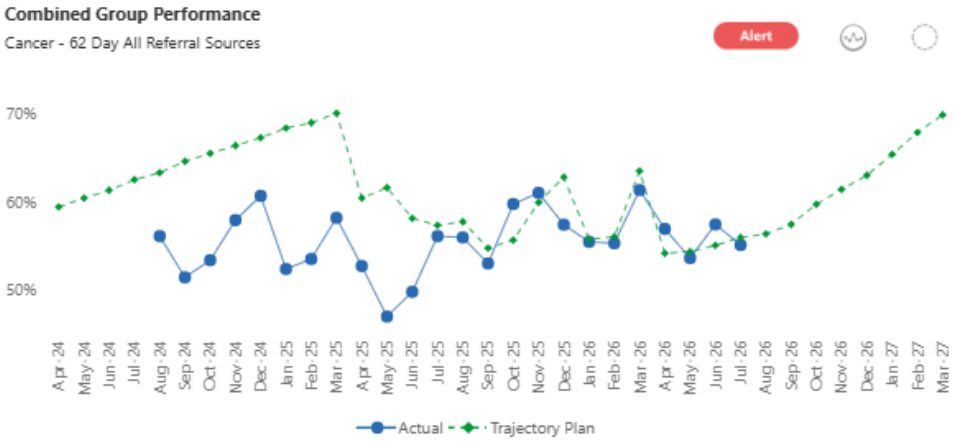
Cancer - 62 Day All Referral Sources

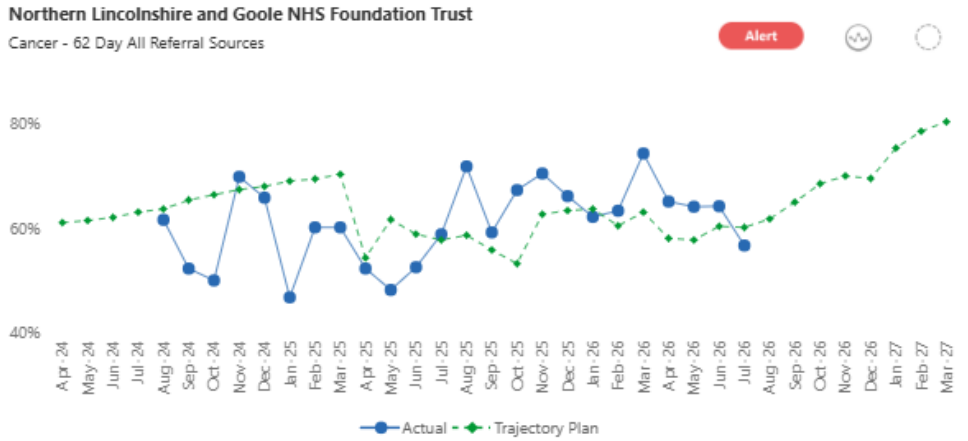
Summary:
August update: the latest available national cancer data remains July. The graph shows 62-day performance of 54.5% at HUTH and 56.7% at NLAG. Both Trusts remain below the 80% standard.

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

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







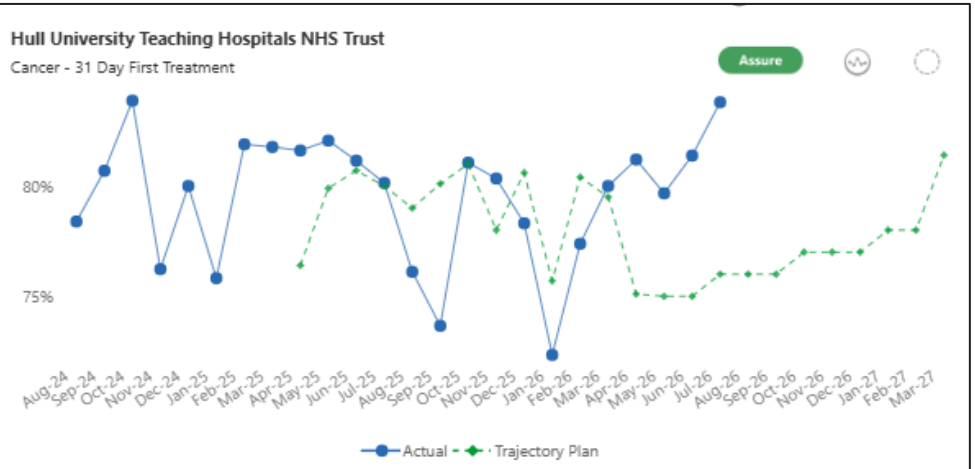
ii. Cancer 31-day First Treatment

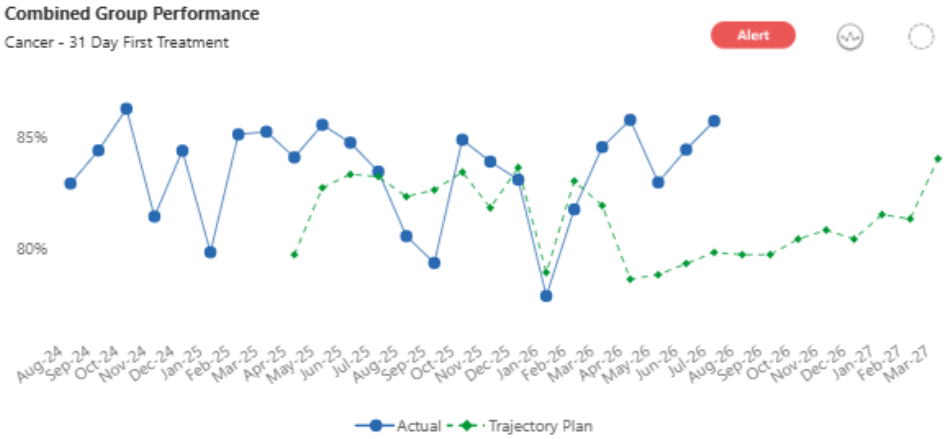
Cancer - 31 Day First Treatment

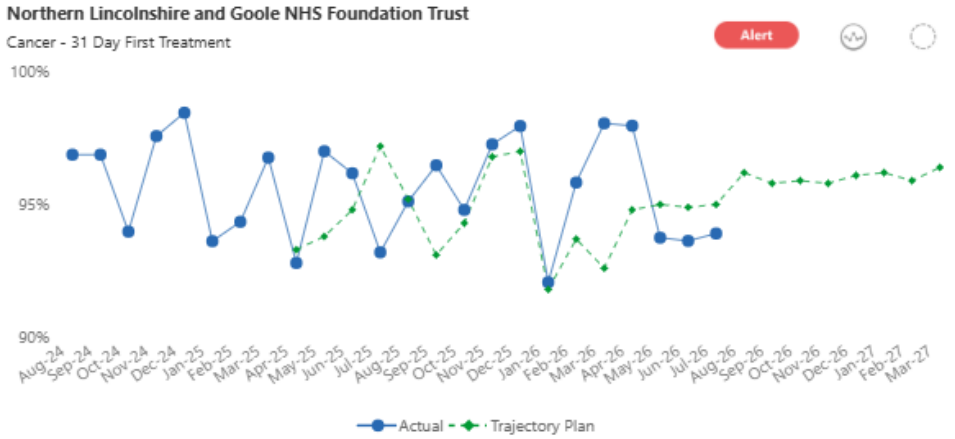
Summary:
August update: the latest available national cancer data remains July. The graph shows 31-day first-treatment performance of 83.8% at HUTH and 93.9% at NLAG. Both remain below the 94% standard.

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

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







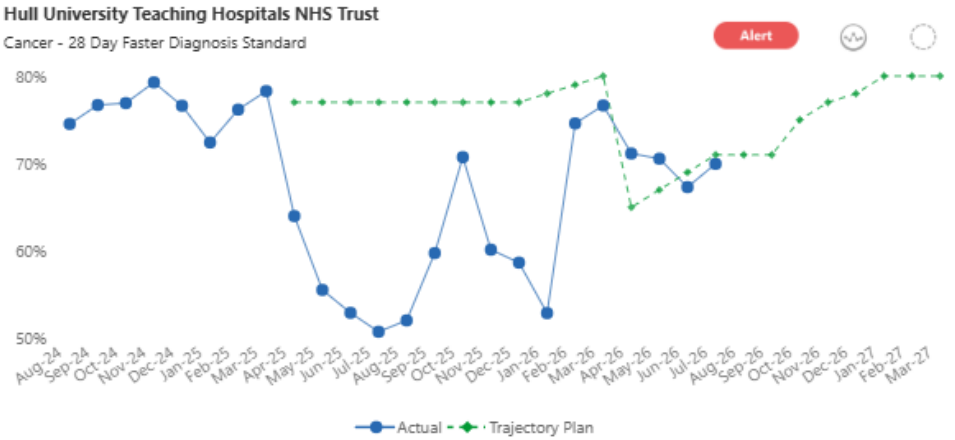
iii. Cancer 28-day Faster Diagnosis Performance

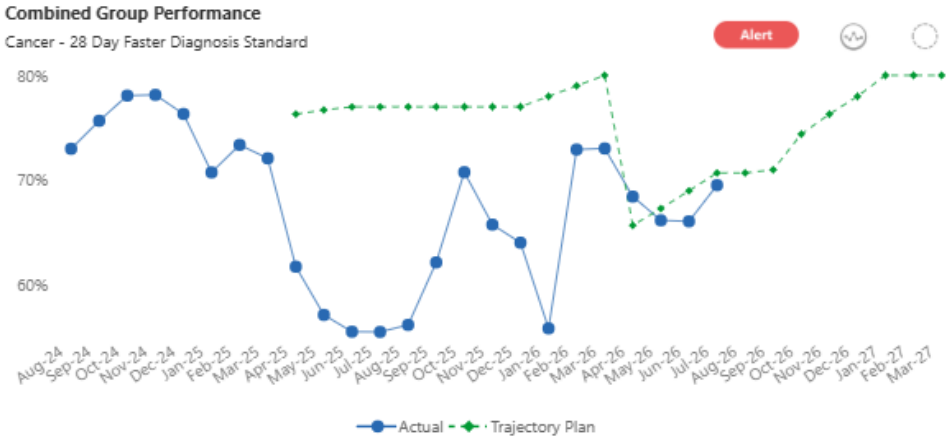
Cancer - 28 Day Faster Diagnosis Standard

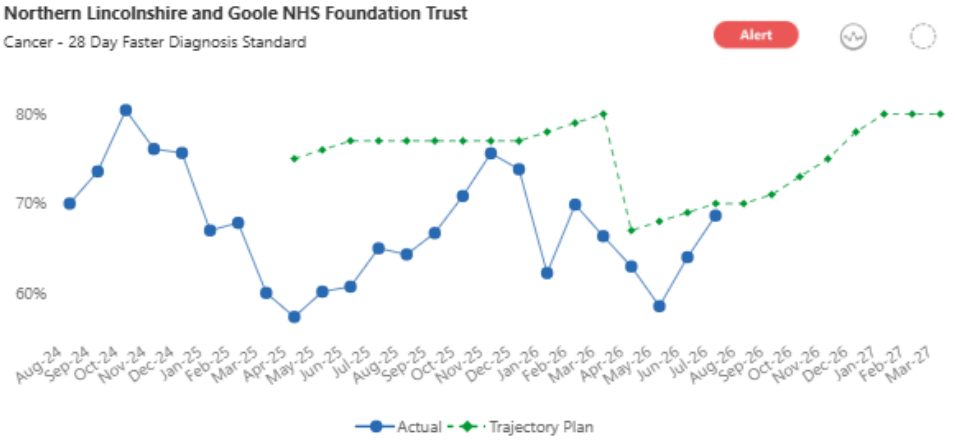
Summary:
August update: the latest available national cancer data remains July. The graph shows Faster Diagnosis performance of 70.0% at HUTH and 68.7% at NLAG. Both Trusts remain below trajectory and the 80% standard.

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

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







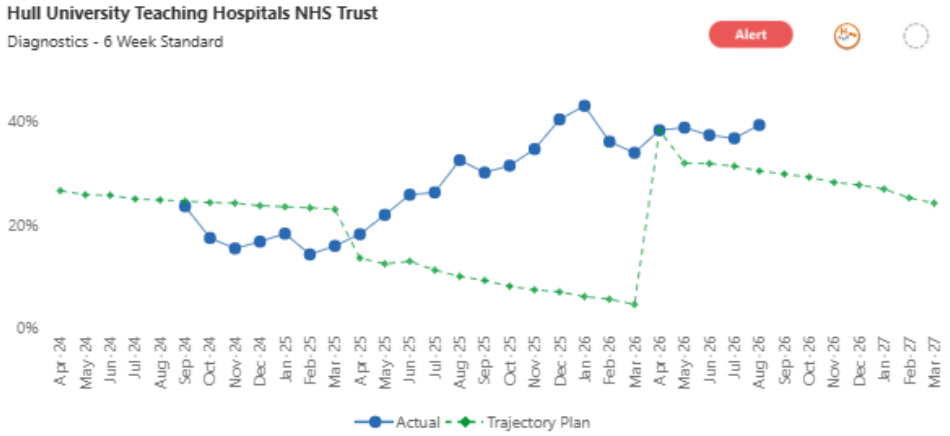
iv. Diagnostic 6-Week Standard

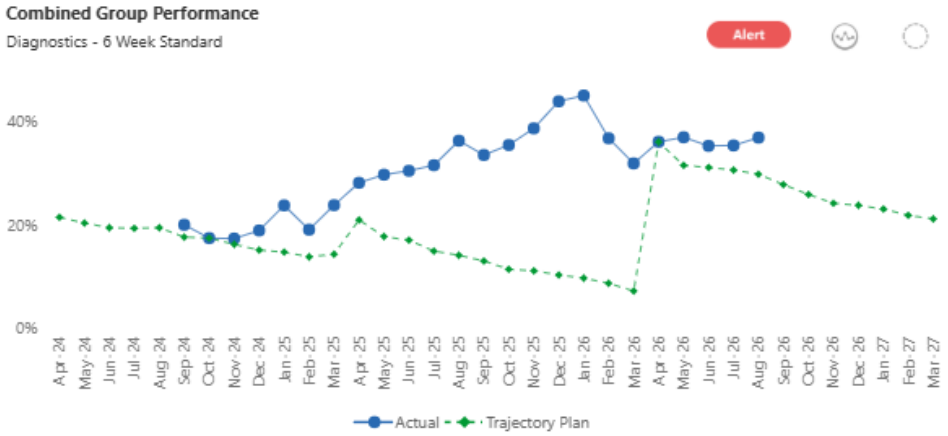
Diagnostics - 6 Week Standard

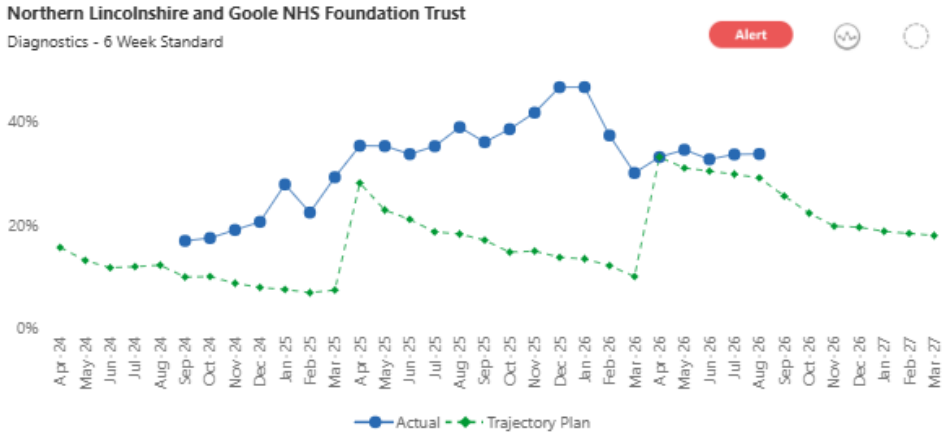
Summary:
August update: the latest graph position is 36.6% at HUTH and 33.5% at NLAG. Both Trusts remain materially above the 1% six-week standard.

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

Action:
Agree monthly recovery trajectories by modality and site. Confirm MRI and CT capacity, workforce, reporting turnaround, funding and seven-day CDC utilisation.







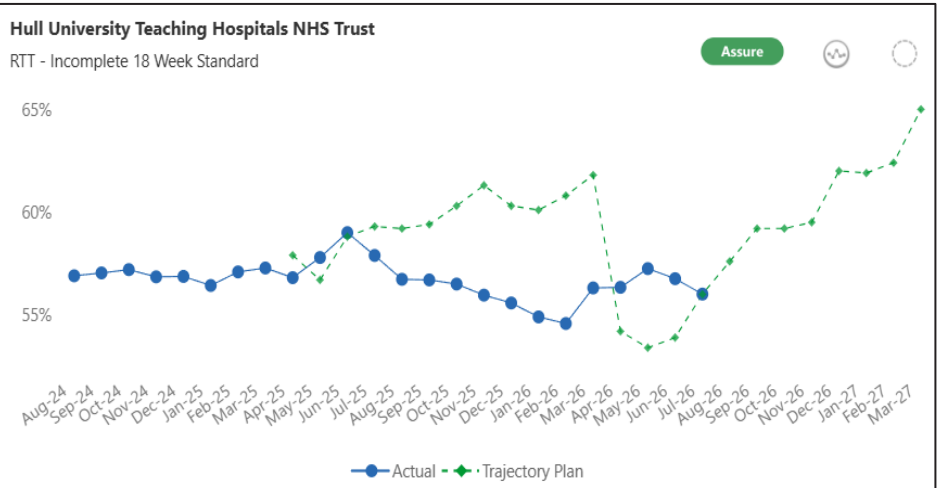
v. RTT Incomplete Performance

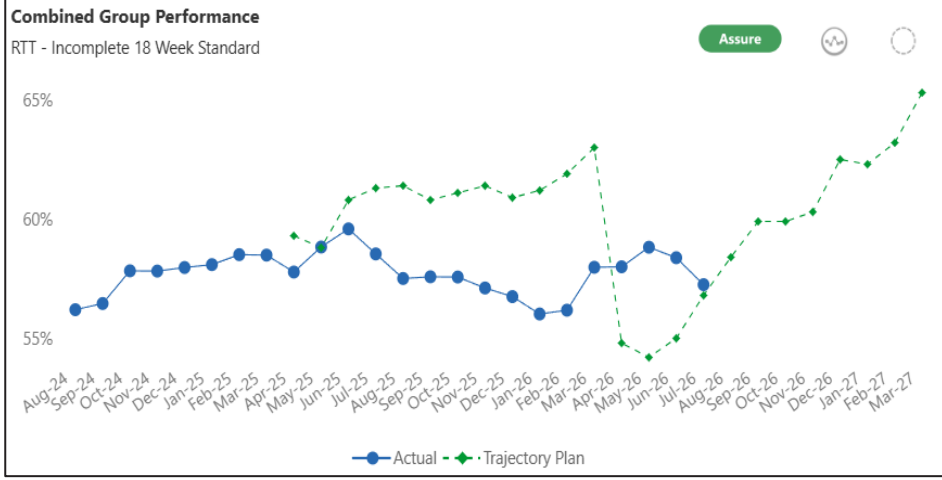
RTT - Incomplete 18 Week Standard

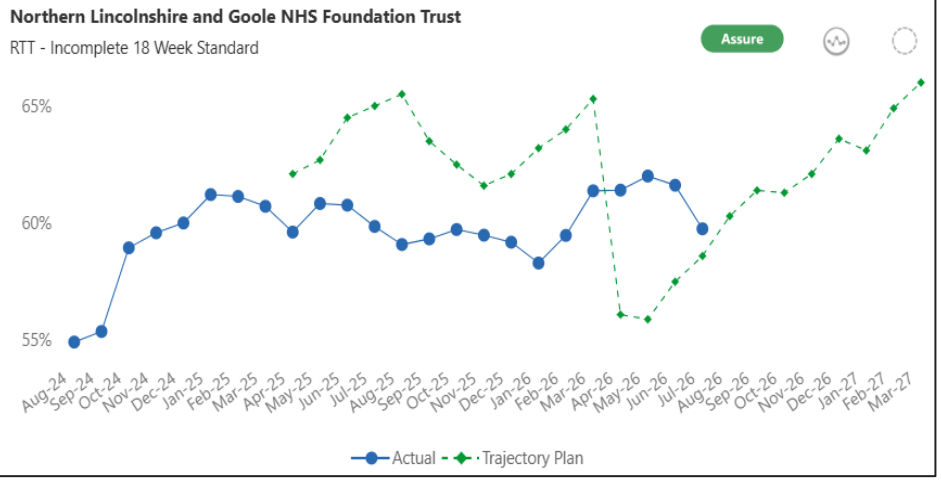
Summary:
July RTT performance reduced by 0.8 percentage points at HUTH to 56.0% and by 1.8 points at NLAG to 59.8%. Both Trusts remain well below the 92% standard and below their July trajectory.

Progress:
Outpatient transformation, demand-and-capacity and scheduler work has not yet produced a sustained improvement in the incomplete position.

Action:
Complete Care Group demand-and-capacity reviews and agreed SPOA and GIRFT changes. Escalate each specialty capacity gap with a named owner and delivery date.







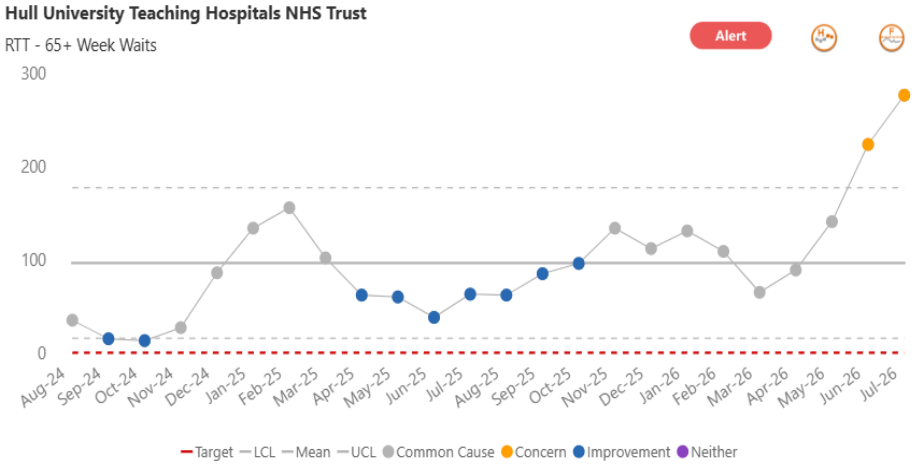
vi. RTT 65 week waits

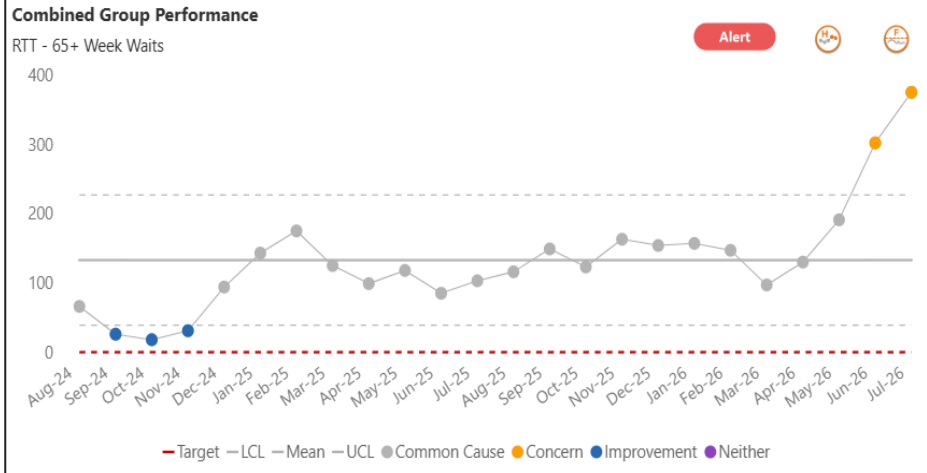
RTT - 65+ Week Waits

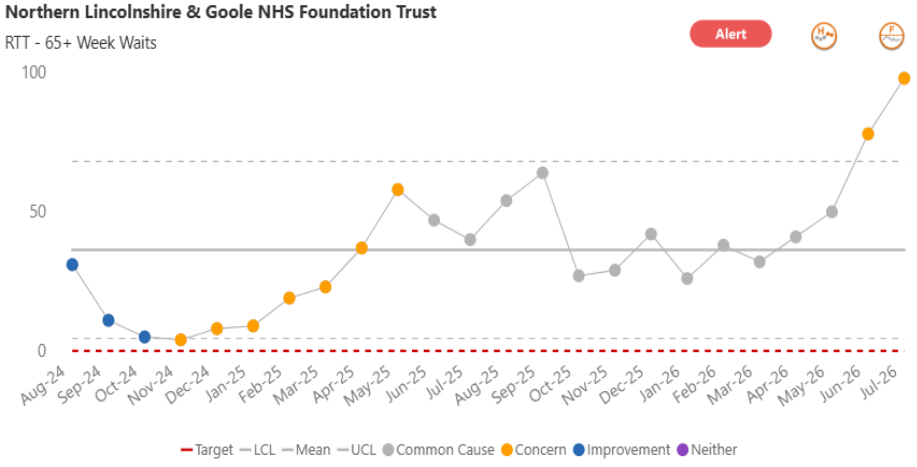
Summary:
65-week waits increased to 355 at HUTH and 163 at NLAG. This sharp deterioration reflects the underlying long wait volumes and capacity restraints.

Progress:
Validation and specialty oversight are established, but replenishment from the 52-week cohort is outstripping treatment capacity.

Action:
Maintain weekly dated-patient plans and protect capacity. Support required: executive escalation of unresolved outpatient, diagnostic, theatre, workforce and mutual-aid gaps.







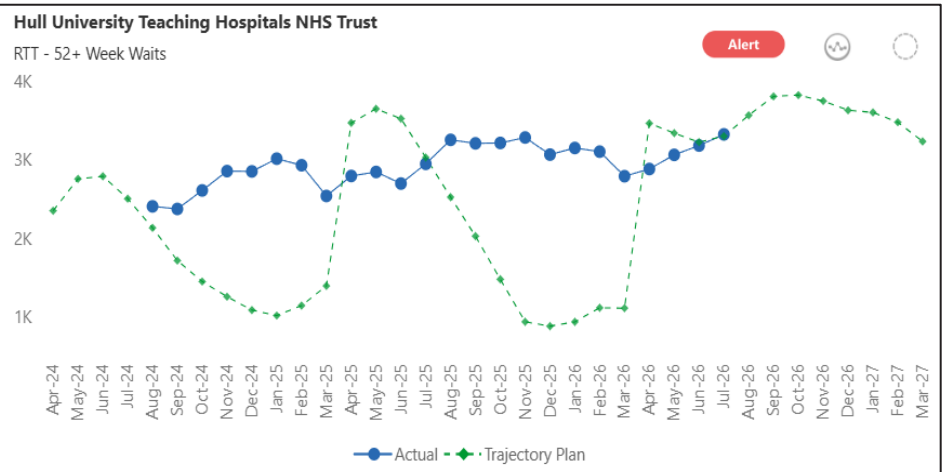
vii. RTT 52 week waits

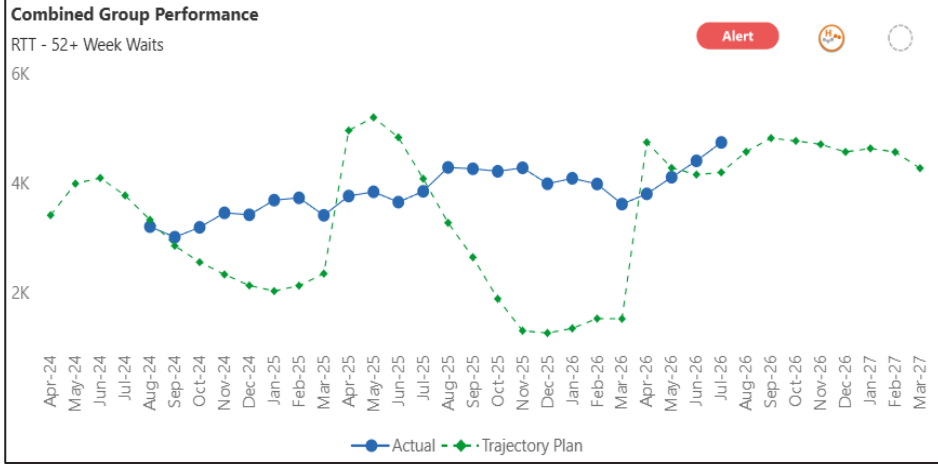
RTT - 52+ Week Waits

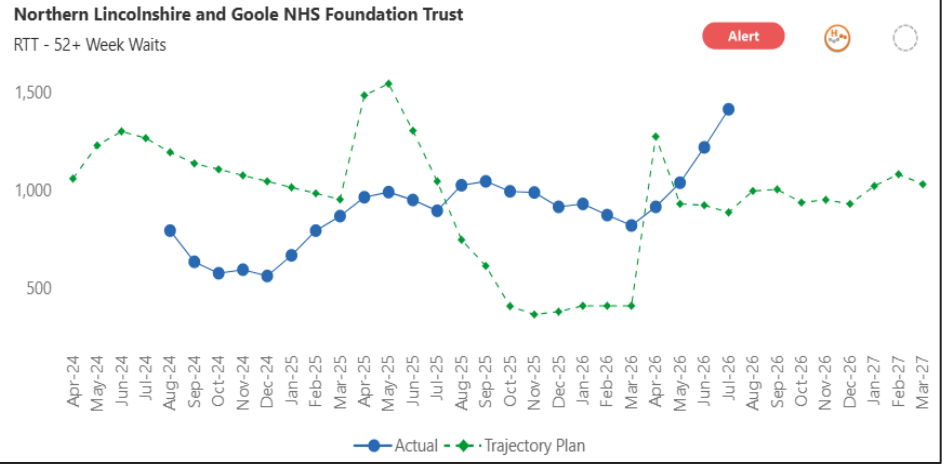
Summary:
52-week waits increased by 141 at HUTH to 3,331 and by 94 at NLAG to 1,412. Growth was not expected; HUTH remains on its plan line, while NLAG is above trajectory.

Progress:
Validation and specialty oversight are in place, but planned recovery has not prevented replenishment of the 65-week cohort.

Action:
Set weekly specialty trajectories and date highest-risk patients. Support required: Care Group ownership and aligned outpatient, diagnostic and treatment capacity.







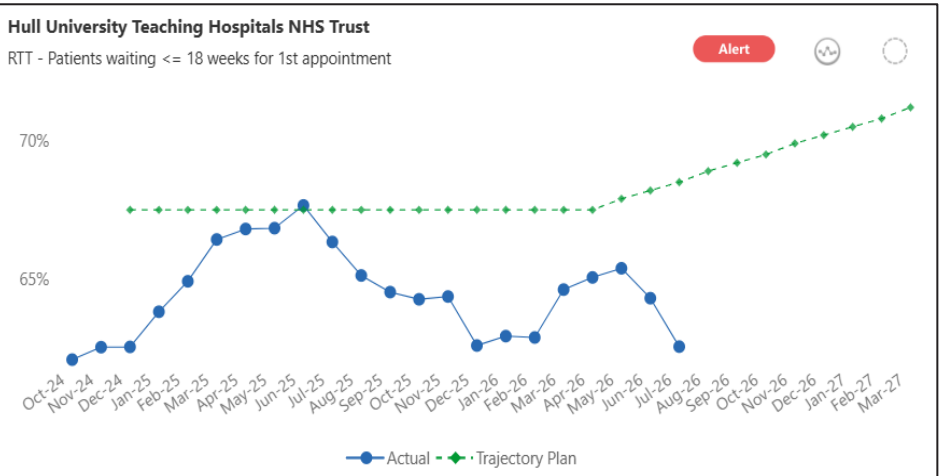
viii. Enabler Metric 1: Time to First Appointment (%)

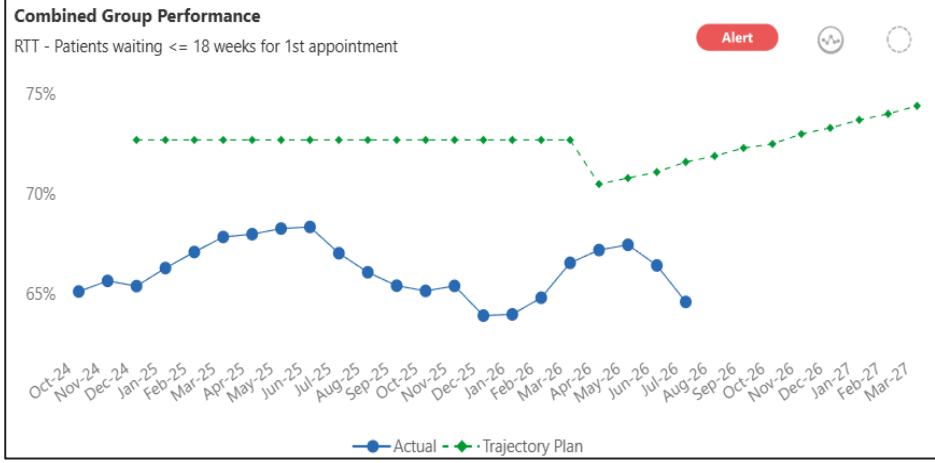
RTT - Patients waiting <= 18 weeks for 1st appointment

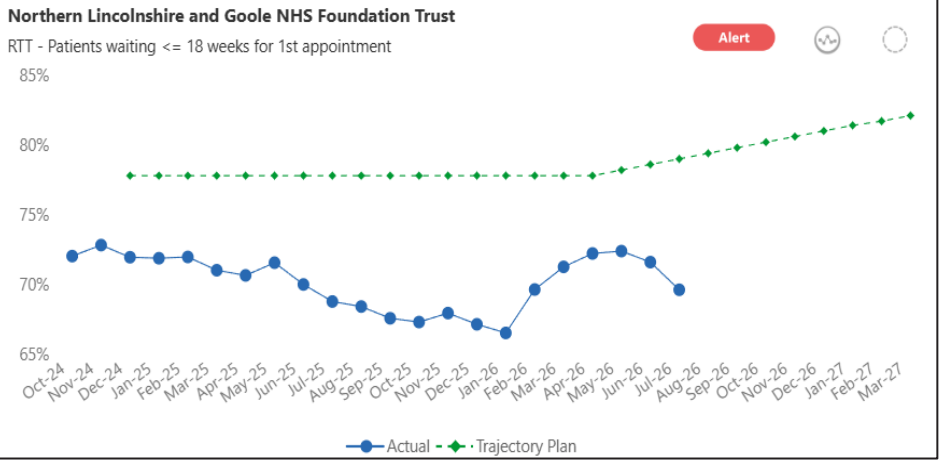
Summary:
August update: the latest graph position is 62.6% at HUTH and 69.6% at NLAG. Both Trusts remain below trajectory for patients waiting no more than 18 weeks for a first appointment.

Progress:
Outpatient transformation and demand-and-capacity reviews have not yet generated the required improvement in first outpatient access.

Action:
Improve slot fill, booking controls and SPOA pathways. Confirm specialty capacity plans, referral-demand controls and resolution of workforce gaps.







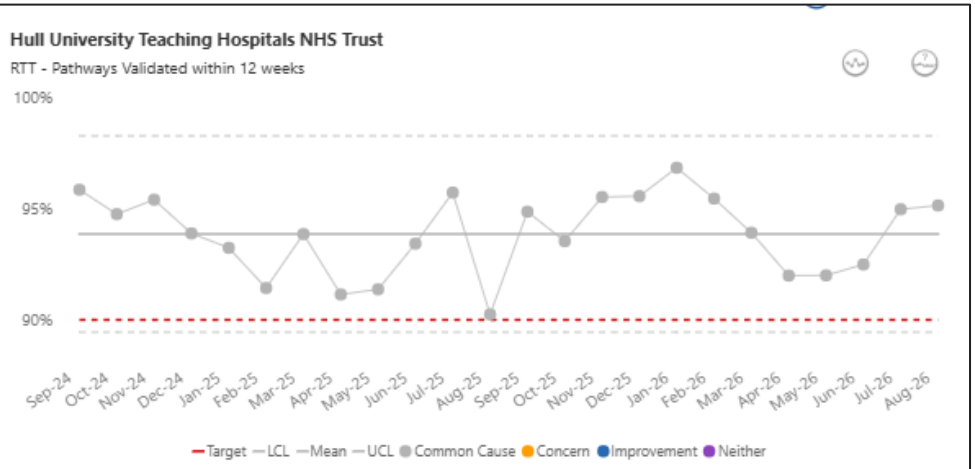
ix. Enabler Metric 2: RTT Data Quality

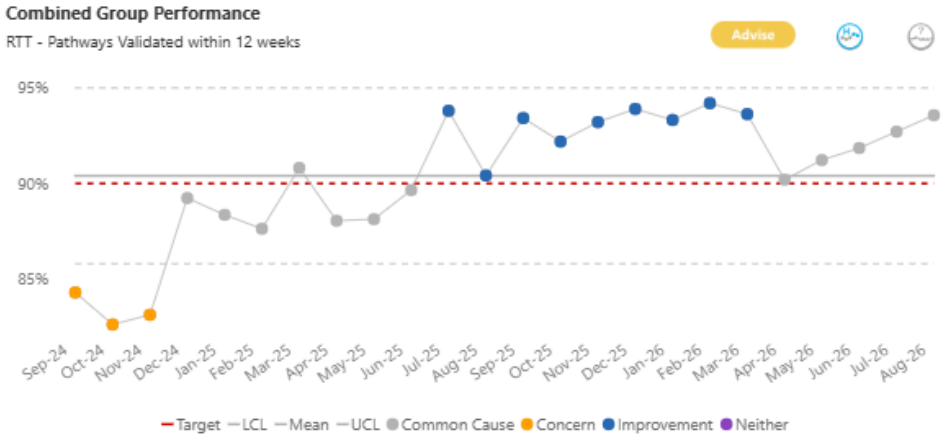
RTT - Pathways Validated within 12 weeks

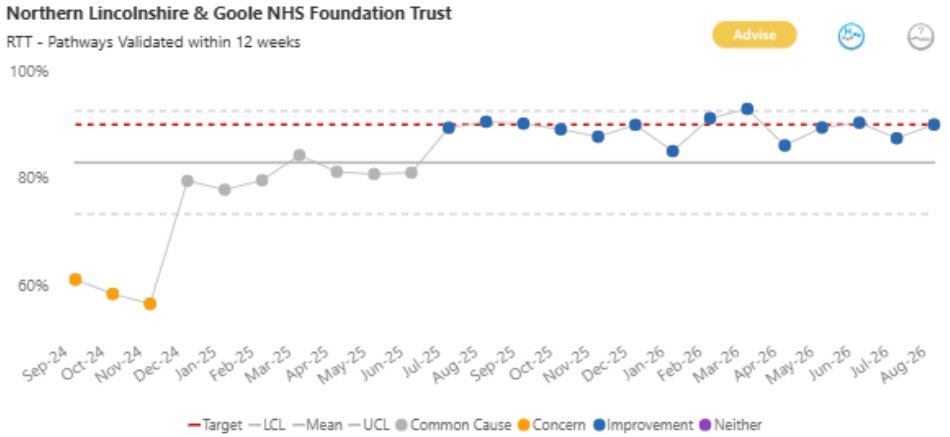
Summary:
August validation improved to 95.2% at HUTH and 90.0% at NLAG. Both Trusts now meet the 90% standard, although NLAG has no headroom.

Progress:
Weekly validation, completeness work and pathway oversight have improved the position. LUNA-ROVA deployment should strengthen patient-level tracking and exception management.

Action:
Sustain validation at or above 90%. Track unresolved exceptions and the time taken to correct records, with immediate escalation where either Trust falls below standard.







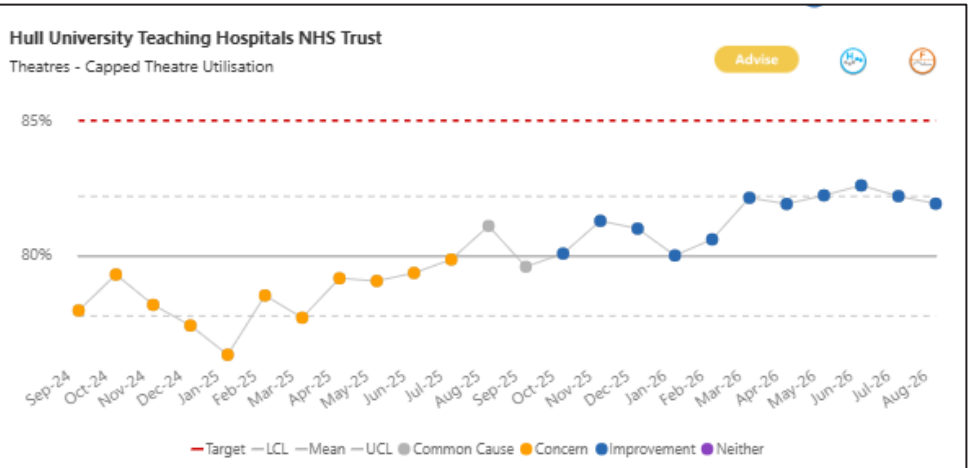
x. Enabler Metric 3: Capped Theatre Utilisation

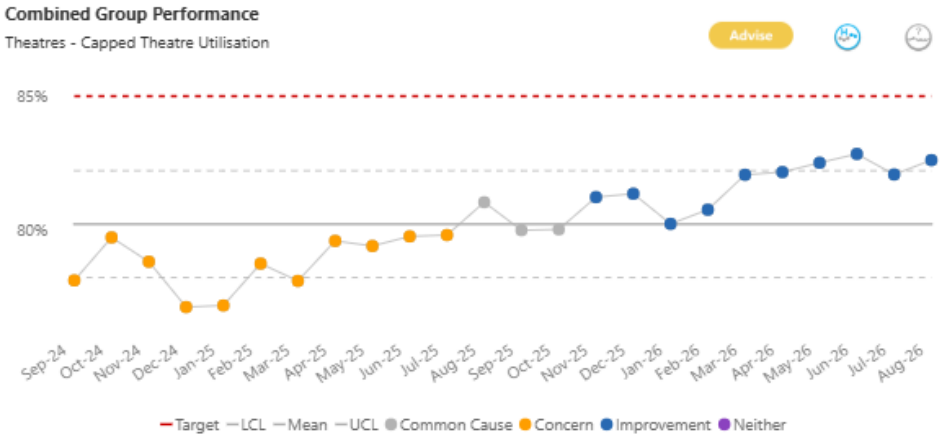
Theatres - Capped Theatre Utilisation

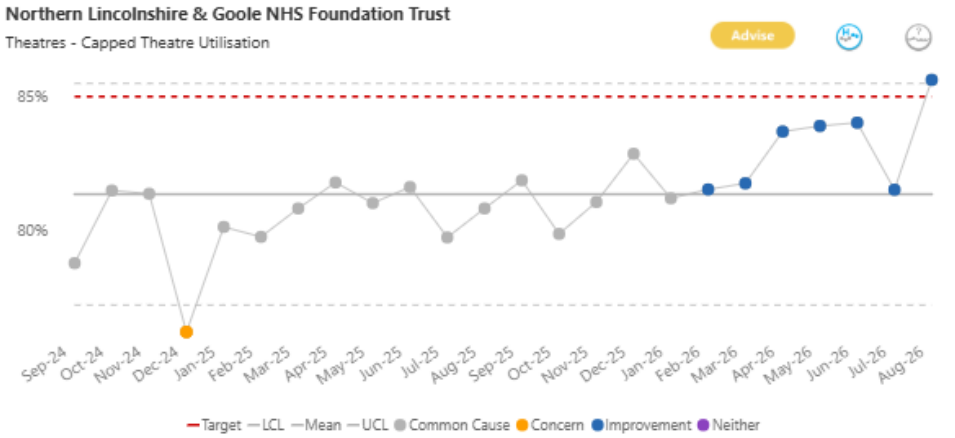
Summary:
August theatre utilisation reduced by 0.3 percentage points at HUTH to 81.9% but improved by 4.1 points at NLAG to 85.6%. NLAG is above the 85% target; HUTH remains 3.1 points below.

Progress:
NLAG has converted improved session delivery into target achievement. HUTH remains off target despite scheduler access and productivity oversight.

Action:
Maintain NLAG above 85% and recover HUTH to 85%. Track session fill, starts, finishes and cancellations weekly, with Care Group action on workforce and long-wait capacity.







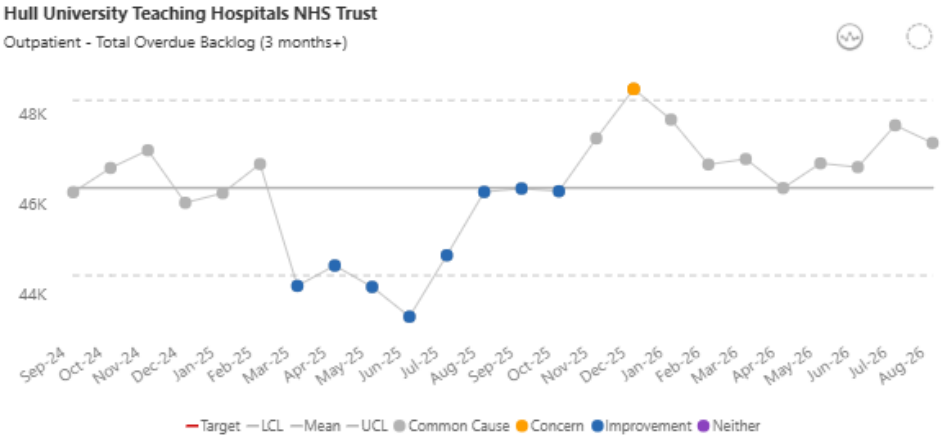
xi. Enabler Metric 4: Outpatient Follow Up Backlog

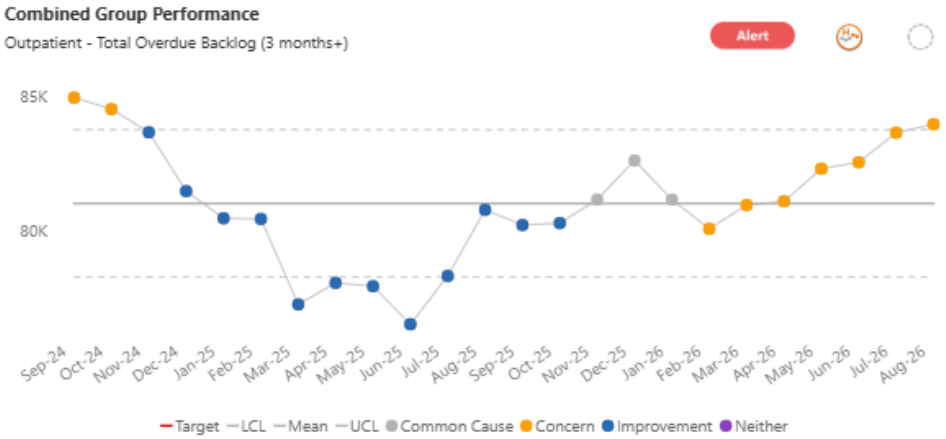
Outpatient - Total Overdue Backlog (3 months+)

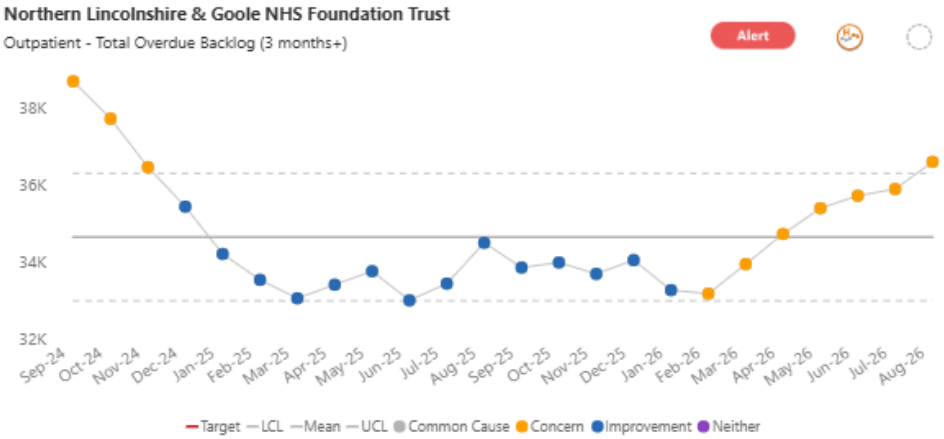
Summary:
The combined August follow-up backlog increased by 314 to 83,969. HUTH reduced by 394 to 47,359, while NLAG increased by 708 to 36,610.

Progress:
HUTH improved in August, but NLAG deterioration prevented a Group-wide reduction and remains the immediate priority.

Action:
Risk-stratify the backlog and assign specialty owners. Set a reduction target and completion date for each priority cohort, using validation, PIFU, discharge and funded capacity.







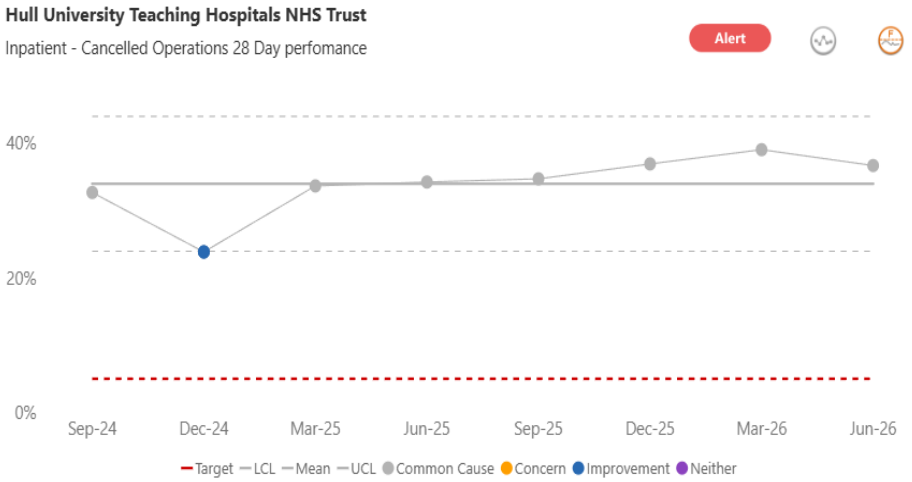
xii. Enabler Metric 5: Cancelled Operations – 28-day Breaches

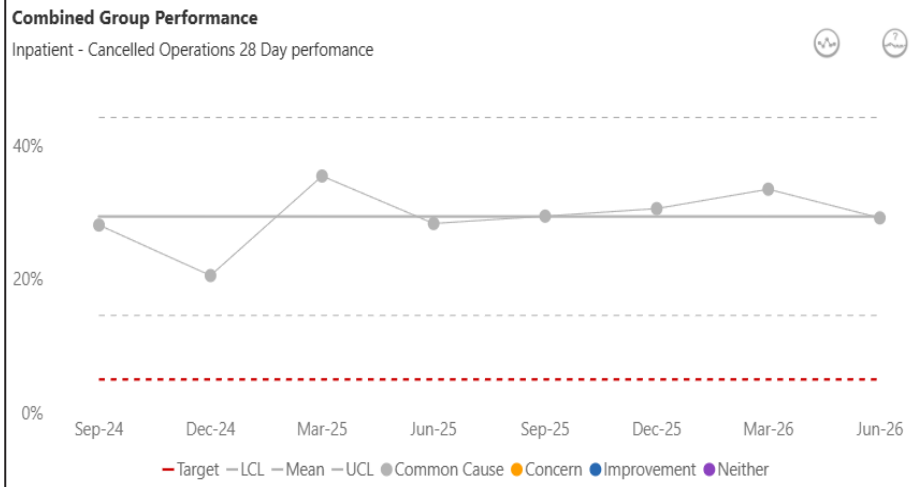
Inpatient - Cancelled Operations 28 Day perfomance

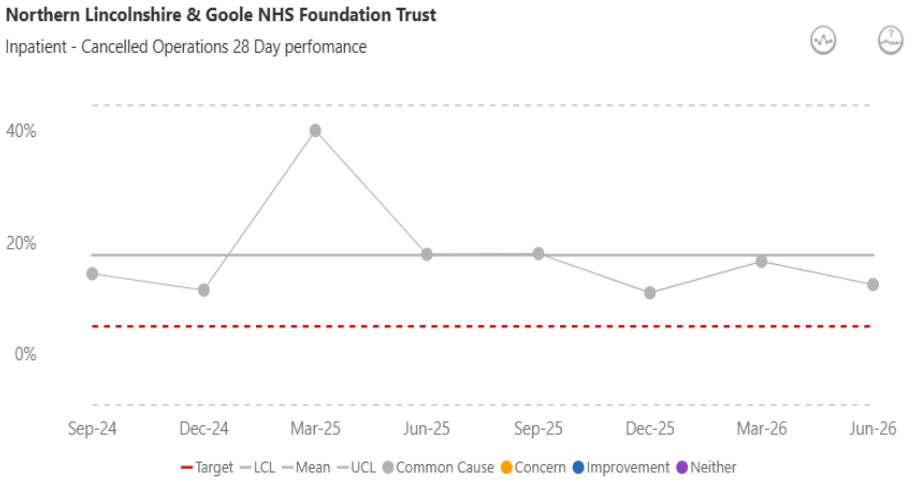
Summary:
August update: the latest quarterly graph remains the June position. Both Trusts improved between March and June, but the proportion of cancelled patients not rebooked within 28 days remains above the 5% standard.

Progress:
The latest direction is positive, but current controls have not yet delivered reliable rebooking within the 28-day guarantee.

Action:
Maintain a daily cancellation PTL with named specialty owners and protected rebooking capacity. Escalate every patient without a replacement date before day 28.







5. HHP Group Executive Summary – Quality

Executive Lead: Hilda Gwilliams, Group Chief Patient Safety Officer Accountable to: Quality Safety Committee

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
Care Hours per Patient Day - Overall	Apr-26	≥ 9.0	7.6		
Complaints - 60 day compliance	Aug-26	≥ 85.0%	56.1%		
Falls - per 1,000 bed days	Aug-26		5.97		
Falls - Serious harm or death	Aug-26		3		
Friends & Family - A&E Score	Jul-26	≥ 85.0%	83.3%		
Friends & Family - Antenatal Score	Jul-26	≥ 95.0%	78.8%		
Friends & Family - Inpatient Score	Jul-26	≥ 95.0%	97.8%		
Friends & Family - Outpatient Score	Jul-26	≥ 95.0%	97.0%		
Infections - C.Difficile (Cumulative)	Jul-26		39		
Infections - E.Coli (Cumulative)	Jul-26		69		
Infections - Klebsiella (Cumulative)	Jul-26		26		
Infections - MRSA (per 1,000 bed days)	Jul-26		0.00		
Inpatient - Corridor Care on Wards	Aug-26		40.8		
Inpatient - Emergency Readmissions within 30 days	Jul-26		9.9%		
Mortality - SHMI	Mar-26	≤ 1.0	1.047		
Never Events	Aug-26		0		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Aug-26		1.39		
Pressure Ulcers - Category 3	Aug-26		1		
Pressure Ulcers - Category 4	Aug-26		1		
Pressure Ulcers - Hospital acquired	Aug-26		147		
VTE Risk Assessment 14 Hour Standard	Jul-26	≥ 95.0%	91.7%		

Northern Lincolnshire and Goole NHS Foundation Trust

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

Metric	Month	Target	Result	Var	Asr
Care Hours per Patient Day - Overall	Apr-26	≥ 9.0	9.5		
Complaints - 60 day compliance	Aug-26	≥ 85.0%	68.6%		
Falls - per 1,000 bed days	Aug-26		5.89		
Falls - Serious harm or death	Aug-26		0		
Friends & Family - A&E Score	Jul-26	≥ 85.0%	60.0%		
Friends & Family - Antenatal Score	Jul-26	≥ 95.0%	50.0%		
Friends & Family - Inpatient Score	Jul-26	≥ 95.0%	98.0%		
Friends & Family - Outpatient Score	Jul-26	≥ 95.0%	98.3%		
Infections - C.Difficile (Cumulative)	Jul-26		20		
Infections - E.Coli (Cumulative)	Jul-26		87		
Infections - Klebsiella (Cumulative)	Jul-26		23		
Infections - MRSA (Cumulative)	Jul-26		6		
Inpatient - Corridor Care on Wards	Aug-26		0.4		
Inpatient - Emergency Readmissions within 30 days	Jul-26		11.0%		
Mortality - SHMI	Mar-26	≤ 1.0	0.993		
Never Events	Aug-26		0		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Aug-26		2.77		
Pressure Ulcers - Category 3	Aug-26		12		
Pressure Ulcers - Category 4	Aug-26		3		
Pressure Ulcers - Hospital acquired	Aug-26		232		
VTE Risk Assessment 14 Hour Standard	Jul-26	≥ 95.0%	94.3%		

Group Chief Patient Safety Officer Update – Quality Overview (August 2026)

Quality performance presents a mixed position across HUTH and NLAG, with the most material oversight risks sitting within patient safety and infection prevention, alongside continuing variation in patient experience and effectiveness indicators. The NOF Quality briefing confirms Patient Safety as a distinct provider oversight domain, combining scored metrics for clinical audit outliers, MRSA, E. coli, C. difficile and the staff survey raising-concerns sub-score with contextual indicators for falls causing harm, pressure ulcers and incidents causing harm.

Patient Experience shows improving grip on 60-day complaint response compliance since October 2025, but complaints received and PALS activity remain variable, indicating that earlier resolution, responsiveness and thematic learning are not yet consistently reducing patient concern activity across services.

Safety remains the principal quality risk area. Care Hours per Patient Day requires continued triangulation with acuity, staffing fill and ward-level risk. Infection prevention indicators are particularly important because MRSA, E. coli and C. difficile are NOF scoring metrics. C. Difficile is over trajectory for HUTH and over the annual threshold for NLAG.

Effectiveness is broadly stable but requires continued governance oversight. VTE assessment compliance remains below the 14 hour target, and will be affected by the national change to emergency admission timing from DTA in Quarter 3. SHMI should continue to be handled as a statistical indicator through established clinical governance and coding assurance, while emergency readmissions within 30 days appear broadly stable but should remain subject to specialty-level review of discharge quality, follow-up arrangements and avoidable readmission themes.

Executive focus should be on creating a unified Quality Foundation Scorecard for each Trust, that brings together scored and contextual NOF measures with local quality indicators, providing clear targets, trajectories and accountability. Quality improvement methodology should be applied to support the areas of the NOF that are below the required thresholds and linked through to the relevant Integrated Improvement Plan workstreams. This should enable consistent oversight from Board to care group and ward level, with escalation focused on infection prevention, safe staffing, complaint responsiveness, VTE compliance, SHMI assurance and avoidable readmissions.

a. Hull University Teaching Hospital Quality AAA Summary

Count: 15

Alert

Care Hours per Patient Day - Overall
Care Hours per Patient Day - Unregistered
Complaints - 40 day compliance
Complaints - 60 day compliance
Duty of Candour - Verbal apology
Inpatient - Discharge to Assess (D2A) over 14 days
PALS - Complaints compliance within 10 working days
Pressure Ulcers - Category 2
Pressure Ulcers - Category 4
Pressure Ulcers - Community acquired
Pressure Ulcers - Hospital acquired
Pressure Ulcers - Hospital acquired (per 1,000 bed days)
Pressure Ulcers - Suspected deep tissue injury
VTE Risk Assessment
VTE Risk Assessment 14 Hour Standard

Count: 7

Advise

Complaints - Average response time
Duty of Candour - Written apology within 10 working days
Friends & Family - A&E Score
Friends & Family - Birth Score
Friends & Family - Outpatient Score
Mortality - HSMR
Mortality - SHMI

Count: 4

Assure

Inpatient - Corridor Care on Wards
Inpatient - Discharge Lounge Utilisation
PALS - Complaints
Patient Safety Incidents - Low harm

b. Northern Lincolnshire & Goole Hospitals Quality AAA Summary

Count: 11

Alert

Care Hours per Patient Day - Unregistered
Complaints - 40 day compliance
Duty of Candour - Written apology
Friends & Family - A&E Score
Infections - MRSA
Infections - MRSA (Cumulative)
Infections - MRSA (per 1,000 bed days)
Inpatient - Annual Growth Under 18s Elective Activity
Inpatient - Discharge Lounge Utilisation
Inpatient - Discharges by 12pm (midday)
Inpatient - Long Stay Occupancy (21+ days)

Count: 1

Advise

Friends & Family - Postnatal Community Score

Count: 5

Assure

Care Hours per Patient Day - Registered
Friends & Family - Community Score
Friends & Family - Inpatient Score
Mortality - HSMR
Patient safety alerts actioned by specified deadline

Experience

Experience narrative updated for August 2026.

Summary

The complaint rate remains static and the timeliness in responding to complaints remains below the target. There has been a reduction in the number of PALS contacts at HUTH latterly. The dashboard data shows some improvement in the mean number of days to respond to complaints in NLAG and this metric should improve as timeliness of responses to complaints improves. The scorecards scope complaints 60-day compliance, complaints received and PALS concerns as the core measures of responsiveness to patient concerns. The strongest improvement signal is complaints 60-day compliance, which has slightly improved since October 2025, although performance remains below the stated compliance level. Improvement in learning from complaints and patient feedback sources is part of a group wide quality improvement plan.

Progress

Since October 2025, both Trusts have shown some improvement on 60-day complaint response timeliness, but further consistency is required to meet the standard reliably. Complaints received remain static and PALS contacts have reduced recently, however the complaint rate does not correlate with this. It may be desirable to have an increased PALS contact rate with reduced complaint rates with more proactive approaches to engage with patients and their families. The pattern suggests earlier resolution and thematic learning are not yet consistently reducing formal complaint or PALS activity.

Action

- Quality Improvement in respect of patient experience interventions, changing behaviours and practice, based on learning identified by care groups.
- Exploration of location of the PALS service are being considered to enable earlier PALS contact in the endeavour to intervene and prevent complaint escalation.
- Sustain the improvement in 60-day complaint compliance through divisional ownership, overdue case escalation and routine review of response quality.
- Strengthening early resolution of concerns to reduce avoidable escalation from PALS to formal complaints, with service-level hotspot review, repeat-theme analysis and evidence of learning embedded through patient experience governance.

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Caring	Experience	Friends & Family - A&E Score	≥ 85.0%	0.0%	0.0%	0.0%	0.0%	100.0%	72.4%	70.8%	90.0%	71.4%	66.7%	100.0%	83.3%	
		Friends & Family - Antenatal Score	≥ 95.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	81.8%	50.0%	93.8%	100.0%	82.4%	78.8%	
		Friends & Family - Birth Score	≥ 95.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
		Friends & Family - Inpatient Score	≥ 95.0%	94.8%	97.8%	98.8%	97.2%	96.2%	96.5%	97.1%	96.1%	96.9%	89.0%	96.9%	97.8%	
		Friends & Family - Outpatient Score	≥ 95.0%	98.8%	96.7%	97.8%	96.7%	94.1%	98.6%	97.1%	96.1%	96.2%	96.2%	97.9%	97.0%	
		Friends & Family - Postnatal Score	≥ 95.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	66.7%	85.7%	100.0%	100.0%	75.0%	100.0%	
Responsive	Experience	Complaints - 60 day compliance	≥ 85.0%	68.2%	71.0%	24.6%	35.4%	51.9%	40.0%	53.5%	50.0%	64.5%	48.8%	57.6%	64.4%	56.1%
		Complaints - Average response time	≤ 40.0	164.4	122.8	116.6	112.1	76.6	77.5	65.2	69.9	47.5	65.8	60.6	48.7	51.2
		Complaints - Received		36	47	51	56	36	31	35	26	18	49	29	28	29
		Complaints - Received (per 1,000 bed days)		1.04	1.37	1.32	1.63	1.11	0.99	1.22	0.69	0.51	1.60	0.93	0.90	0.84
		Complaints - Reopened		3	3	2	1	4	2	2	4	3	2	0	1	0
		PALS - Complaints		280	250	397	272	241	254	216	140	64	219	159	130	122
		PALS - Complaints compliance within 10 working days		49.6%	46.9%	52.5%	42.9%	42.0%	38.3%	47.4%	41.1%	46.6%	55.3%	33.0%	36.4%	27.3%

NLAG Scorecard

Tier 1 - Foundation Scorecard

Oversight | CQC

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

Tier 1 - Foundation Scorecard

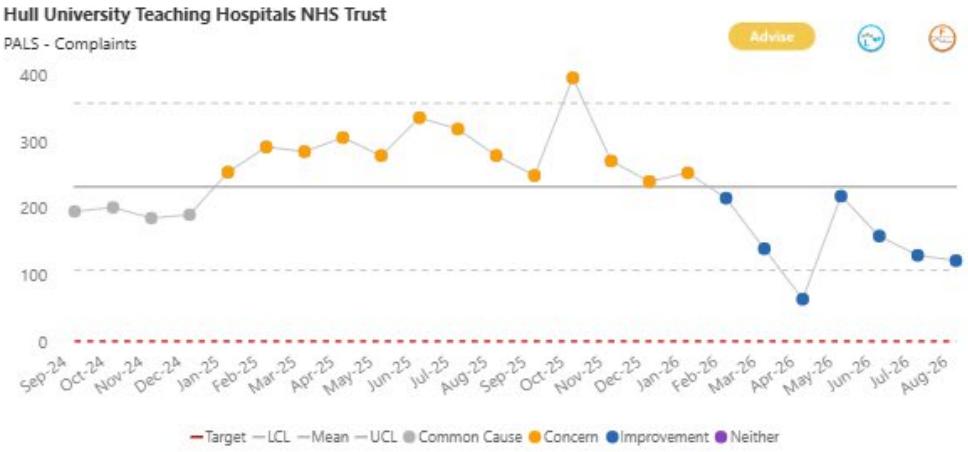
Domain	Subj Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Caring	Experience	Friends & Family - A&E Score	≥ 85.0%	82.0%	75.6%	75.6%	75.6%	75.0%	76.8%	76.8%	76.4%	79.4%	74.3%	76.0%	60.0%	
		Friends & Family - Antenatal Score	≥ 95.0%	82.8%	65.6%	65.6%	76.2%	75.8%	68.0%	96.3%	87.0%	100.0%	66.7%	66.7%	50.0%	
		Friends & Family - Birth Score	≥ 95.0%	91.7%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	
		Friends & Family - Inpatient Score	≥ 95.0%	95.8%	97.4%	97.4%	97.5%	97.2%	97.5%	98.2%	98.7%	98.5%	98.4%	98.6%	98.0%	
		Friends & Family - Outpatient Score	≥ 95.0%	95.1%	96.9%	96.9%	95.9%	97.7%	95.1%	96.9%	95.5%	97.9%	96.3%	97.9%	98.3%	
		Friends & Family - Postnatal Score	≥ 95.0%	92.9%	100.0%	100.0%	92.9%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	66.7%	100.0%	
Responsive	Experience	Complaints - 60 day compliance	≥ 85.0%	36.6%	50.0%	37.1%	53.1%	67.9%	48.3%	63.9%	71.8%	78.6%	59.2%	72.2%	62.1%	68.6%
		Complaints - Average response time	≤ 40.0	69.3	59.5	74.2	67.2	43.8	63.3	55.3	40.8	45.8	48.6	42.4	48.8	40.6
		Complaints - Received		28	27	20	26	19	47	45	43	46	34	26	45	34
		Complaints - Received (per 1,000 bed days)		1.44	1.39	0.97	1.29	0.91	2.22	2.33	2.12	2.30	1.63	1.29	2.22	1.65
		Complaints - Reopened		3	1	1	7	0	5	4	2	6	1	3	0	0
		PALS - Complaints		221	247	278	228	240	262	208	233	253	226	248	263	149
		PALS - Complaints compliance within 10 working days		59.6%	60.9%	59.0%	56.1%	57.3%	61.4%	63.4%	64.8%	66.9%	63.3%	54.0%	59.9%	54.7%

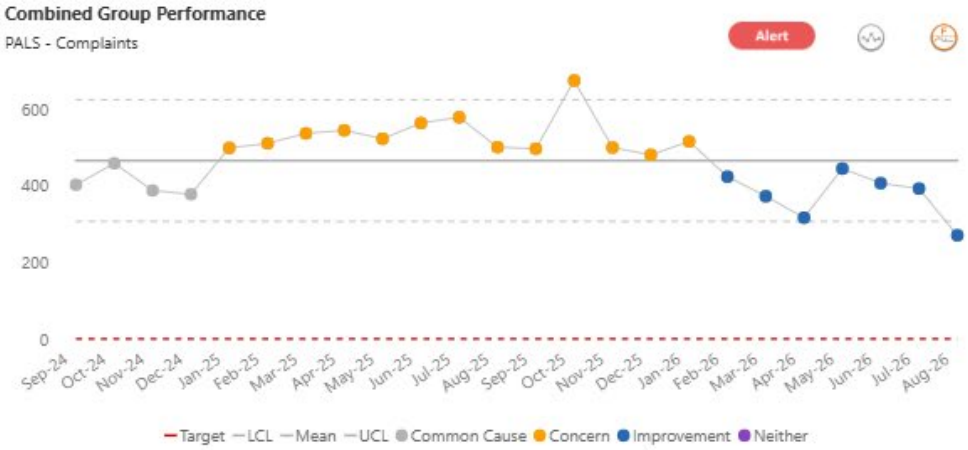
i. PALS Contacts

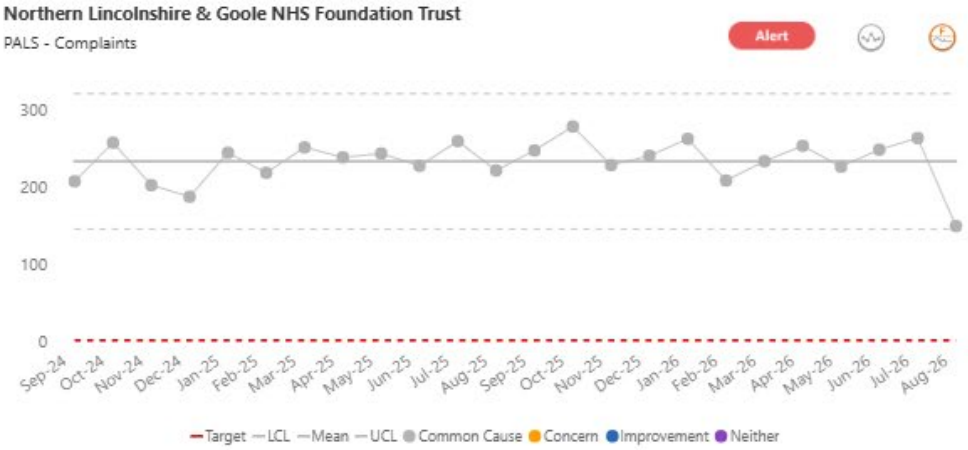
PALS - Complaints

HUTH:
PALS contact rates show continued variation across the period, with a reduction of contacts at HUTH since February 2026, triggering special cause and Advise alert. The trend should be interpreted alongside formal complaints received and complaints 60-day compliance to understand whether concerns are being resolved early or escalating into formal complaint routes.

NLAG:
NLAG shows common cause variation in PALS contacts, with no clear sustained change evident from the chart, however this has triggered an alert on not achieving the target. The balance of the target should be considered in the context of complaints prevention and learning from complaints. Continued focus is required on early resolution, responsiveness to patient concerns and thematic learning, particularly where repeat issues are identified across services.







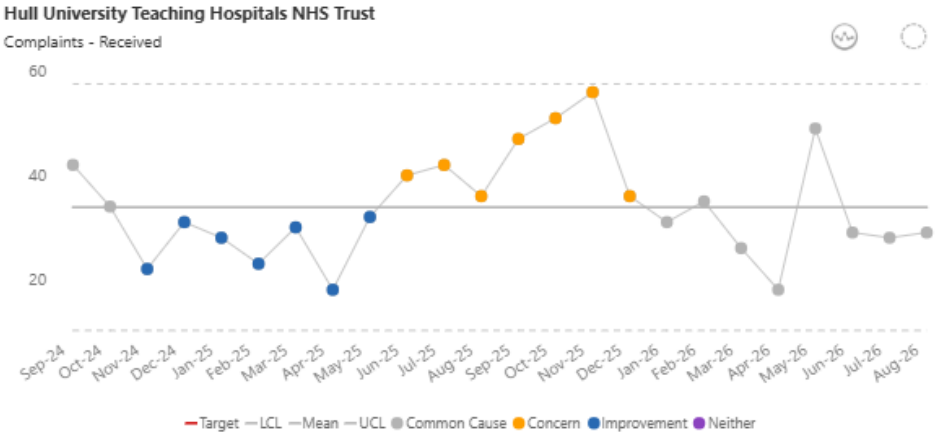
ii. Complaints Received

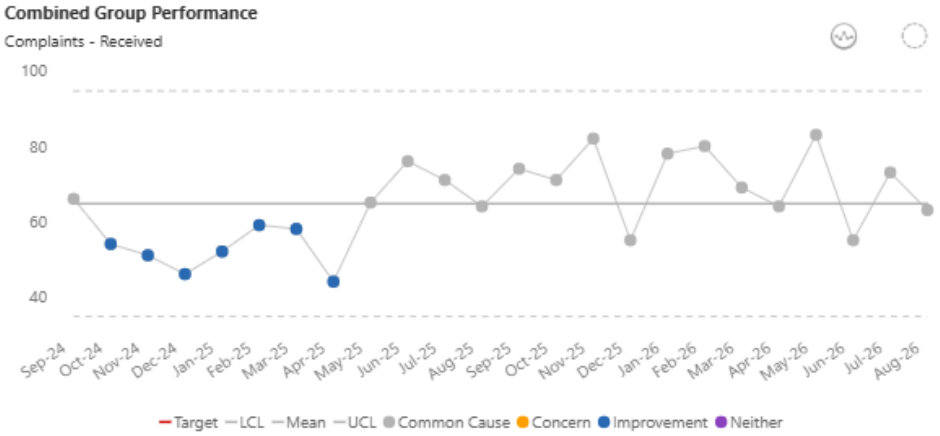
Complaints - Received

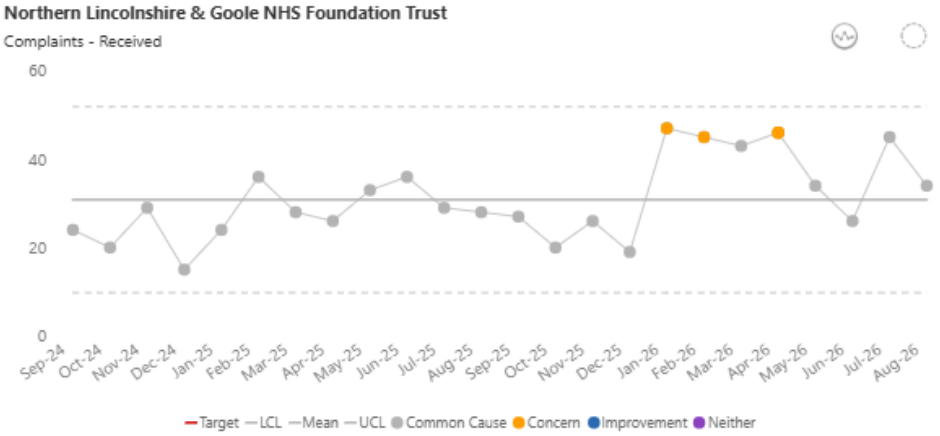
HUTH:
Complaints received rate shows common cause variation over the recent period, with significant variation historically.

NLAG:
Complaints received rate shows common cause variation over the recent period, with an increased rate during the period from January to April 2026.

Continued focus is required on complaint themes, service-level hotspots and early resolution, particularly where repeated issues are driving formal complaints. Targeting learning from complaints and making improvements in patient experience is desired and this improvement activity, if successful, will then show a reduction in complaints and correlating reduction in PALS contacts will demonstrate the required improvement.





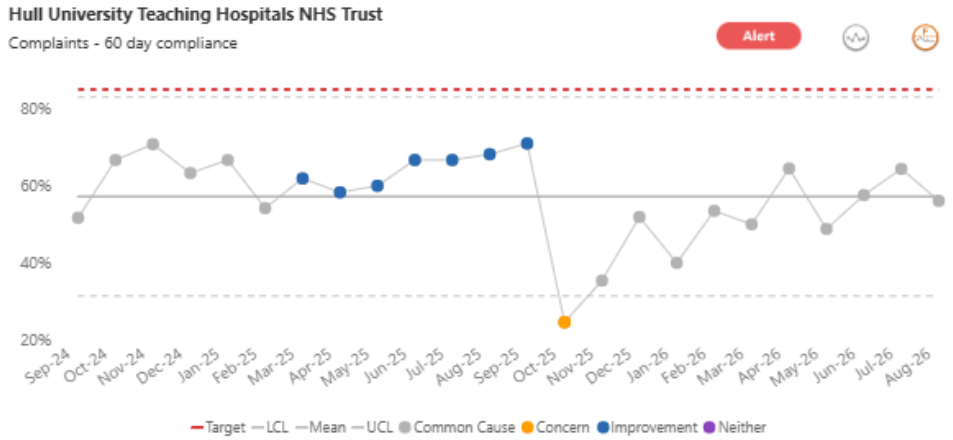


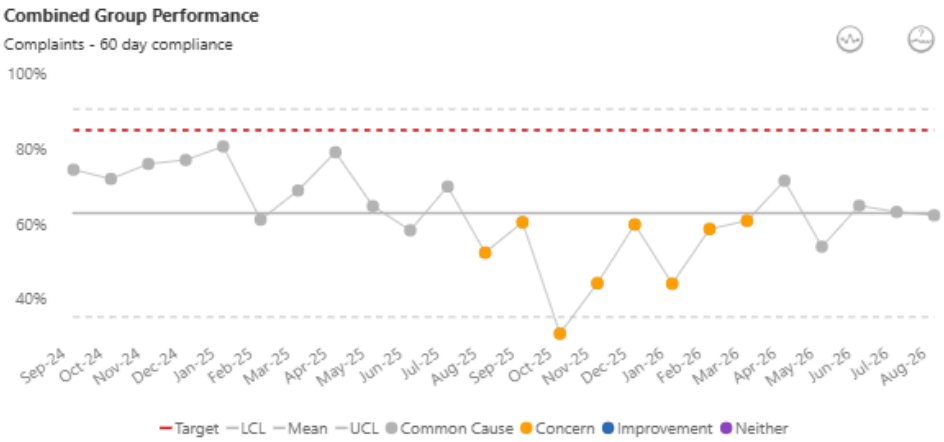
iii. Complaints 60 Day Compliance

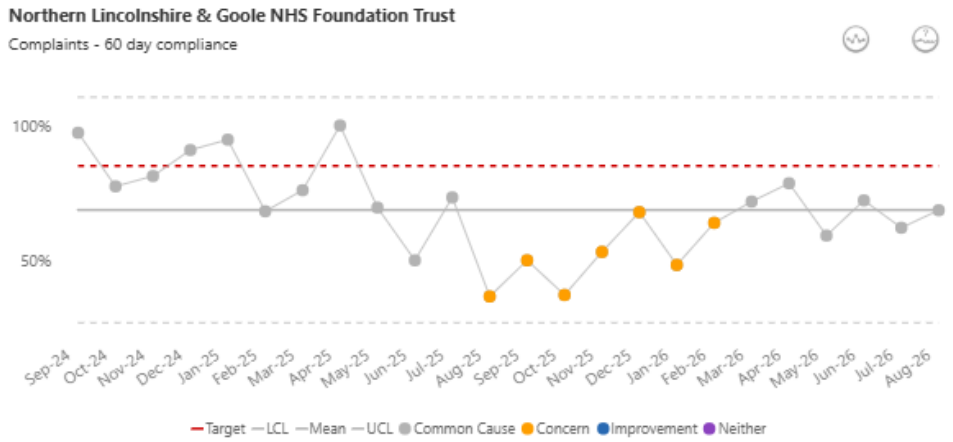
Complaints - 60 day compliance

HUTH:
There is common cause variation seen, with consistency in not achieving the target of 60 days completion. Backlog, complexity and volume of casework are contributory elements. The average number of days to complete is high and close to the target in the dashboard data.

NLAG:
There is common cause variation seen latterly, following a period of completion below the mean, and consistently not achieving the target. Similarly to HUTH the backlog, complexity and volume of casework are contributory elements.







c. Safety

Summary

Safety performance remains mixed. HUTH's overall Care Hours per Patient Day remains under target at 7.6, driven by the unregistered staff group. NLAG also has pressure in unregistered staffing, but stronger registered staffing keeps the overall CHPPD position above target. Infection prevention remains a key safety risk, with C. difficile, MRSA and E. coli requiring continued oversight.

Progress

For infection indicators, the latest FYTD position is C. difficile: HUTH 48 and NLAG 23. MRSA is HUTH 0 YTD and 0 latest month, while NLAG is 1 YTD with 0 in the latest reporting period. E. coli is HUTH 90 FYTD and NLAG 30 FYTD. NLAG has breached the national threshold on C.Difficle, and MRSA bacteraemia. HUTH is over trajectory for C.Difficile and slightly over on E.coli, so opportunity to achieve the threshold remains.

Action

Maintain ward-level safe staffing review, with specific focus on HUTH unregistered fill and NLAG skill-mix balance. Continue systematic IPC case review, thematic learning, antimicrobial stewardship and targeted improvement plans for C. difficile, MRSA and E. coli, with particular executive focus on NLAG MRSA and E. coli and HUTH C. difficile latest-month activity. The Quality Priority workstream and increased surveillance continue.

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Safe	Patient Safety	Care Hours per Patient Day - Overall	≥ 9.0	7.3	7.2	7.6	7.6	7.5	7.4	7.3	7.4	7.6				
		Care Hours per Patient Day - Registered	≥ 5.0	4.9	4.9	5.0	5.2	5.2	5.1	5.0	5.1	5.2				
		Care Hours per Patient Day - Unregistered	≥ 4.0	2.4	2.3	2.6	2.4	2.3	2.3	2.3	2.3	2.4				
		Falls - Serious harm or death		3	4	1	0	5	4	4	3	1	2	2	2	3
		Falls - Total incidents		260	279	286	258	271	308	262	284	222	235	214	244	206
		Infections - C.Difficile		6	8	6	6	8	16	9	11	16	10	8	5	
		Infections - E.Coli		20	19	17	14	13	12	16	14	23	17	13	16	
		Infections - Klebsiella		0	3	7	10	5	7	3	10	6	5	8	7	
		Infections - MRSA		0	0	0	0	1	0	0	1	0	0	0	0	
		Infections - MSSA		6	8	12	7	5	8	11	8	11	3	5	7	
		Infections - Pseudomonas aeruginosa		0	3	6	1	4	1	1	2	2	3	1	3	
		Medication Incidents		148	148	103	120	127	94	109	115	100	117	105	102	99
		Patient Safety Incidents - % Harmful		2.3%	3.2%	3.8%	2.7%	3.2%	2.6%	2.1%	2.4%	1.5%	2.0%	1.8%	2.6%	2.3%
		Patient Safety Incidents - Fatal		1	7	4	2	8	3	4	7	2	5	3	4	3
		Patient Safety Incidents - Moderate harm		37	49	63	44	51	43	32	44	29	34	28	50	40
		Patient Safety Incidents - Severe harm		7	9	12	5	5	8	6	5	2	2	5	3	5
		Pressure Ulcers - Category 3		0	0	4	1	2	2	1	1	0	1	1	3	1
		Pressure Ulcers - Category 4		0	0	0	0	0	0	1	0	0	1	0	0	1
		Pressure Ulcers - Community acquired		310	310	390	346	353	406	371	458	416	388	376	397	401
		Pressure Ulcers - Hospital acquired		43	59	109	110	132	129	114	129	146	148	116	135	147
		Pressure Ulcers - Suspected deep tissue injury		16	16	19	26	34	29	22	26	32	27	29	24	38

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Safe	Patient Safety	Care Hours per Patient Day - Overall	≥ 9.0	10.0	9.5	9.2	9.3	9.0	9.2	9.1	9.7	9.5				
		Care Hours per Patient Day - Registered	≥ 5.0	6.0	5.7	5.5	5.7	5.6	5.6	5.6	6.0	5.8				
		Care Hours per Patient Day - Unregistered	≥ 4.0	4.0	3.8	3.7	3.7	3.4	3.6	3.5	3.8	3.7				
		Falls - Serious harm or death		1	0	2	0	3	2	0	0	0	0	2	3	0
		Falls - Total incidents		108	107	149	119	136	139	107	108	125	116	122	128	121
		Infections - C.Difficile		4	3	6	4	7	3	3	6	4	3	5	8	
		Infections - E.Coli		20	28	32	20	18	14	26	15	21	25	21	20	
		Infections - Klebsiella		9	6	12	8	10	6	13	9	7	5	6	5	
		Infections - MRSA		1	0	1	0	1	1	1	2	1	3	1	1	
		Infections - MSSA		6	6	9	6	10	6	3	4	3	10	7	5	
		Infections - Pseudomonas aeruginosa		5	3	3	4	4	1	2	2	0	4	3	2	
		Medication Incidents		65	58	69	89	76	82	78	76	65	71	76	79	81
		Patient Safety Incidents - % Harmful		2.7%	3.2%	3.9%	3.9%	3.2%	2.9%	2.6%	3.2%	2.8%	2.7%	2.8%	3.4%	3.9%
		Patient Safety Incidents - Fatal		2	0	1	1	3	1	3	0	0	0	1	2	1
		Patient Safety Incidents - Moderate harm		37	44	60	55	41	46	36	48	46	43	44	47	53
		Patient Safety Incidents - Severe harm		1	3	6	5	4	2	0	0	0	1	2	6	3
		Pressure Ulcers - Category 3		7	11	6	5	10	13	10	6	5	16	8	16	12
		Pressure Ulcers - Category 4		0	2	4	1	1	0	1	2	0	0	1	1	3
		Pressure Ulcers - Hospital acquired		198	200	244	222	210	267	213	231	210	240	245	207	232
		Pressure Ulcers - Suspected deep tissue injury		34	43	42	40	45	59	54	48	35	51	46	34	46

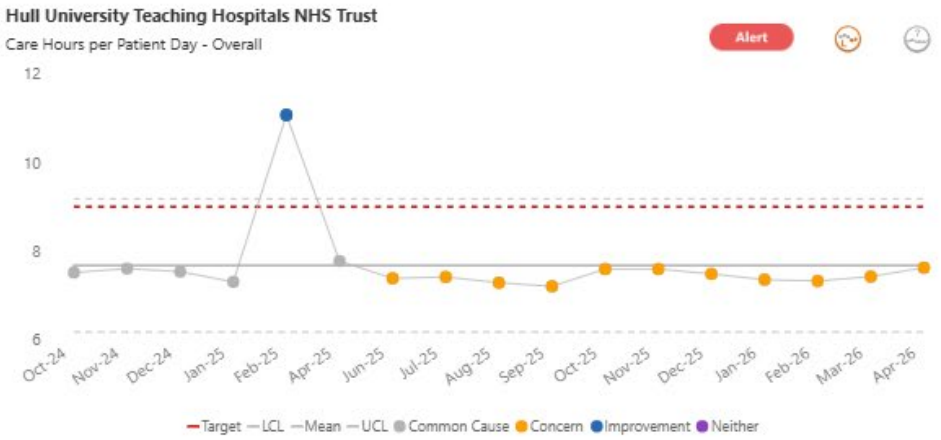
i. Care Hours per Patient Day

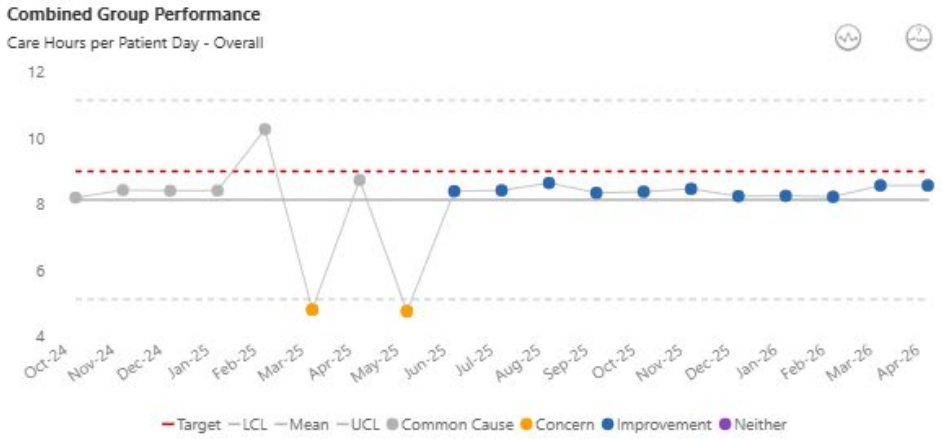
Care Hours per Patient Day - Overall

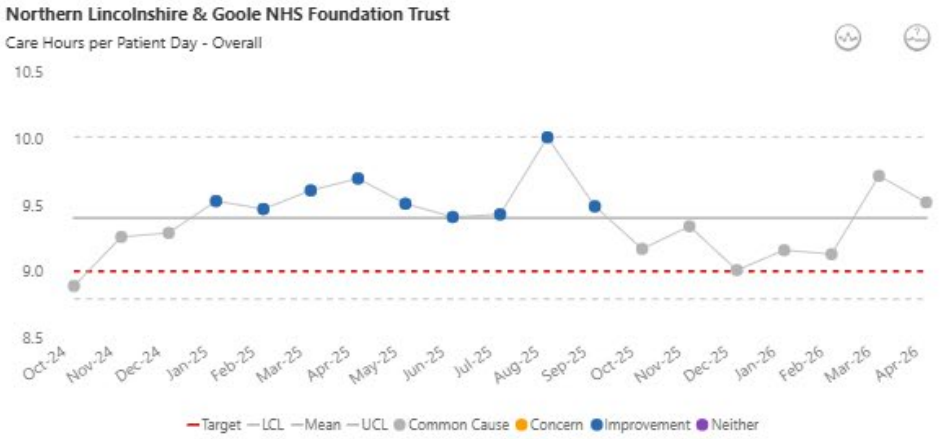
The latest available data in the public domain is from April 2026.

HUTH:
HUTH's overall Care Hours per Patient Day remains under target at 7.6, with the shortfall driven by the unregistered staff group. This indicates that the overall staffing position is being constrained by support workforce capacity, requiring continued ward-level review of roster fill, deployment and escalation where unregistered hours are below planned levels.

NLAG:
NLAG also shows pressure within the unregistered staff group, but this is offset by stronger registered staff performance, keeping the overall Care Hours per Patient Day position above target.







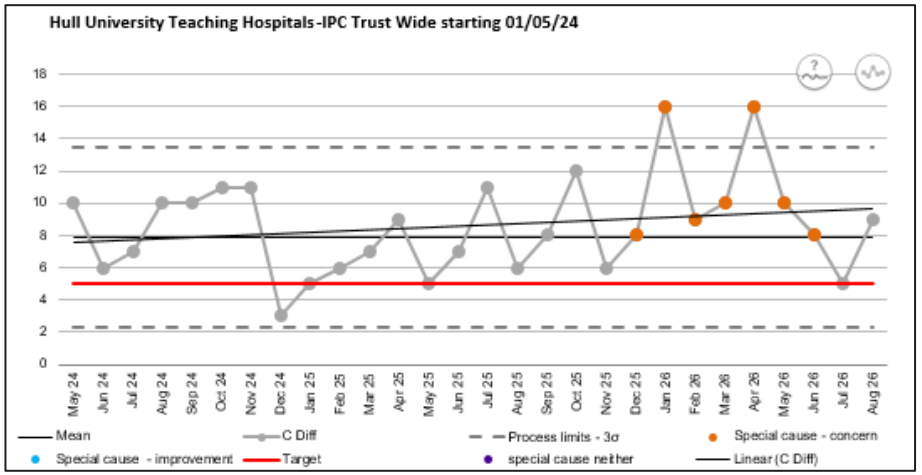
ii. C.Difficile Cases

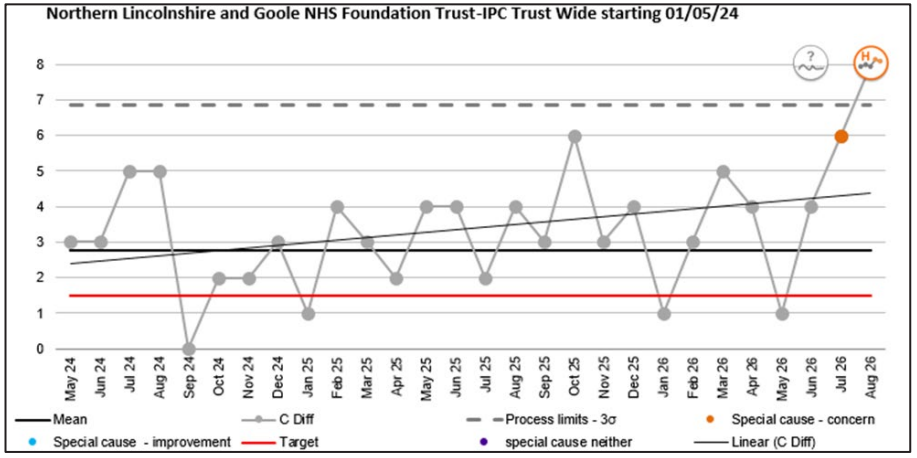
HUTH:
There have been 48 cases in the financial year to date, with a threshold of 61 for the year, so over the trajectory for the financial year at month five.

NLAG:
There have been 23 cases in the financial year to date, with a threshold of 18, so over the financial year threshold at month 5. The August data shows a significant increase at NLAG. This has been reviewed and determined that it is not one specific location or service. Enhanced monitoring and surveillance has been put in place.

A thematic review of C.Difficile cases has been undertaken and reported to Strategic Infection Reduction Committee to support focus on the areas for improvement, linked to the Quality Priority workstreams. Antimicrobial stewardship, handwashing, PPE use, standardising Swarm huddle reviews and action planning oversight, sporicidal cleaning standards for patient equipment.

The charts used are provided from the IPC team to reflect accurate data and the team are working with Information Services to rectify data quality issues with the BI reports.





iii. MRSA Cases

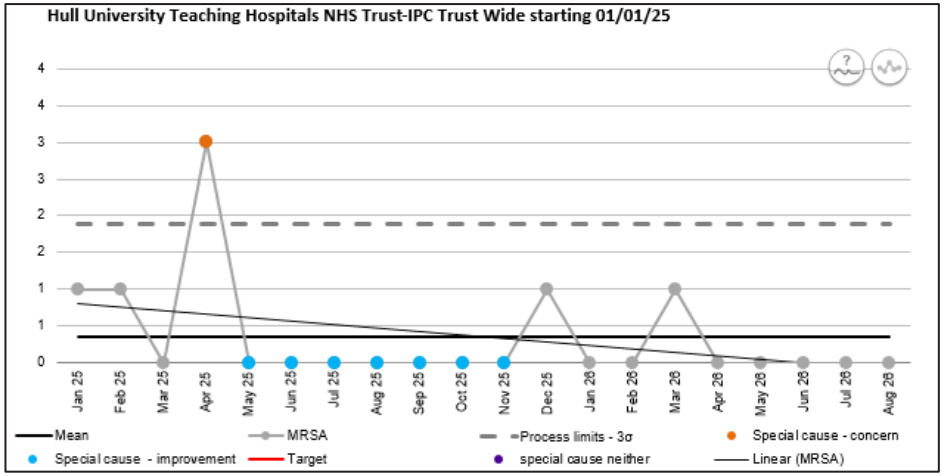
HUTH:
MRSA cases are 0 YTD, with 0 cases in the latest month.

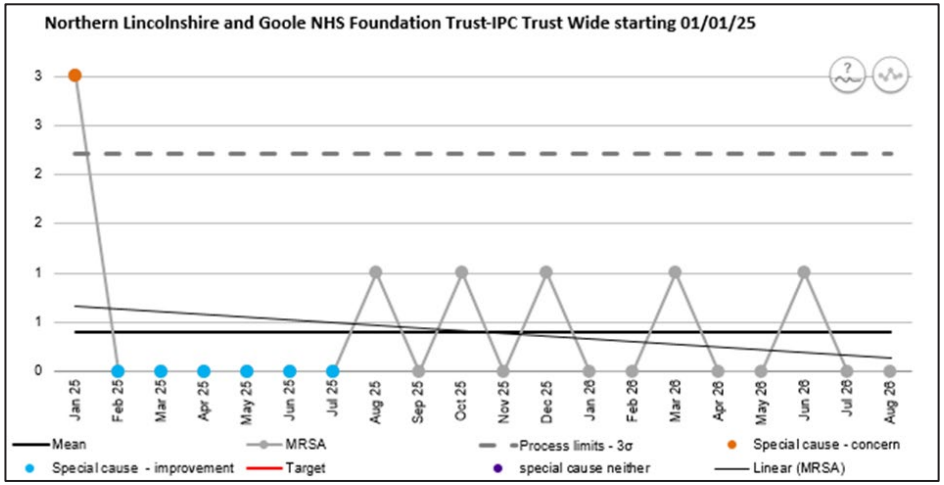
NLAG:
MRSA cases are 1 YTD, with 0 cases in the latest reporting period.

Actions being taken to reduce the risk of MRSA BSI include:

- Review of the MRSA screening and decolonisation policy and alignment to national guidance.
- Review the compliance with the screening and decolonisation processes.
- Aligned with IV device care improvement across all blood stream infections.

The charts used are provided from the IPC team to reflect accurate data and the team are working with Information Services to rectify data quality issues with the BI reports.





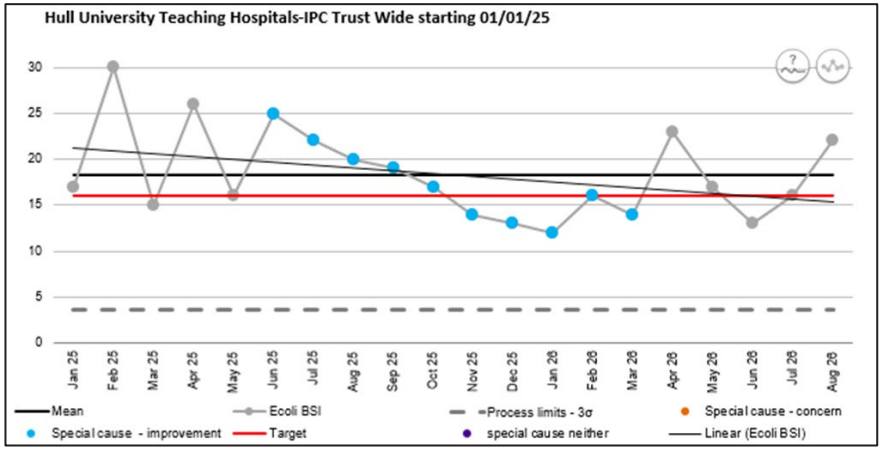
iv. E.Coli Case

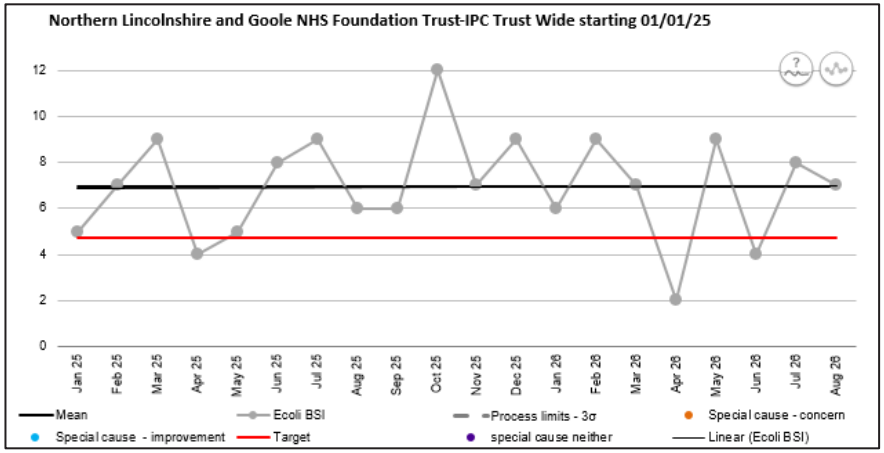
HUTH:
There have been 90 cases reported in the financial year to date against a 192 annual threshold. There is common cause variation for the recent period and more points over the mean in the year to date, so over trajectory, but within the national set threshold.

NLAG:
There have been 30 cases reported in the financial year to date against a threshold of 57 cases for the year. The rate is greater than the threshold trajectory for this point in the year. There is common cause variation shown on the SPC chart.

Similarly to other blood stream infection risks, IV access and management are a focus for assuring compliance to best practice standards, aligned to the Quality Priority workstream for IPC.

The charts used are provided from the IPC team to reflect accurate data and the team are working with Information Services to rectify data quality issues with the BI reports.





d. Effectiveness

Summary

Effectiveness performance is broadly stable overall, with continued monitoring required across VTE assessment, SHMI and emergency readmissions. VTE assessment compliance remains variable and requires consistent completion within the 14-hour standard. SHMI should be interpreted factually as a statistical indicator, with review focused on whether reported values remain within expected limits. Emergency readmissions within 30 days appear broadly stable at both Trusts, with no clear sustained deterioration indicated.

Progress

HUTH and NLAG both require continued operational grip on timely VTE assessment, particularly as national changes to emergency admission VTE assessment timing from DTA are expected to affect Quarter 3 performance. SHMI reporting continues through separate detailed releases to clinical leads, with mutlifactoral aspects of care provision, best practice adherence and documentation of care, coupled with effective clinical coding quality contribution to elements that impact on the SHMI calculations and the patient risk profiles by diagnosis group, with all spells of care, not only those patients who die. Readmissions remain an effectiveness indicator for both Trusts and should continue to be reviewed alongside discharge quality, follow-up arrangements, frailty pathways and avoidable readmission themes.

Action

Maintain ward and specialty-level oversight of VTE assessment compliance, with escalation where completion within 14 hours is inconsistent. Continue factual SHMI review through established clinical governance and coding assurance routes. For readmissions, strengthen specialty-level review of themes, discharge planning, post-discharge support and community interface actions where variation emerges.

HUTH Scorecard

Tier 1 - Foundation Scorecard

Oversight | CQC

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

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Effective	Effectiveness	Inpatient - Emergency Readmissions within 30 days		10.9%	10.3%	10.5%	10.2%	10.5%	10.3%	10.4%	10.4%	10.1%	10.2%	10.0%	9.9%	
		Mortality - Crude Mortality (non-elective)		2.5%	2.5%	2.8%	3.2%	3.2%	3.2%	3.2%	2.9%	2.6%	2.8%	2.4%	2.3%	2.7%
		Mortality - HSMR	≤ 100.0	101.9	101.0	99.9	100.1	100.1	98.6	98.7	98.9	98.9				
		Mortality - SHMI	≤ 1.0	1.020	1.025	1.018	1.023	1.027	1.024	1.038	1.047					
		Mortality - Still Births (per 1,000 births)		2.625	2.439	7.979	2.632	5.115	7.444	2.890	7.853	10.526	0.000	0.000	11.601	0.000
Safe	Patient Safety	Clinical Harm Reviews - Cancer 104 day wait		83	71					0	0	0	0	0	0	0
		Clinical Harm Reviews - RTT 78 week wait		2	0									0	0	0
		VTE Risk Assessment	≥ 95.0%	93.6%	93.5%	92.4%	92.1%	92.5%	91.8%	91.8%	92.0%	92.3%	92.6%	92.9%	92.1%	92.2%
		VTE Risk Assessment 14 Hour Standard	≥ 95.0%	92.0%	91.7%	90.5%	90.7%	90.9%	90.1%	90.8%	91.2%	91.8%	92.0%	92.2%	91.7%	

NLAG Scorecard

Tier 1 - Foundation Scorecard

Oversight | CQC

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

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Effective	Effectiveness	Inpatient - Emergency Readmissions within 30 days		11.0%	11.7%	11.5%	10.9%	11.3%	11.2%	11.6%	11.0%	11.3%	11.0%	11.0%	11.0%	
		Mortality - Crude Mortality (non-elective)		1.6%	1.6%	1.6%	1.8%	2.4%	1.8%	1.9%	1.9%	1.9%	2.3%	1.9%	1.6%	1.5%
		Mortality - HSMR	≤ 100.0	93.5	92.3	90.6	89.8	88.5	85.4	85.3	84.8	84.8				
		Mortality - SHMI	≤ 1.0	1.030	1.021	1.009	1.001	0.999	0.976	0.977	0.993					
		Mortality - Still Births (per 1,000 births)		6.135	0.000	9.804	6.024	0.000	3.413	6.645	6.452	3.401	0.000	0.000	0.000	0.000
Safe	Patient Safety	Clinical Harm Reviews - Cancer 104 day wait												0		
		Clinical Harm Reviews - RTT 78 week wait												0		
		VTE Risk Assessment	≥ 95.0%	96.1%	96.5%	95.4%	92.2%	95.6%	96.1%	95.8%	95.7%	96.9%	96.8%	96.6%	96.5%	96.1%
		VTE Risk Assessment 14 Hour Standard	≥ 95.0%	93.0%	93.7%	93.1%	88.1%	92.6%	93.6%	93.2%	93.3%	94.8%	94.8%	94.5%	94.3%	

i. VTE Assessment within 14hrs

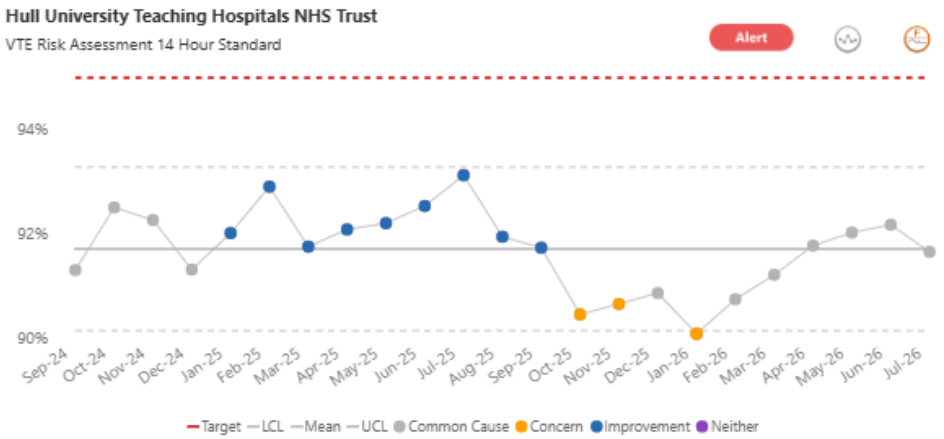
VTE Risk Assessment 14 Hour Standard

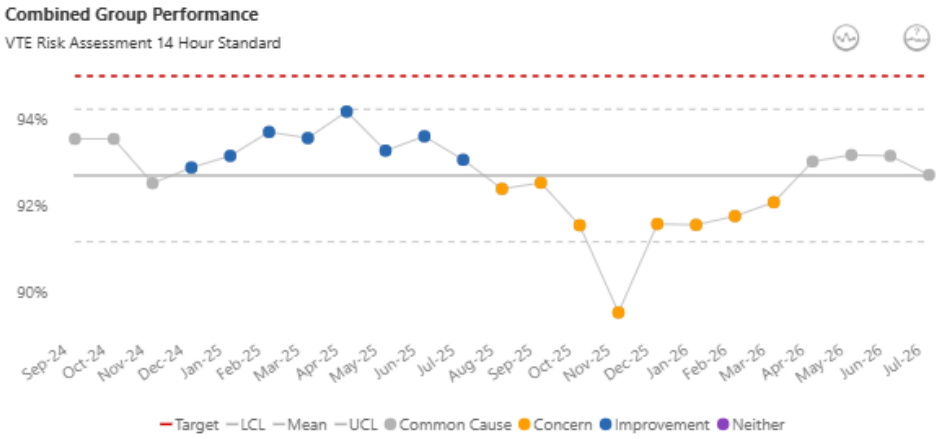
HUTH:
The charts show common cause variation and below the 14 hour target. The dashboard shows overall untimed compliance is also below the 95% target.

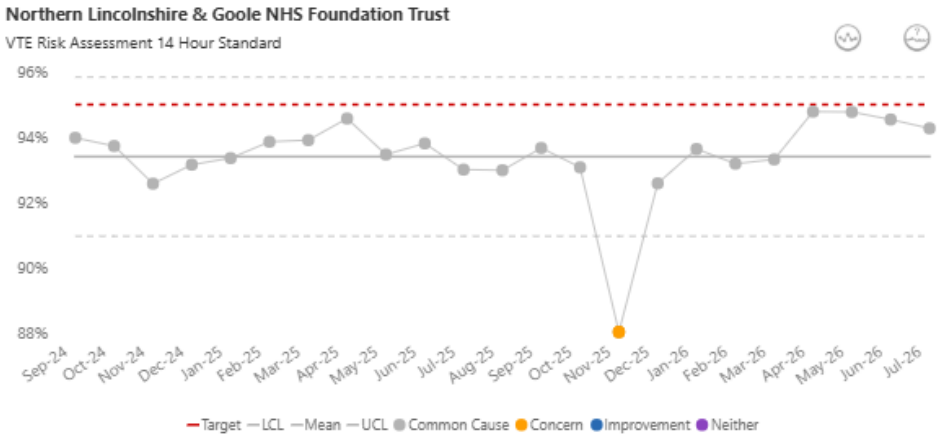
NLAG:
The charts show common cause variation and below the 14 hour target. The dashboard shows overall untimed compliance is over the 95% target.

Continued operational oversight is required to ensure timely VTE assessment completion, with escalation where ward or specialty-level compliance is inconsistent. Local BI data is available to enable targeted monitoring.

National changes to VTE Risk Assessments for Emergency Admissions needing to include time from DTA will have a material impact upon our performance in Quarter 3.





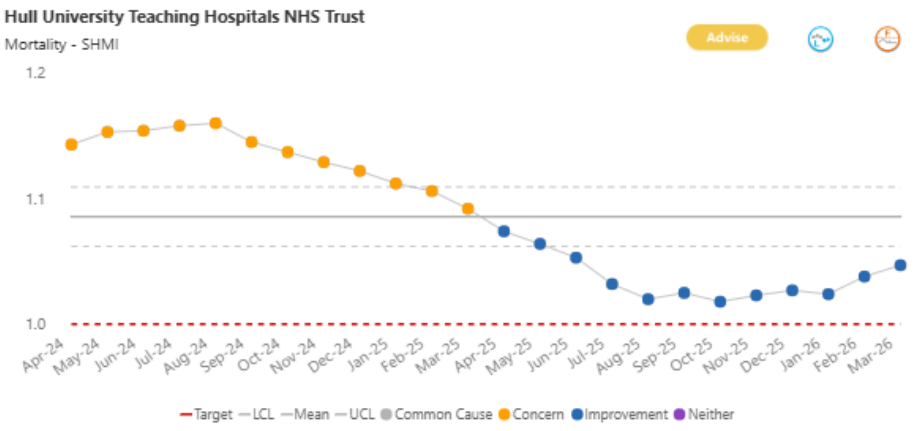


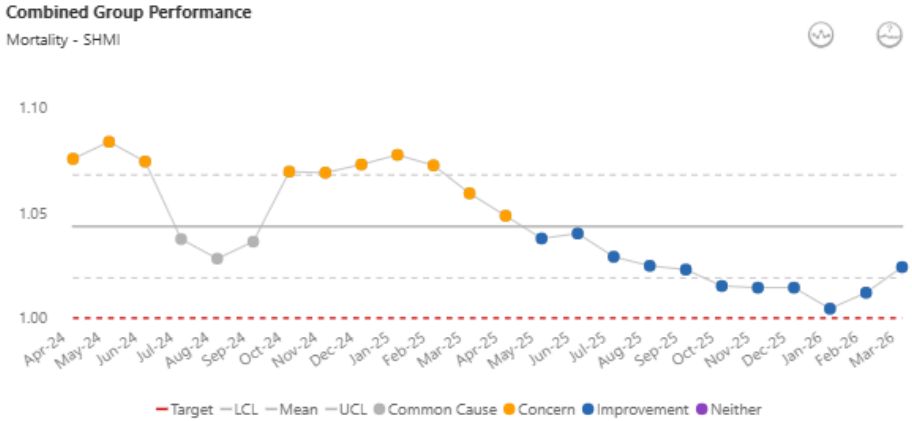
ii. Summary Hospital Mortality Indicator

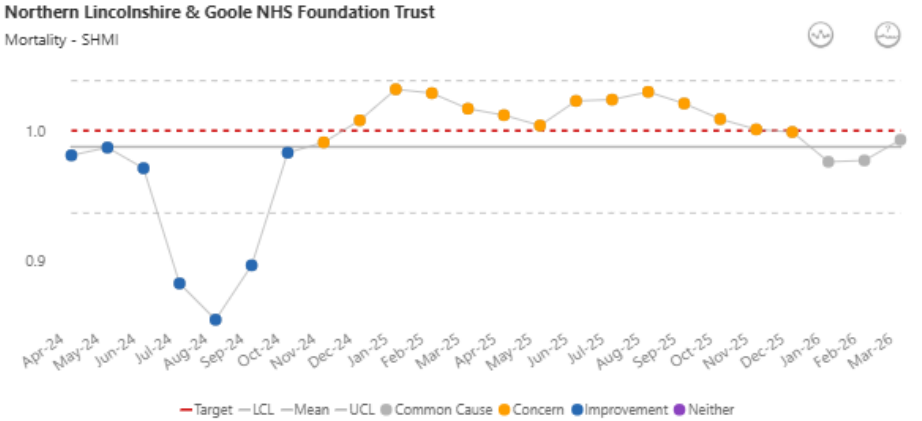
Mortality - SHMI

The national mean is 1.0 with HUTH showing slightly higher rolling 12 month scores and within the overall expected range, with sustained rates below the mean.
NLAG has been reporting a SHMI just under the 1.0 mean for the last 4 data points and has common cause variation.
Separate and detailed SHMI reporting is provided to Clinical Leads upon each release of national data.
Several factors can impact and influence the SHMI score, including:

- Clinical care quality and best practice evidence adherence.
- Depth of coding, accuracy of comorbidities,
- Diagnosis on admission accuracy.
- Sufficient Clinical Coding services crucial for accuracy.







iii. Emergency Readmissions within 30 Days

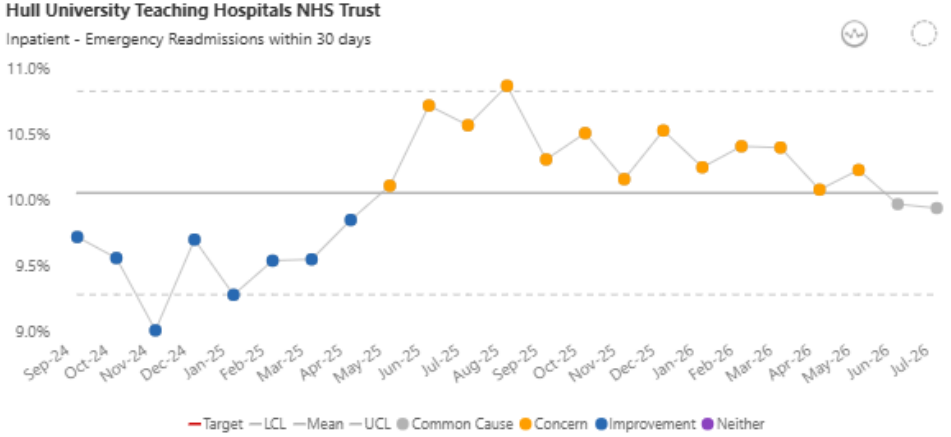
Inpatient - Emergency Readmissions within 30 days

Emergency readmission rates can assist in identifying discharge planning effectiveness, with specialty level analysis over time. The position should continue to be monitored through specialty-level review, with focus on discharge quality, follow-up arrangements and readmission themes where variation emerges.

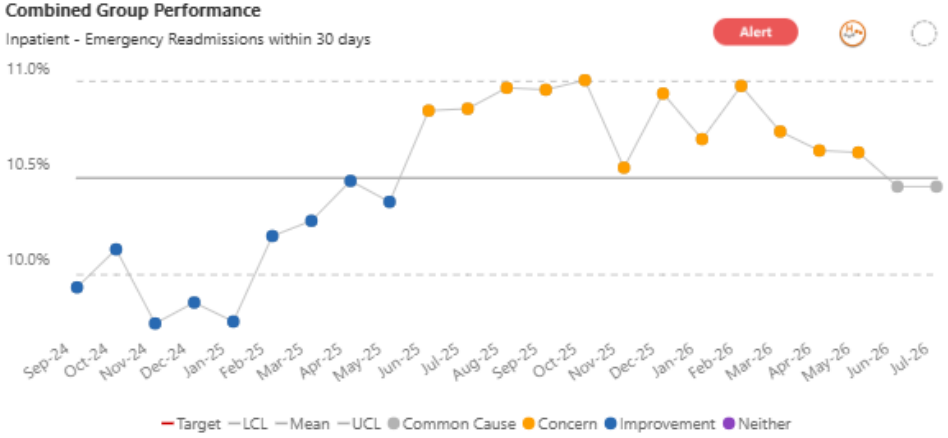
HUTH:
Emergency readmissions within 30 days shows a return to common cause variation after a period of increased rates of emergency readmission.

NLAG:
The data shows an increased rate above the mean from September 2025.

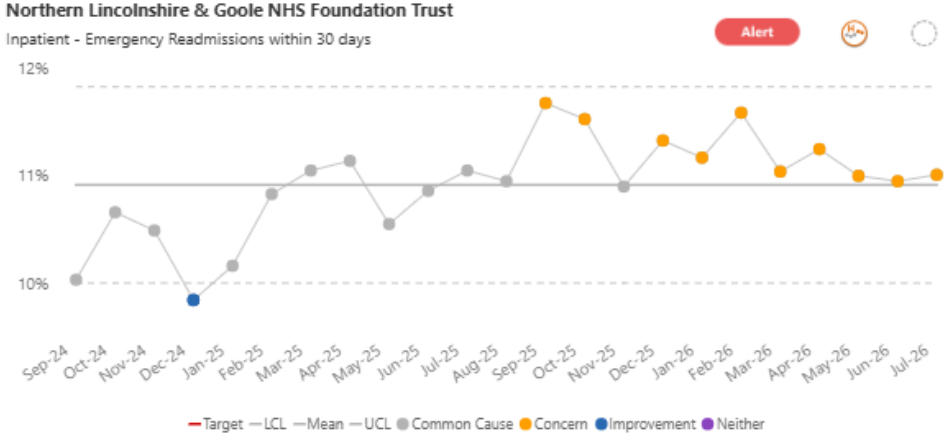
Hull University Teaching Hospitals NHS Trust



Combined Group Performance



Northern Lincolnshire & Goole NHS Foundation Trust



Sample pages only – awaiting further Lead review

6. HHP Group Executive Summary – Workforce

Executive Lead: Helen Marks, Group Chief People Officer Accountable to:

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
Healthcare Worker Flu Vaccination Rate	Apr-26	≥ 60.0%	51.0%		
Staff Appraisal Rate (AfC)	Jul-26	≥ 85.0%	82.0%		
Staff e-Job Planning	Aug-26	≥ 95.0%	89.1%		
Staff Mandatory Training - Core	Jul-26	≥ 85.0%	87.4%		
Staff Mandatory Training - Role Specific	Jul-26	≥ 85.0%	81.2%		
Staff Sickness Absence Rate	Jul-26	≤ 4.0%	4.5%		
Staff Survey - Raising Concerns sub-score	Aug-26		6.0		
Staff Time to Employment Checks	Jul-26	≤ 20.0	21.0		
Staff Time to Offer	Jul-26	≤ 2.0	2.4		
Staff Time to Shortlist	Jul-26	≤ 5.0	7.6		
Staff Turnover Annual FTE Rate	Jul-26	≤ 8.0%	13.7%		

Northern Lincolnshire and Goole NHS Foundation Trust

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

Metric	Month	Target	Result	Var	Asr
Healthcare Worker Flu Vaccination Rate	Apr-26	≥ 60.0%	51.1%		
Staff Appraisal Rate (AfC)	Jul-26	≥ 85.0%	81.1%		
Staff e-Job Planning	Aug-26	≥ 95.0%	78.5%		
Staff Mandatory Training - Core	Jul-26	≥ 85.0%	83.0%		
Staff Mandatory Training - Role Specific	Jul-26	≥ 85.0%	81.3%		
Staff Sickness Absence Rate	Jul-26	≤ 4.0%	5.2%		
Staff Survey - Raising Concerns sub-score	Aug-26		6.1		
Staff Time to Employment Checks	Jul-26	≤ 20.0	21.6		
Staff Time to Offer	Jul-26	≤ 2.0	7.4		
Staff Time to Shortlist	Jul-26	≤ 5.0	7.5		
Staff Turnover Annual FTE Rate	Jul-26	≤ 8.0%	12.0%		

Chief People Officer Update – Workforce Overview (July 2026)

Summary

The workforce position remains mixed across the Group, with the clearest risk in workforce availability and recruitment responsiveness. HUTH sickness absence is showing a deteriorating signal, with the latest four data points above the mean, indicating a sustained adverse shift rather than normal variation. NLAG sickness absence is more stable, remaining around the mean. Across both Trusts, appraisal and role-specific mandatory training remain variable without evidence of sustained improvement. Recruitment timeliness is also variable, with NLAG **Staff Time to Offer** in **Alert**, highlighting a specific risk in converting recruitment activity into timely offers.

Progress

HUTH's workforce culture and experience position is most affected by the sickness absence trend, while appraisal and role-specific mandatory training require continued grip to improve consistency. NLAG does not show the same deterioration in sickness absence, but appraisal and role-specific training completion remain inconsistent. In recruitment and retention, HUTH appears broadly stable but variable across shortlist, offer and employment check stages, with no clear sustained improvement. NLAG shows greater risk across the recruitment pathway, particularly at the offer stage, where the alert status indicates delay against trajectory. Employment checks at both Trusts appear broadly stable but remain a potential later-stage recruitment bottleneck if not actively managed.

Action

Executive focus should remain on targeted sickness absence intervention at HUTH, including divisional hotspot review, attendance management and wellbeing support. Across both Trusts, strengthen workforce governance for appraisal and role-specific mandatory training completion, with routine escalation of areas below trajectory. Recruitment actions should focus on end-to-end pathway grip from vacancy review to start date, including manager shortlisting, interview outcome turnaround, offer approvals and employment check completion. Priority escalation is required for NLAG Time to Offer, with named ownership of delays and routine monitoring of bottlenecks to protect workforce supply.

Sample pages only – awaiting further Lead review

a. Hull University Teaching Hospital Workforce AAA Summary

Count: 6

Alert

Healthcare Worker Flu Vaccination Rate
Staff Appraisal Rate (AfC)
Staff Sickness Absence Rate
Staff Survey - Raising Concerns sub-score
Staff Time to Shortlist
Staff Turnover Annual FTE Rate

Count: 3

Advise

Staff Mandatory Training - Core
Staff Mandatory Training - Role Specific
Staff Time to Offer

Count: 0

Assure

b. Northern Lincolnshire & Goole Hospitals Workforce AAA Summary

Count: 4

Alert

Healthcare Worker Flu Vaccination Rate
Staff Sickness Absence Rate
Staff Time to Offer
Staff Turnover Annual FTE Rate

Count: 3

Advise

Staff Appraisal Rate (AfC)
Staff Mandatory Training - Core
Staff Time to Shortlist

Count: 1

Assure

Staff Survey - Raising Concerns sub-score

c. Staff Culture & Experience

Summary

Staff Culture and Experience remains mixed, with no consistent improvement across the three supporting indicators. The key adverse signal is HUTH sickness absence, where the latest four data points sit above the mean, indicating a recent deterioration. NLAG sickness absence remains around the mean, while appraisal and role-specific mandatory training performance at both Trusts remain variable without sustained improvement.

Progress

HUTH has a clear sickness absence deterioration requiring focus, alongside appraisal and role-specific training trends that remain variable rather than improving. NLAG does not show the same sickness deterioration, with absence broadly around the mean, but appraisal and role-specific training completion remain inconsistent and require continued management grip.

Action

Prioritise targeted action on HUTH sickness absence through divisional hotspot review, attendance management and wellbeing support. Across both Trusts, strengthen accountability for appraisal and role-specific mandatory training completion, with routine monitoring of areas below trajectory, escalation of non-compliance and evidence of recovery through workforce governance.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Safe	Patient Safety	Staff Survey - Raising Concerns sub-score		6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0
	People & Workforce	Healthcare Worker Flu Vaccination Rate	≥ 60.0%			28.2%	41.5%	50.8%	51.7%	51.6%	51.3%	51.0%				
Well Led	People & Workforce	Staff Appraisal Rate (AfC)	≥ 85.0%	79.2%	79.7%	80.7%	81.4%	82.3%	80.9%	80.8%	80.1%	81.5%	81.6%	82.2%	82.0%	
		Staff Mandatory Training - Core	≥ 85.0%	86.5%	86.6%	87.7%	88.2%	88.4%	89.4%	89.0%	89.8%	89.8%	87.8%	88.5%	87.4%	
		Staff Mandatory Training - Role Specific	≥ 85.0%	79.4%	80.4%	82.6%	82.0%	82.7%	83.0%	82.0%	82.8%	83.1%	83.3%	83.5%	81.2%	
		Staff Sickness Absence Rate	≤ 4.0%	4.1%	4.2%	4.2%	4.2%	4.3%	4.1%	4.4%	4.4%	4.4%	4.4%	4.4%	4.5%	

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

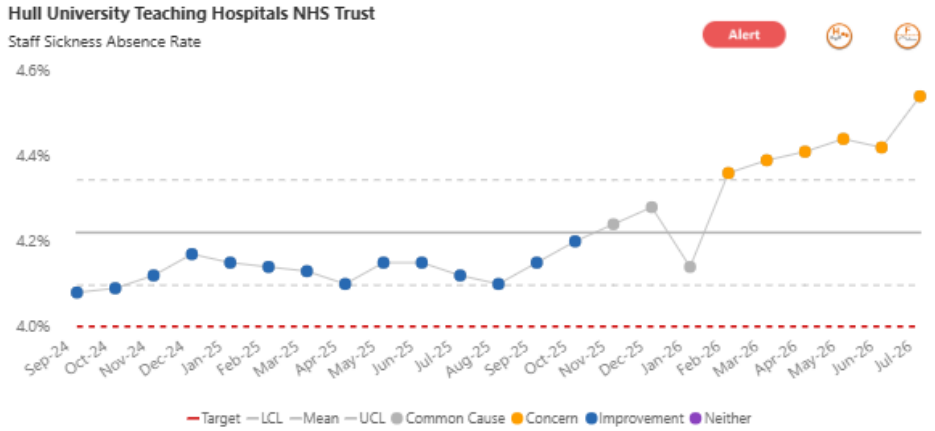
Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Safe	Patient Safety	Staff Survey - Raising Concerns sub-score		6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1
	People & Workforce	Healthcare Worker Flu Vaccination Rate	≥ 60.0%			26.9%	43.0%	50.7%	51.7%	51.7%	51.4%	51.1%				
Well Led	People & Workforce	Staff Appraisal Rate (AfC)	≥ 85.0%	82.1%	79.4%	77.9%	78.6%	79.3%	79.3%	78.9%	77.7%	79.1%	79.8%	81.4%	81.1%	
		Staff Mandatory Training - Core	≥ 85.0%	84.9%	86.4%	86.9%	87.5%	84.6%	87.1%	86.9%	89.1%	89.2%	85.1%	85.5%	83.0%	
		Staff Mandatory Training - Role Specific	≥ 85.0%	85.0%	84.7%	83.4%	84.2%	82.7%	80.9%	80.8%	81.5%	80.9%	79.5%	82.0%	81.3%	
		Staff Sickness Absence Rate	≤ 4.0%	5.6%	5.6%	5.5%	5.5%	5.5%	5.5%	5.3%	5.4%	5.4%	5.4%	5.4%	5.2%	

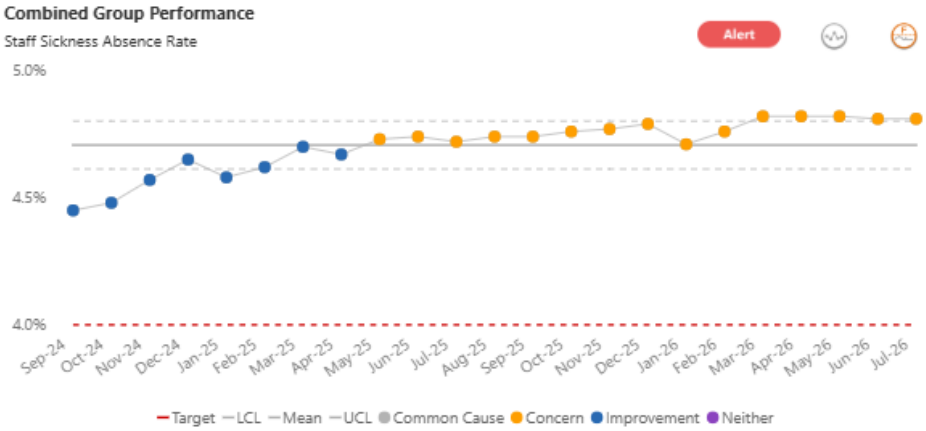
i. Staff Sickness Absence Rate

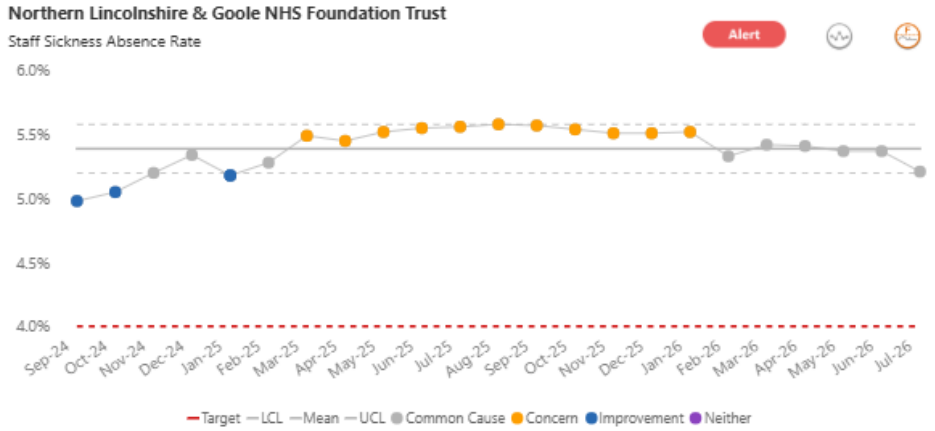
Staff Sickness Absence Rate

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)

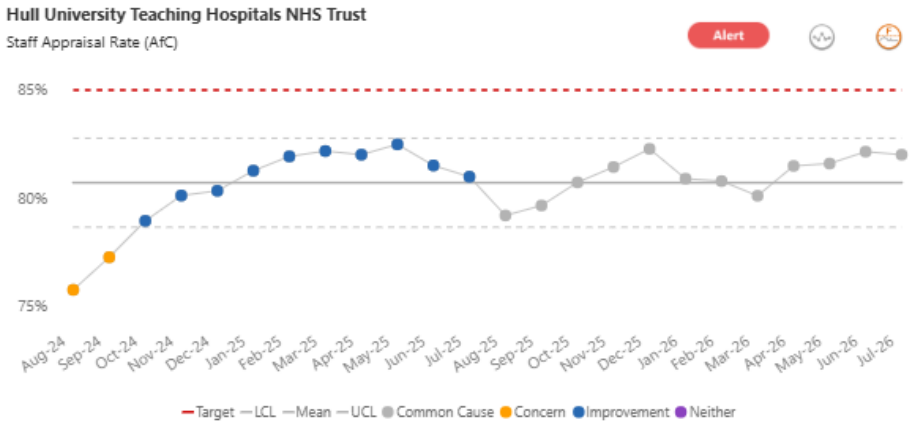
Staff Appraisal Rate (AfC)

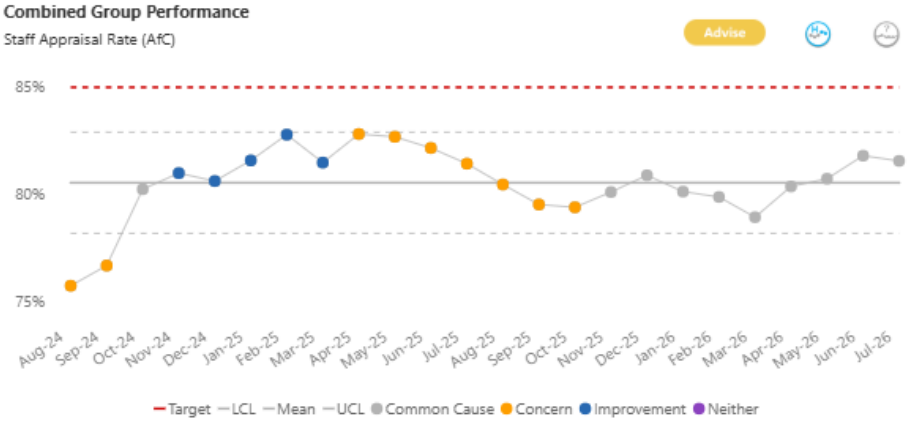
HUTH:

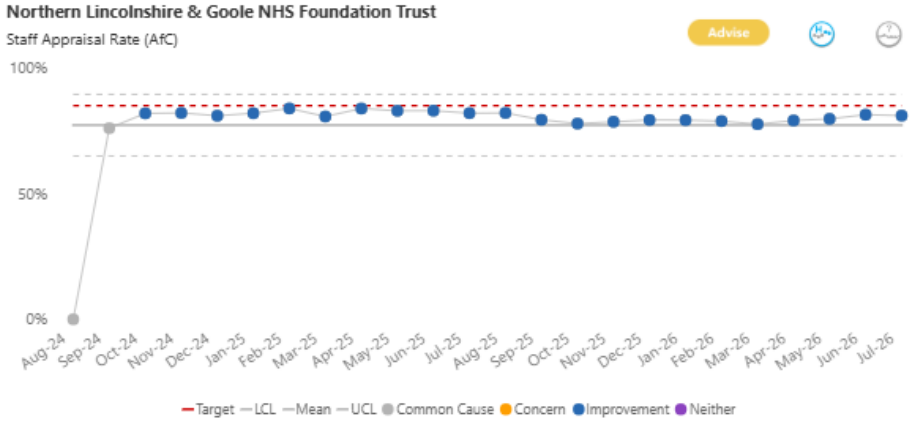
Staff appraisal performance remains variable and does not show a sustained improving trend. Recent data points appear to continue around the mean, indicating normal variation rather than clear recovery. Continued divisional focus is required to improve completion rates and ensure appraisal compliance 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

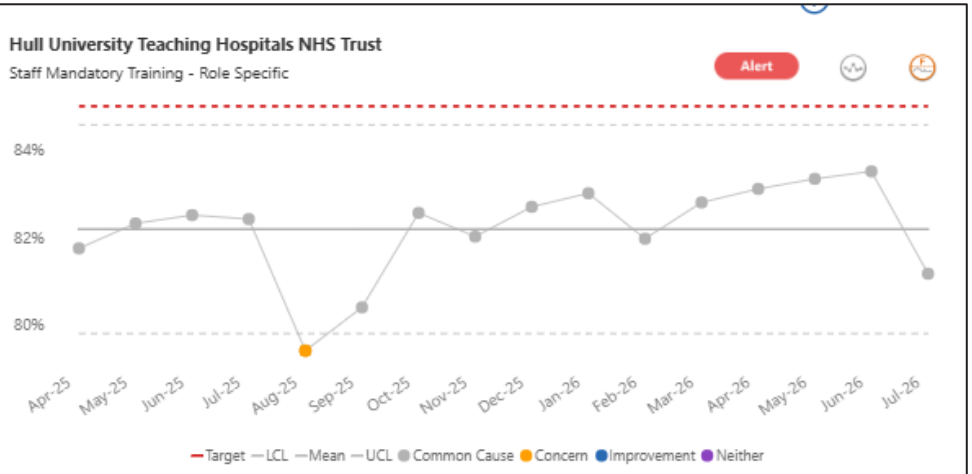
Staff Mandatory Training - Role Specific

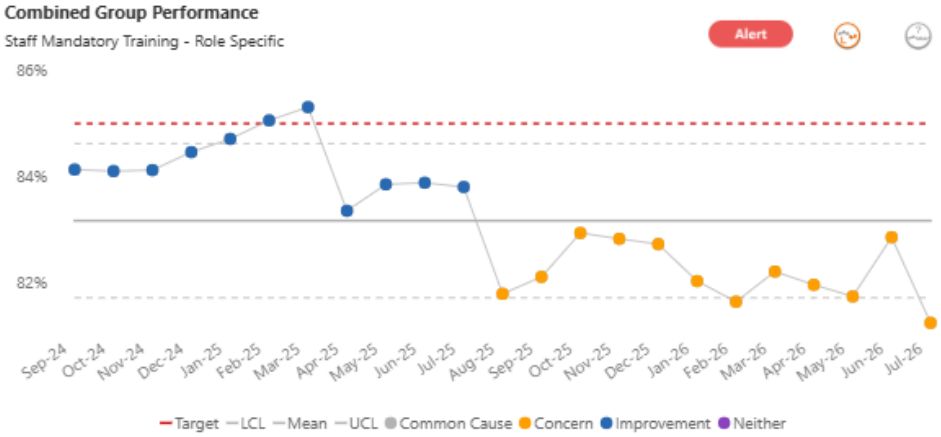
HUTH:

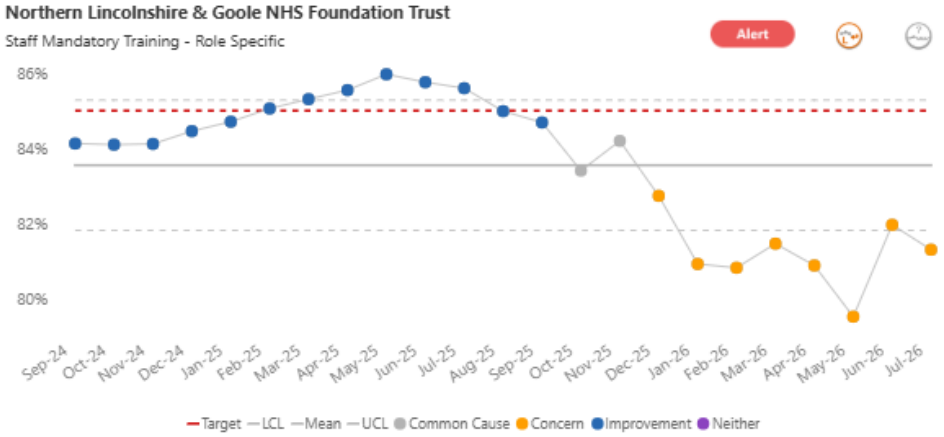
The latest position suggests compliance is not yet consistently improving at the required pace, requiring continued divisional grip, targeted follow-up with areas below trajectory and active monitoring through workforce governance.

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	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Safe	People & Workforce	Staff Time to Employment Checks	≤ 20.0	35.0	38.8	38.5	36.4	27.7	48.2	13.8	12.6	13.6	16.0	18.9	21.0	
		Staff Time to Offer	≤ 2.0	6.3	3.3	2.7	2.1	2.1	2.0	2.0	2.2	2.3	2.2	2.3	2.4	
		Staff Time to Shortlist	≤ 5.0	9.2	9.4	8.6	9.0	8.2	8.5	7.1	7.2	7.0	6.6	7.6	7.6	
Well Led	People & Workforce	Staff Turnover Annual FTE Rate	≤ 8.0%	7.2%	6.4%	6.7%	6.4%	6.2%	5.8%	6.2%	6.4%	6.3%	6.5%	12.2%	13.7%	

NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Safe	People & Workforce	Staff Time to Employment Checks	≤ 20.0	28.7	41.2	34.6	41.2	41.3	37.4	27.5	27.0	22.0	17.3	17.8	21.6	
		Staff Time to Offer	≤ 2.0	2.4	3.1	2.8	2.6	2.5	2.4	2.2	2.5	2.9	3.4	3.5	7.4	
		Staff Time to Shortlist	≤ 5.0	40.0	50.6	68.2	95.7	110.8	52.3	48.8	47.8	6.1	6.8	6.9	7.5	
Well Led	People & Workforce	Staff Turnover Annual FTE Rate	≤ 8.0%	8.7%	8.4%	8.4%	8.3%	8.0%	8.0%	7.8%	7.6%	6.5%	7.2%	11.9%	12.0%	

i. Staff Time to Shortlist

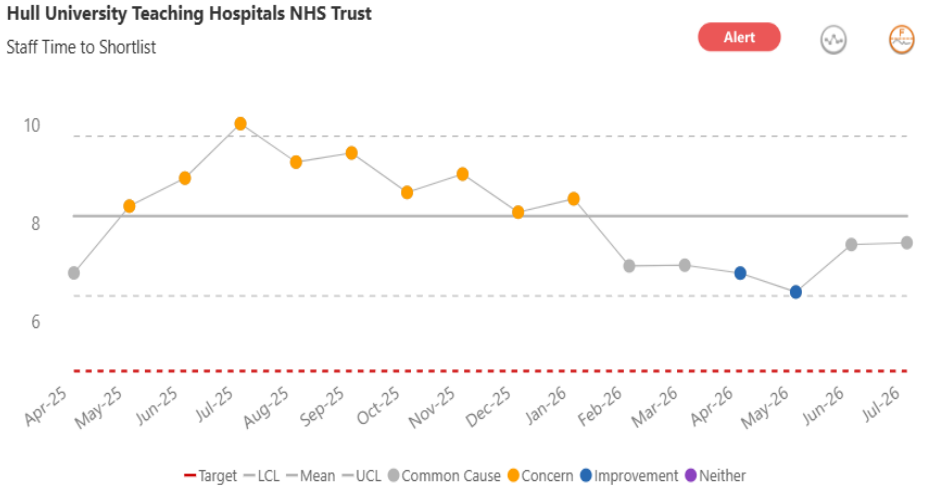
Staff Time to Shortlist

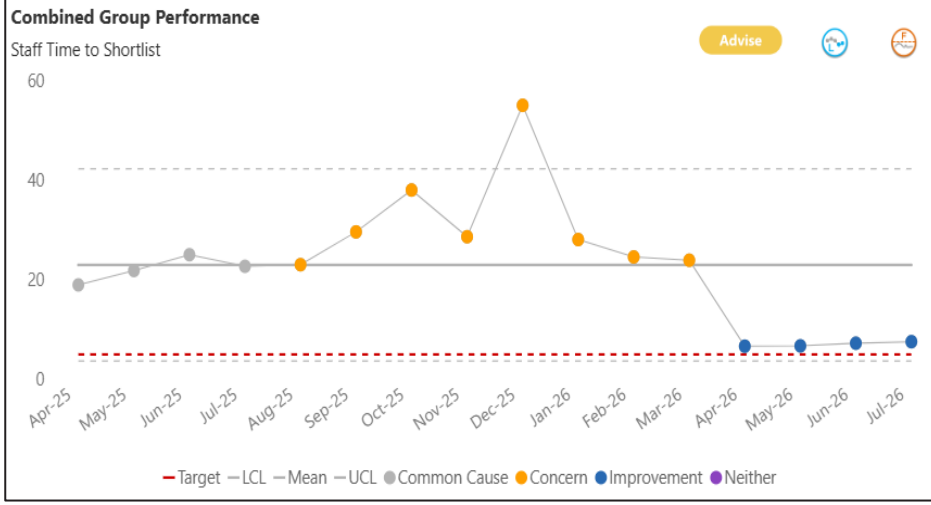
HUTH:

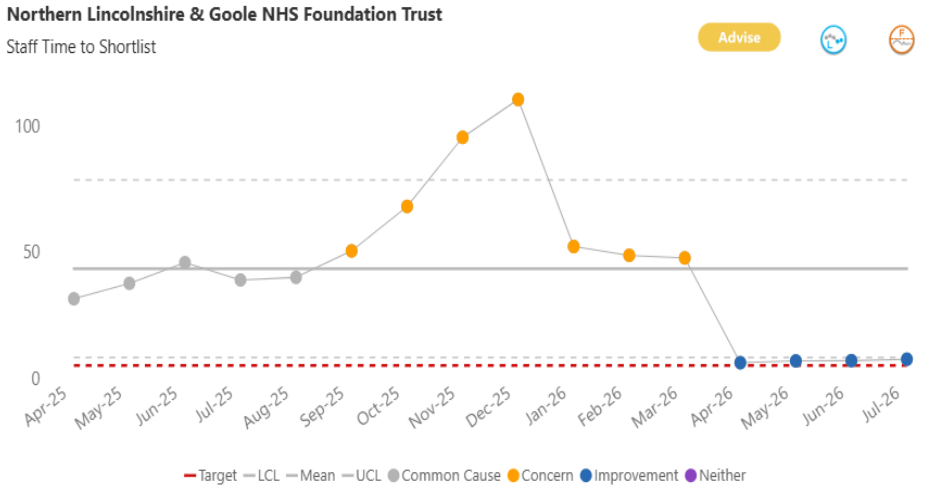
Staff Time to Shortlist shows continued variation across the period, with no clear sustained improvement. The latest position suggests the process remains vulnerable to delays at the early recruitment stage, requiring continued focus on timely vacancy review, manager shortlisting and recruitment team escalation where turnaround is off trajectory.

NLAG:

Staff Time to Shortlist also remains variable, with performance not yet demonstrating a consistent reduction. The trend indicates ongoing risk in progressing vacancies quickly from advert close to shortlist, requiring tighter operational grip on recruiting manager responsiveness, vacancy prioritisation and escalation of overdue shortlisting.







ii. Staff Time to Offer

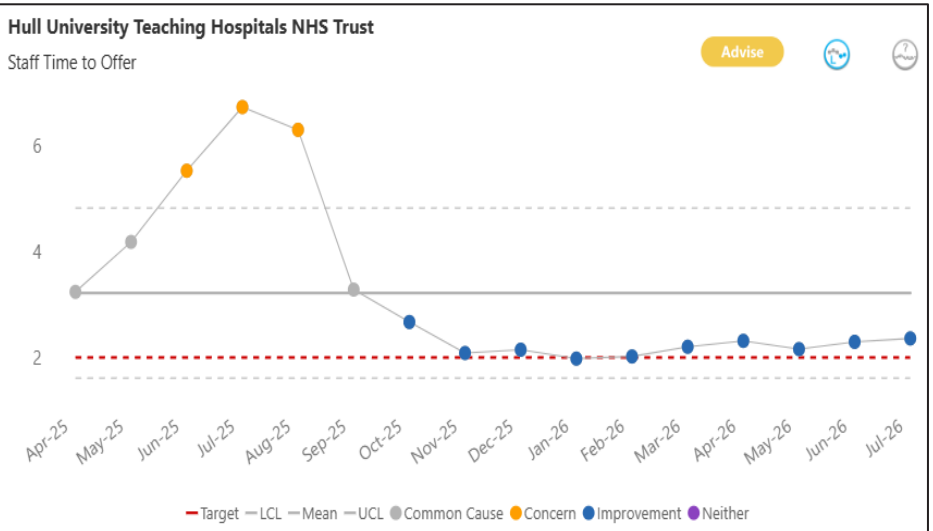
Staff Time to Offer

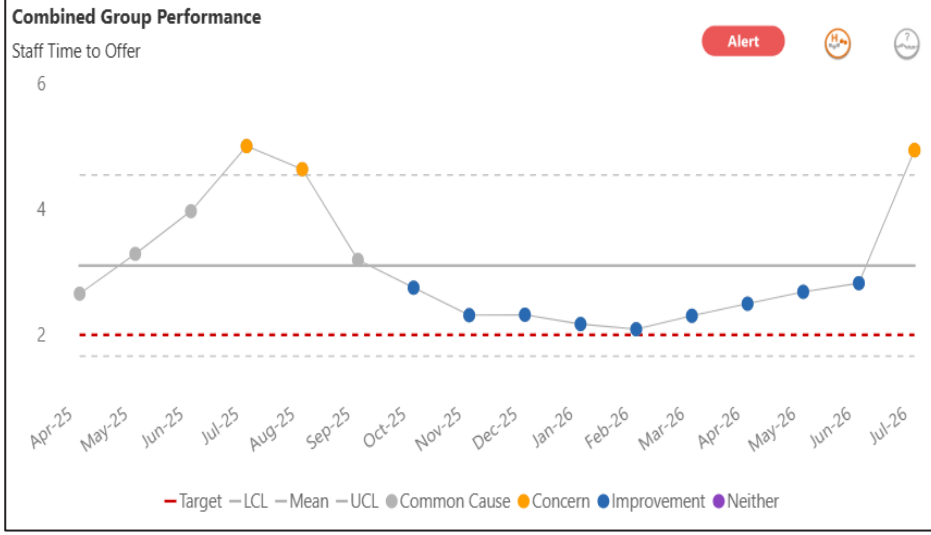
HUTH:

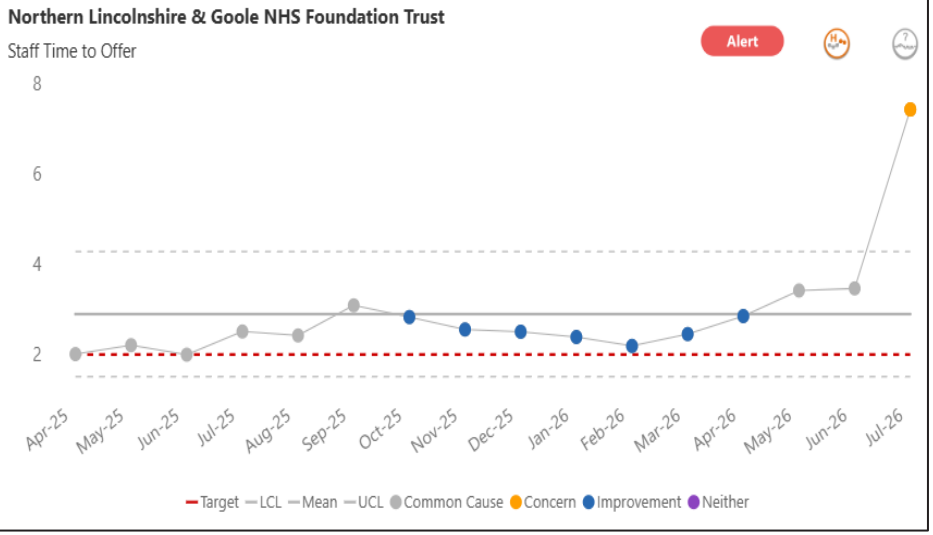
Staff Time to Offer shows variation across the period, with no clear sustained improvement. The recent position appears broadly stable but remains above the level required for consistent recruitment responsiveness, so continued focus is needed on timely interview outcomes, approval steps and offer processing.

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

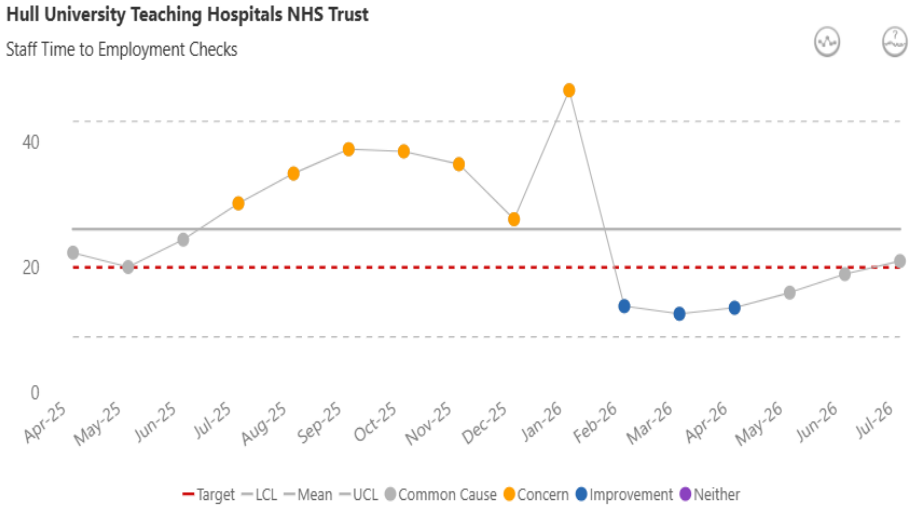
Staff Time to Employment Checks

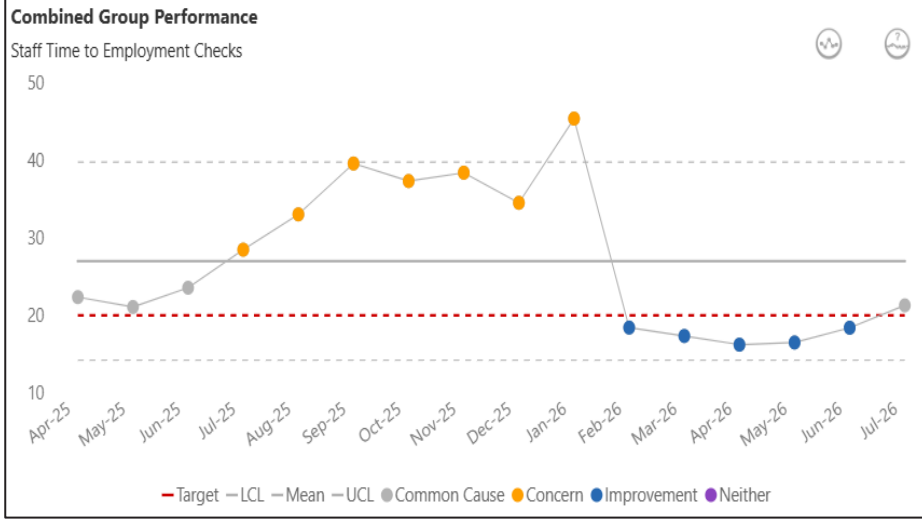
HUTH:

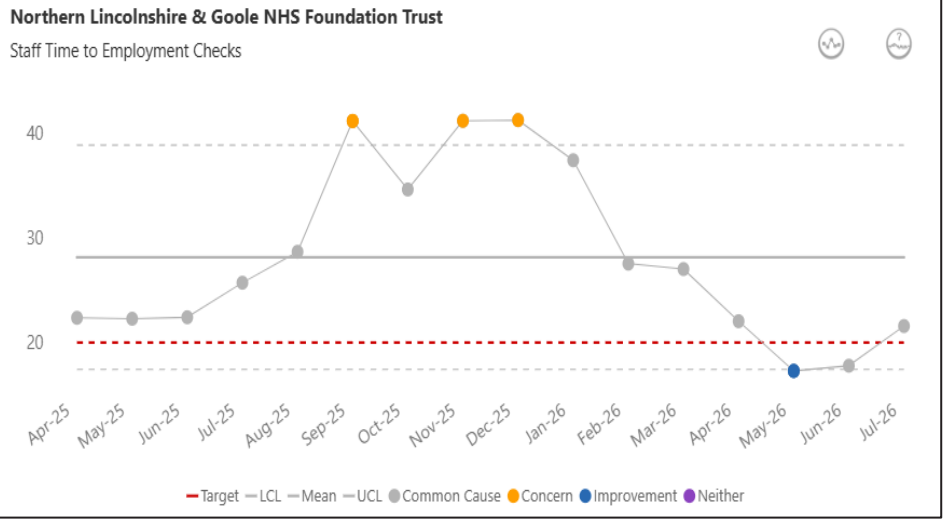
Time to employment checks shows a broadly stable trend with no clear sustained improvement; performance remains variable and should continue to be monitored to ensure checks do not become a recruitment delay point.

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

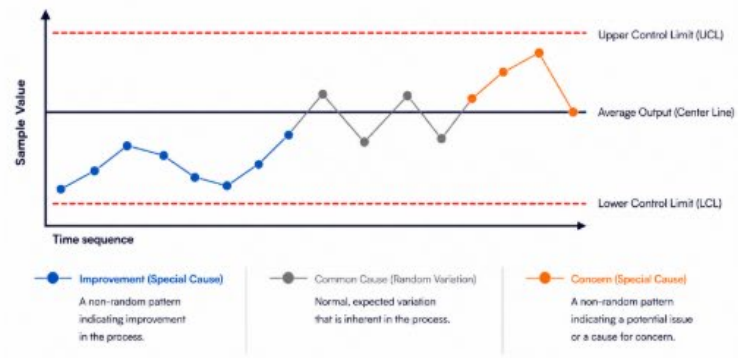
These indicate how reliably the target is being met.
Blue indicates target is consistently achieved; **Amber** indicates target is not consistently achieved; **Grey** indicates target is inconsistently achieved due to random variation.

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

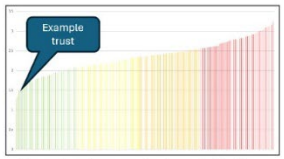
Step two: determine overall score

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:

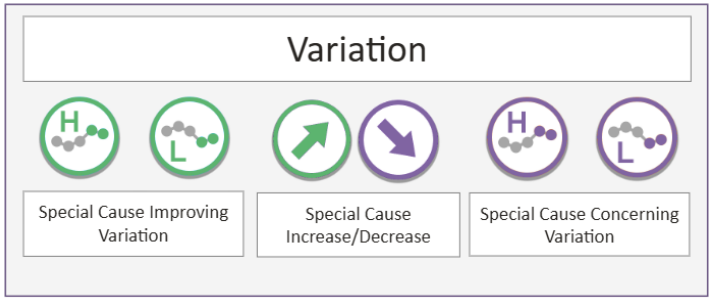
An organisation's organisational delivery score, adjusted if applicable for financial deficit, translates directly to the segment it is allocated. For some providers that are allocated to segment 4, the relevant NHS England region will consider their capability rating and determine whether they should be entered into the Provider Improvement Programme (PIP).

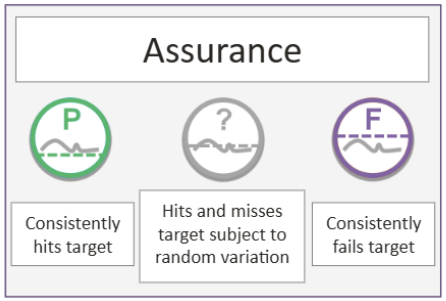
All providers in the PIP will be placed in segment 5.

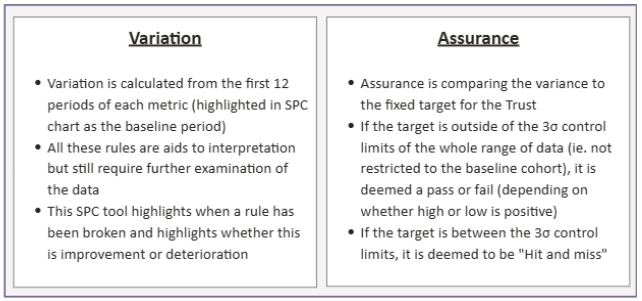
3. Using Data Insights to identify Alert, Advise and Assure status

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.

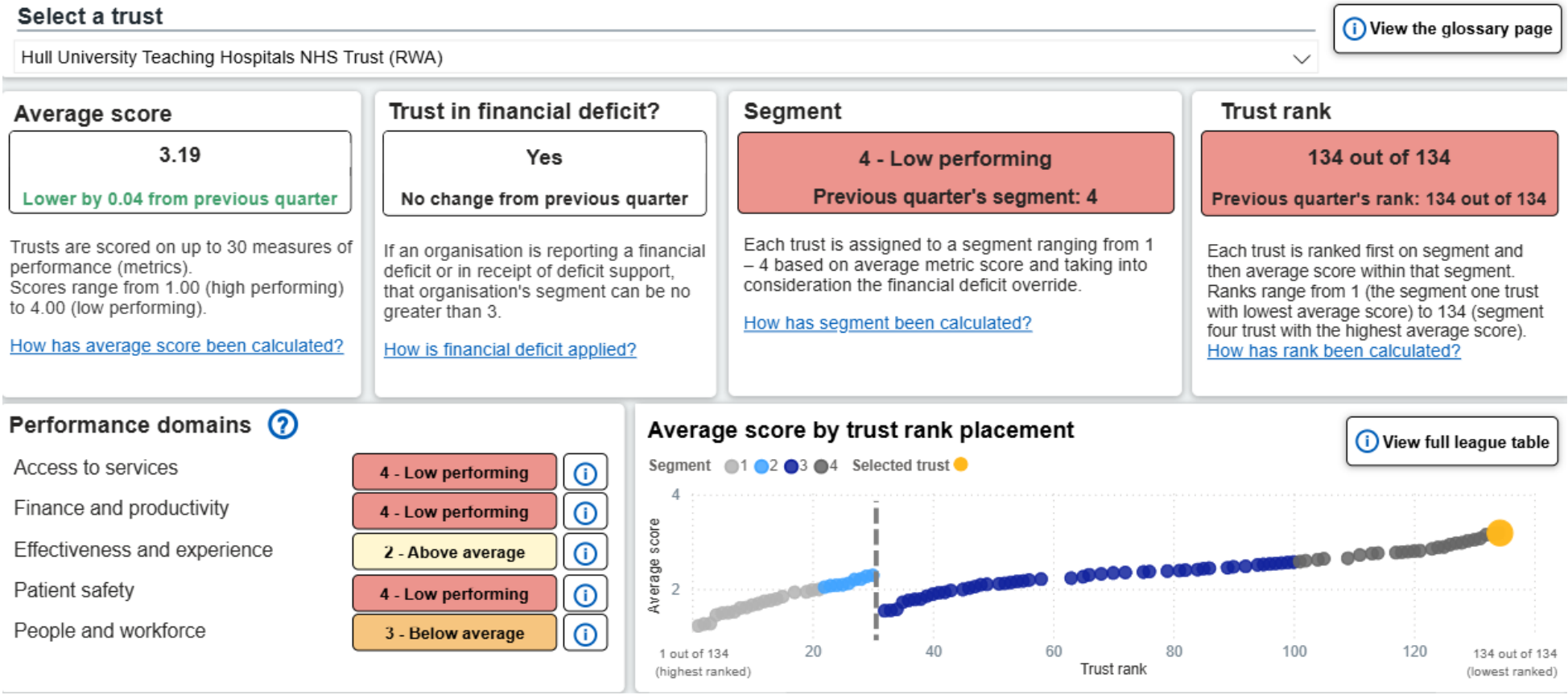
'Assurance' would be better demonstrated by the combination of variation – still using SPC insight – and whether the latest reporting period is matching trajectory.

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



Comparative League table in Appendices

NLAG Overview

Select a trust

Northern Lincolnshire and Goole NHS Foundation Trust (RJL)

View the glossary page

Average score

2.79

Lower by 0.07 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).
Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

Yes

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

4 - Low performing

Previous quarter's segment: 4

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

119 out of 134

Previous quarter's rank: 114 out of 134

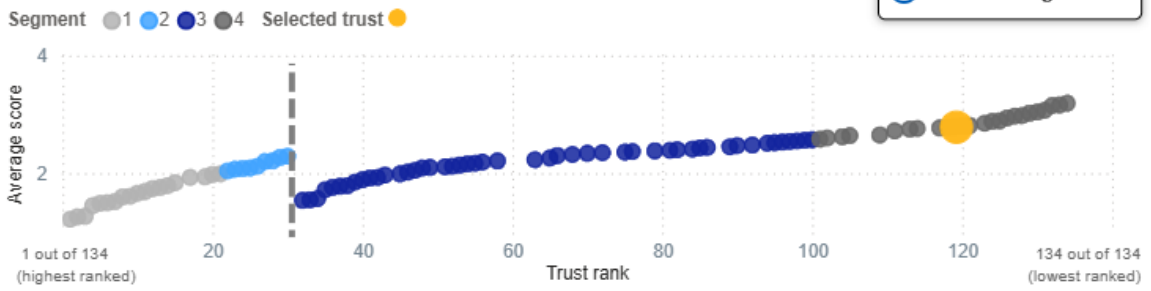
Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Access to services	4 - Low performing
Finance and productivity	4 - Low performing
Effectiveness and experience	1 - High performing
Patient safety	4 - Low performing
People and workforce	3 - Below average

Average score by trust rank placement

View full league table



Comparative League table in Appendices

Regional Context – Public View Data Source

Access to Services

Key Performance Indicator	Hull University Teaching Hospitals INDICATIVE DELIVERY SCORE 3.93	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.91	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.88	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 1.52
Cancer - Patients treated within 62 of referral QTD Q2 26/27 80.00%	54.50% 3.86	56.65% 3.84	74.46% 2.51	81.73% 1.00
Cancer - Urgent referrals diagnosis within 4 weeks QTD Q2 26/27 80.0%	70.0% 3.67	68.7% 3.71	73.0% 3.38	86.9% 1.00
Diagnostics - 6 Week Standard Jul 26	36.58% 3.70	33.51% 3.61	22.25% 2.95	30.32% 3.48
ED - Attendances managed within 4 hours - Acute trust footprint QTD Q2 26/27 82.00%	70.55% 3.46	72.22% 3.21	66.02% 3.83	72.63% 3.16
ED - Attendances over 12 hours in department QTD Q2 26/27	5.7% 1.84	17.2% 3.78	14.3% 3.45	1.9% 1.27
RTT - Patients waiting 18 weeks or less Jul 26	56.01% 3.91	59.78% 3.65	58.50% 3.79	73.59% 1.40
RTT - Patients waiting over 52 weeks Jul 26 0.00%	3.88% 3.97	3.31% 3.92	2.05% 3.54	0.06% 2.15
RTT - Planned v actual 18 week performance Q4 25/26 0.0%	-5.5% 3.60	-3.7% 3.24	-3.9% 3.33	5.2% 1.00

Effectiveness & Experience

Key Performance Indicator	Hull University Teaching Hospitals INDICATIVE DELIVERY SCORE 3.93	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.91	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.88	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 1.52
EXPERIENCE OF CARE	MEAN SCORE 2.84	MEAN SCORE 2.84	MEAN SCORE 3.16	MEAN SCORE 1.53
CQC inpatient survey satisfaction rate 2026	4.0 2.00	4.0 2.00	4.0 2.00	4.0 2.00
Patients cared for in corridors - ED QTD Q2 26/27	1,065 2.78	1,256 2.98	4,062 3.88	0 1.00
Staff Survey - Advocacy sub-score 2025	5.92 3.73	6.03 3.55	5.99 3.61	7.14 1.59
EFFECTIVENESS OF CARE	MEAN SCORE 3.33	MEAN SCORE 2.80	MEAN SCORE 1.59	MEAN SCORE 2.27
Delayed inductions rate Q1 26/27	609.4 4.00	30.1 2.40	17.8 1.76	130.6 3.80
Patients readmitted within 30 days of discharge 2025	15.8% 4.00	15.2% 4.00	14.3% 1.00	13.3% 1.00
Summary Hospital Mortality Indicator Apr 26	1.05 2.00	0.99 2.00	0.88 2.00	1.01 2.00

Patient Safety

Key Performance Indicator	Hull University Teaching Hospitals INDICATIVE DELIVERY SCORE 3.93	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.91	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.88	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 1.52
PATIENT SAFETY	MEAN SCORE 3.19	MEAN SCORE 2.59	MEAN SCORE 2.86	MEAN SCORE 1.48
Clinical audit outlier score Q1 26/27	3 3.00	1 1.00	1 1.00	1 1.00
Inpatients who suffer a new hip fracture while an inpatient - YTD 2026	5.0% 3.92	1.5% 1.26	3.7% 3.66	2.0% 1.86
Number of MRSA bacteraemia cases Jul 26 0	2 2.22	5 3.08	5 3.08	1 2.00
Rate of C-Difficile Jul 26	1.87 4.00	2.11	0.92	1.04 3.00
Rate of E-Coli bacteraemia Jul 26	0.00 2.00	0.00	0.00	0.00 1.00
Staff Survey - Raising Concerns sub-score 2025	6.04 3.55	6.09 3.45	6.00 3.70	6.87 1.16

Finance & Productivity

Key Performance Indicator	Hull University Teaching Hospitals INDICATIVE DELIVERY SCORE 3.93	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.91	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.88	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 1.52
FINANCE, PRODUCTIVITY AND INNOVATION	MEAN SCORE 3.04	MEAN SCORE 3.14	MEAN SCORE 3.33	MEAN SCORE 2.93
Clinical trials set up within 90 days Q1 26/27	71.43% 4.00	0.00% 4.00	60.00% 4.00	100.00% 1.00
Data Quality Maturity Index (DQMI) May 26	96.4 1.25	91.0 3.05	91.2 3.03	87.4 3.84
Finance - Combined finance score Q1 26/27	4 4.00	4 4.00	4 4.00	4 4.00
Finance - Planned surplus/deficit Q1 26/27 0.00%	-4.05% 4.00	-3.88% 4.00	-2.56% 4.00	-3.85% 4.00
Finance - Variance year-to-date to financial plan Q1 26/27 0.00%	-3.40% 4.00	-1.22% 4.00	-1.33% 4.00	-7.42% 4.00
Productivity - Implied productivity level Mar 26	-1.0% 3.53	1.3% 2.98	-1.7% 3.64	-0.2% 3.35
Productivity - Relative difference in costs Q1 26/27 100.0%	91.0% 1.00	95.3% 1.00	86.3% 1.00	96.0% 1.00

People & Workforce

Key Performance Indicator	Hull University Teaching Hospitals INDICATIVE DELIVERY SCORE 3.93	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.91	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.88	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 1.52
PEOPLE	MEAN SCORE 2.64	MEAN SCORE 3.15	MEAN SCORE 2.73	MEAN SCORE 1.69
Frontline healthcare workers to receive a flu vaccination Q4 25/26	51.0% 2.24	51.1% 2.17	51.1% 2.20	66.4% 1.00
NETS - Overall Experience subscore 2025	71.47 3.57	64.44 3.98	75.25 2.75	81.26 1.31
NHS staff standards sub-score 2026	7.37 3.53	7.38 3.48	7.43 3.14	7.82 1.14
Sickness Absence Rate QTD Q1 26/27	4.23% 1.65	4.97% 2.71	5.27% 3.03	4.83% 2.53
Staff Survey - Engagement Theme Score 2025	6.40 3.75	6.46 3.59	6.51 3.36	7.07 1.50
Temporary staffing cost relative band Q1 26/27	1 1.00	3 3.00	1 1.00	2 2.00

5. Trust League Tables

a. HUTH – Filtered to Teaching Hospitals

Quarter	Select trust type(s)	Select trust(s)	Statistics methodology	Return to overview
Q4 2025/26	Acute - Teaching	All		

Trust type	Trust	Average score	Segment	Trust in financial deficit?	Rank	Likely range of rank	Previous quarter's rank
Acute - Teaching	Hull University Teaching Hospitals NHS Trust (RWA)	3.19	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

Copyright © NHS England, 2026

b. NLAG – Filtered to Medium

Quarter	Select trust type(s)	Select trust(s)	Statistics methodology	Return to overview
Q4 2025/26	Acute - Medium	All		

Trust type	Trust	Average score	Segment	Trust in financial deficit?	Rank	Likely range of rank	Previous quarter's rank
Acute - Medium	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

Copyright © NHS England, 2026

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

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)104

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	4 November 2026
Director Lead	Keith Haynes, Interim Board Secretary
Contact Officer/Author	Alison Hurley, Deputy Director of Assurance
Title of the Report	**Acronyms and Glossary of Terms**
Executive Summary	A reference guide for any words, phrases or acronyms used during the meeting – updated March 2026. Document for information only.
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:

Northern Lincolnshire and Goole NHS Foundation Trust

ACRONYMS & GLOSSARY OF TERMS

Mar 2026 – v9.2

2WW - Two week wait

A&E – Accident and Emergency: A walk-in facility at hospitals that provides urgent treatment for serious injuries and conditions

A4C – Agenda for Change. NHS system of pay that is linked to the job content, and the skills and knowledge staff apply to perform jobs

ACE – A Commitment to Excellence – Accreditation scheme previously known as 15 Step Reviews. Replaced by Putting Patients First in March 2026

Acute - Used to describe a disorder or symptom that comes on suddenly and needs urgent treatment

AAU – Acute Assessment Unit

Accounting Officer - The NHS Act 2006 designates the chief executive of an NHS foundation trust as the accounting officer.

Acute Hospital Trust - Hospitals in England are managed by acute trusts (Foundation Trusts). Acute trusts ensure hospitals provide high-quality healthcare and check that they spend their money efficiently. They also decide how a hospital will develop, so that services improve

Admission - A term used to describe when someone requires a stay in hospital, and admitted to a ward

Adult Social Care - Provide personal and practical support to help people live their lives by supporting individuals to maintain their independence and dignity, and to make sure they have choice and control. These services are provided through the local authorities

Advocate - An advocate is someone who supports people, at times acting on behalf of the individual

AGC – Audit & Governance Committee

AGM – Annual General Meeting

AHP – Allied Health Professional

ALoS – Average Length of Stay

AMM – Annual Members' Meeting

AO – Accounting Officer

AoMRC – Association of Medical Royal Colleges

AOP – Annual Operating Plan

ARC – the Governor Appointments & Remuneration Committee has delegated authority to consider the appointment and remuneration of the Group Chair, Vice Chair

and Non-Executive Directors on behalf of the Council of Governors, and provide advice and recommendations to the full Council in respect of these matters

ARM – Annual Review Meeting for CoG

Audit Committee - A Trust's own committee, monitoring its performance, probity and accountability

ARGC – Audit Risk & Governance Committees-in-Committee

Auditor - The internal auditor helps organisations (particularly boards of directors) to achieve their objectives by systematically evaluating and proposing improvements relating to the effectiveness of their risk management, internal controls and governance processes. The external auditor gives a professional opinion on the quality of the financial statements and report on issues that have arisen during the annual audit

BAF - Board Assurance Framework

BAME – Black and Minority Ethnic: Defined by ONS as including White Irish, White other (including White asylum seekers and refugees and Gypsies and Travellers), mixed (White & Black Caribbean, White & Black African, White & Asian, any other mixed background), Asian or Asian British (Indian, Pakistani, Bangladeshi, any other Asian background), Black or Black British (Caribbean, African or any other Black background), Chinese, and any other ethnic group

Benchmarking - Comparing performance or measures to best standards or practices or averages

BLS – Basic Life Support

BMA – British Medical Association

Boards-in-Common – The meeting of the Boards of Directors for both NLaG and HUTH

Board of Directors (BoD) - A Board of Directors is the executive body responsible for the operational management and conduct of an NHS Foundation Trust. It is includes a Non-Executive Group Chair, Non-Executive Directors, the Group Chief Executive and other Executive Directors. The Group Chair and Non-Executive Directors are in the majority on the Board

Caldicott Guardian - The person with responsibility for the policies that safeguard the confidentiality of patient information

CAMHS - Child and Adolescent Mental Health Services work with children and young people experiencing mental health problems

CAP – Collaborative Acute Providers

CPE - Carbapenemase-Producing Enterobacterales

Care Plan - A signed written agreement setting out how care will be provided. A care plan may be written in a letter or using a special form

CCG – Clinical commissioning groups (CCGs) were NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in each of their local areas in England. On 1 July 2022 they were abolished and replaced by Integrated Care Systems as a result of the Health and Care Act 2022.

CDC – Community Diagnostic Centre

CFC – Charitable Funds Committee

CFO – Chief Financial Officer

C Diff - Clostridium difficile is a type of bacteria. Clostridium difficile infection usually causes diarrhoea and abdominal pain, but it can be more serious

CE/CEO – Chief Executive Officer

CF – Cash Flow

CIP – the Cost Improvement Programme is a vital part of Trust finances. Every year a number of schemes/projects are identified. The Trust have an agreed CIP process which has been influenced by feedback from auditors and signed off at the CIP & Transformation Programme Board

Clinical Audit - Regular measurement and evaluation by health professionals of the clinical standards they are achieving

Clinical Governance - A system of steps and procedures through which NHS organisations are accountable for improving quality and safeguarding high standards

CMO – Chief Medical Officer

CMP or C&MP – Capital & Major Projects Committees-in-Common

Code of Governance – NHS England has issued this Code of Governance (the code) to help NHS providers deliver effective corporate governance, contribute to better organisational and system performance and improvement, and ultimately discharge their duties in the best interests of patients, service users and the public.

CoG - Council of Governors. Each NHS Foundation Trust is required to establish a Board of Governors. A group of Governors who are either elected by Members (Public Members elect Public Governors and Staff Members elect Staff Governors) or are nominated by partner organisations. The Council of Governors is the Trust's direct link to the local community and the community's voice in relation to its forward planning. It is ultimately accountable for the proper use of resources in the Trust and therefore has important powers including the appointment and removal of the Chair

Commissioners - Commissioners specify in detail the delivery and performance requirements of providers such as NHS Foundation Trusts, and the responsibilities of each party, through legally binding contracts. NHS Foundation Trusts are required to meet their obligations to commissioners under their contracts. Any disputes about contract performance should be resolved in discussion between commissioners and NHS Foundation Trusts, or through their dispute resolution procedures

Committee - A small group intended to remain subordinate to the board it reports to

Committees-in-Common (CiC) - NLaG and HUTH are implementing a governance structure which will ensure that they have single focussed discussions on major areas of service change. These discussions would take place in the Committees in Common

Co-morbidity - The presence of one or more disorders in addition to a primary disorder, for example, dementia and diabetes

Constituency - Membership of each NHS Foundation Trust is divided into constituencies that are defined in each trust's constitution. An NHS Foundation Trust must have a public constituency and a staff constituency, and may also have a patient, carer and/or service users' constituency. Within the public constituency, an NHS Foundation Trust may have a "rest of England" constituency. Members of the various constituencies vote to elect Governors and can also stand for election themselves

Constitution - A set of rules that define the operating principles for each NHS Foundation Trust. It defines the structure, principles, powers and duties of the trust

CoP – Code of Practice

CPA – Care Programme Approach

CPD – Continuing Professional Development. It refers to the process of tracking and documenting the skills, knowledge and experience that is gained both formally and informally at work, beyond any initial training. It's a record of what is experienced, learned and then applied

CPIS - Child Protection Information Sharing

CPN – Community Psychiatric Nurse

CPO – Chief People Officer

CQC - Care Quality Commission - is the independent regulator of health and social care in England, aiming to make sure better care is provided for everyone in hospitals, care homes and people's own homes. Their responsibilities include registration, review and inspection of services; their primary aim is to ensure that quality and safety are met on behalf of patients

CQUIN – Commissioning for Quality and Innovation are measures which determine whether we achieve quality goals or an element of the quality goal. These achievements are on the basis of which CQUIN payments are made. The CQUIN payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For the patient – this means better experience, involvement and outcomes

CSPO – Chief Strategy and Partnerships Officer

CSU – Commissioning Support Unit support clinical commissioning groups by providing business intelligence, health and clinical procurement services, as well as back-office administrative functions, including contract management

Datix - is the patient safety web-based incident reporting and risk management software, widely used by NHS staff to report clinical incidents (Replaced by Ulysses in 2023)

DBS – Disclosure & Barring Service (replaces Criminal Records Bureau (CRB))

DD – Due Diligence

Depreciation – A reduction in the value of a fixed asset over its useful life as opposed to recording the cost as a single entry in the income and expenditure account.

DGH – District General Hospitals

DH or DoH – Department of Health – A Government Department that aims to improve the health and well-being of people in England

DHSC - Department of Health and Social Care is a government department responsible for government policy on health and adult social care matters in England and oversees the NHS

DN - District Nurse, a nurse who visits and treats patients in their homes, operating in a specific area or in association with a particular general practice surgery or health centre

DNA - Did not attend: when a patient misses a health or social care appointment without prior notice. The appointment is wasted and therefore a cost incurred

DNR - Do not resuscitate

DoF – Director of Finance

DOI - Declarations of Interest

DOLS - Deprivation of Liberty Safeguards

DOSA – Day of Surgery Admission

DPA - Data Protection Act

DPH - Director of Public Health

DPoW - Diana, Princess of Wales Hospital, Grimsby

DTOCs – Delayed Transfers of Care

EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortisation. An approximate measure of a company's operating cash flow based on data from the company's income statement

ECC - Emergency Care Centre

ED – Executive Directors or Emergency Department

EDI – Equality, Diversity and Inclusion

EHR – Electronic Health Record

EIA - Equality Impact Assessment

Elective admission - A patient admitted to hospital for a planned clinical intervention, involving at least an overnight stay

Emergency (non-elective) admission - An unplanned admission to hospital at short notice because of clinical need or because alternative care is not available

ENT – Ear, nose and throat treatment. An ENT specialist is a physician trained in the medical and surgical treatment of the ears, nose throat, and related structures of the head and neck

EoL – End of Life

EPR - Electronic Patient Record

ERF – Elective Recovery Fund

ERoY – East Riding of Yorkshire

ESR - Electronic Staff Record

Executive Directors - Board-level senior management employees of the NHS Foundation Trust who are accountable for carrying out the work of the organisation. For example the Chief Executive and Finance Director, of a NHS Foundation Trust who sit on the Board of Directors. Executive Directors have decision-making powers and a defined set of responsibilities, thus playing a key role in the day to day running of the Trust.

FD – Finance Director

FFT - Friends and Family Test: is an important opportunity for patients to provide feedback on the services that provided care and treatment. This feedback will help NHS England to improve services for everyone

FOI - Freedom of information. The FOI Act 2000 is an Act of Parliament of the United Kingdom that creates a public "right of access" to information.

FRC – Financial Risk Rating

FT – Foundation Trust. NHS foundation trusts are public benefit corporations authorised under the NHS 2006 Act, to provide goods and services for the purposes of the health service in England. They are part of the NHS and provide over half of all NHS hospital, mental health and ambulance services. NHS foundation trusts were created to devolve decision making from central government to local organisations and communities. They are different from NHS trusts as they: have greater freedom to decide, with their governors and members, their own strategy and the way services are run; can retain their surpluses and borrow to invest in new and improved services for patients and service users; and are accountable to, among others, their local communities through their members and governors

FTE – Full Time Equivalent

FTGA – Foundation Trust Governors' Association

FTN – Foundation Trust Network

FTSUG - Freedom to Speak Up Guardians help to protect patient safety and the quality of care, whilst improving the experience of workers

FY – Financial Year

GAG – the Governor Assurance Group has oversight of areas of Trust governance and assurance frameworks in order to provide added levels of assurance to the work of the Council of Governors (Replaced by Member and Public Engagement & Assurance Group (MPEAG) from April 2024)

GDH – Goole & District Hospital

GDP – Gross Domestic Product

GDPR – General Data Protection Regulations

GIRFT – Getting It Right First Time

GMC - General Medical Council: the organisation that licenses doctors to practice medicine in the UK

GP - General Practitioner - a doctor who does not specialise in any particular area of medicine, but who has a medical practice in which he or she treats all types of illness (family doctor)

Governance - This refers to the "rules" that govern the internal conduct of an organisation by defining the roles and responsibilities of groups (e.g. Board of Directors, Council of Governors) and individuals (e.g. Chair, Chief Executive Officer, Finance Director) and the relationships between them. The governance arrangements of NHS Foundation Trusts are set out in the constitution and enshrined in the Licence

Governors - Elected or appointed individuals who represent Foundation Trust Members or stakeholders through a Council of Governors

Group Executive Team – assists the Chief Executive in the performance of his duties, including recommending strategy, implementing operational plans and budgets, managing risk, and prioritising and allocating resources

Group Model - Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) will still exist as separate legal entities but will operate within a singular Group model and one Group Executive Team

GUM - Genito Urinary Medicine: usually used as the name of a clinic treating sexually transmitted disease

H1 - First Half (financial or calendar year)

H2 - Second Half (financial or calendar year)

HAS - Humber Acute Services

HCA - a Health Care Assistant is someone employed to support other health care professions

HCAI - Healthcare Acquired Infections or Healthcare Associated Infections, are those acquired as a result of health care

HCCP - Humber Clinical Collaboration Programme

HDU - Some hospitals have High Dependency Units (HDUs), also called step-down, progressive and intermediate care units. HDUs are wards for people who need more intensive observation, treatment and nursing care than is possible in a general ward but slightly less than that given in intensive care

Health inequalities - Variations in health identified by indicators such as infant mortality rate, life expectancy which are associated with socio-economic status and other determinants

Healthwatch England - Independent consumer champion for health and social care. It also provides a leadership and support role for the local Healthwatch network.

HEE – Health Education England

HES - Hospital Episode Statistics – the national statistical data warehouse for England of the care provided by the NHS. It is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals

HOBS - High Observations Beds

HOSC - Health Overview and Scrutiny Committee. Committee that looks at the work of the clinical commissioning groups, and National Health Service (NHS) trusts, and

the local area team of NHS England. It acts as a 'critical friend' by suggesting ways that health related services might be improve

HR – Human Resources

HSCA – Health & Social Care Act 2012

HSMR - Hospital Standardised Mortality Ratio

HTF - Health Tree Foundation (Trust charity)

HTFTC - Health Tree Foundation Trustees' Committee

Human Resources (HR) - A term that refers to managing "human capital", the people of an organisation

Humber and North Yorkshire Health and Care Partnership - The Humber and North Yorkshire Health and Care Partnership is a collaboration of health, social care, community and charitable organisations

HW – Healthwatch

HWB/HWBB – Health & Wellbeing Board

HWNL - Healthwatch North Lincolnshire

HWNEL - Healthwatch North East Lincolnshire

HWER - Healthwatch East Riding

H&WB Board - Health and Wellbeing Board. A statutory forum where political, clinical, professional and community leaders from across the care and health system come together to improve the health and wellbeing of their local population and reduce health inequalities. The joint strategy developed for this Board is based on the Joint Strategic Needs Assessment. Each ICB has its own Health and Wellbeing Board.

HUTH – Hull University Teaching Hospitals NHS Trust

IAAU – Integrated Acute Assessment Unit

IAPT – Improved Access to Psychological Therapies

IBP – Integrated Business Plan

I & E – Income and Expenditure. A record showing the amounts of money coming into and going out of an organisation, during a particular period.

ICB – Integrated Care Board

ICP – Integrated Care Partnership

ICS – Integrated Care Systems - Partnership between NHS organisations, local councils and others, who take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. There are 44 ICS 'footprint' areas. The size of a system is typically a population of 1-3 million.

ICU – Intensive Care Unit

IG – Information Governance

Integrated Care - Joined up care across local councils, the NHS, and other partners. It is about giving people the support they need, joined up across local councils, the

NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. The aim is that people can live healthier lives and get the care and treatment they need, in the right place, at the right time.

IP – Inpatient

IPC - Infection Prevention & Control

IPR – Integrated Performance Report

IT – Information Technology

ITU – Intensive Therapy Unit

JAG – Joint Advisory Group accreditation

JHOSH - Joint Health Overview and Scrutiny Committee

Joint committees - In a joint committee, each organisation can nominate one or more representative member(s). The joint committee has delegated authority to make binding decisions on behalf of each member organisation without further reference back to their board.

JSNA – Joint Strategic Needs Assessment

KLOE – Key Line of Enquiry

KPI – Key Performance Indicator. Targets that are agreed between the provider and commissioner of each service, which performance can be tracked against

KSF – Knowledge and Skills Framework- This defines and describes the knowledge and skills which NHS staff (except doctors and dentists) need to apply in their work in order to deliver quality services

LA – NHS Leadership Academy

LATs – Local Area Teams

LD – Learning Difficulties

Lead Governor - The Lead Governor has a role in facilitating direct communication between NHS England and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the Chair or the Trust Secretary, if one is appointed.

LETB – Local Education and Training Board

LGBTQ+ – Lesbian, gay, bisexual, transgender, questioning, queer, intersex, pansexual, two-spirit (2S), androgynous and asexual.

LHE – Local Health Economy

LHW – Local Healthwatch

LiA – Listening into Action

Licence - The NHS provider licence contains obligations for providers of NHS services that will allow Monitor to fulfil its new duties in relation to: setting prices for NHS-funded care in partnership with NHS England; enabling integrated care; preventing anti-competitive behaviour which is against the interests of patients; supporting commissioners in maintaining service continuity; and enabling Monitor to

continue to oversee the way that NHS Foundation Trusts are governed. It replaces the Terms of Authorisation

LMC – the Local Medical Council is the local representative committee of NHS GPs which represents individual GPs and GP practices as a whole in their localities

Local Health Economy - This term refers to the different parts of the NHS working together within a geographical area. It includes GP practices and other primary care contractors (e.g. pharmacies, optometrists, dentists), mental health and learning disabilities services, hospital services, ambulance services, primary care trusts (England) and local health boards (Wales). It also includes the other partners who contribute to the health and well-being of local people – including local authorities, community and voluntary organisations and independent sectors bodies involving in commissioning, developing or providing health services

LOS - length of stay for patients is the duration of a single episode of hospitalisation

LTC - Long Term Condition

M&A – Mergers & Acquisitions

MCA - Mental Capacity Act

MDT - Multi-disciplinary Team

Members - As part of the application process to become an NHS Foundation Trust, NHS trusts are required to set out detailed proposals for the minimum size and composition of their membership. Anyone who lives in the area, works for the trust, or has been a patient or service user there, can become a Member of an NHS Foundation Trust, subject to the provisions of the trust's constitution. Members can: receive information about the NHS Foundation Trust and be consulted on plans for future development of the trust and its services; elect representatives to serve on the Council of Governors; and stand for election to the Council of Governors

MHA – Mental Health Act

MI – Major Incident

MIU – Major Incident Unit

MLU - Midwifery led unit

Monitor - Monitor was the sector regulator of health care services in England, now replaced by NHS Improvement as of April 2016 (which has since merged with NHS England)

MPEAG – Membership and Public Engagement & Assurance Group is responsible for overseeing the development, implementation and regular review of the Trust's Member and Public Engagement Strategy. This incorporates oversight of member recruitment and communication, public engagement initiatives and mechanisms to feed back the views of members and the public to the CoG, and Trust Board.

MRI – Magnetic Resonance Imaging

MRSA – Metacillin Resistant Staphylococcus Aureus is a common type of bacteria that lives harmlessly in the nose or on the skin

MSA – Mixed Sex Accommodation

National Tariff - This payment system covers national prices, national currencies, national variations, and the rules, principles and methods for local payment arrangements

NCTR – No Criteria to Reside

NED – Non-Executive Director

Neighbourhoods - Areas typically covering a population of 30-50,000, where groups of GPs and community-based services work together to coordinate care, support and prevention and wellbeing initiatives. Primary care networks and multidisciplinary community teams form at this level.

Neonatal – Relates to newborn babies, up to the age of four weeks

Nephrology - The early detection and diagnosis of renal (kidney) disease and the long-term management of its complications.

Neurology - Study and treatment of nerve systems.

NEWS - National Early Warning Score

Never Event - Serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented

NEL - North East Lincolnshire

NGO - National Guardians Office for the Freedom to Speak Up Guardian

NHS - National Health Service

NHS 111 - NHS 111 makes it easier to access local NHS healthcare services in England. You can call 111 when you need medical help fast but it's not a 999 emergency. NHS 111 is a fast and easy way to get the right help, whatever the time

NHS Confederation - is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland.

NHS ICS Body - ICS NHS bodies will be established as new organisations that bind partner organisations together in a new way with common purpose. They will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population

NHSE - NHS England. NHS England provides national leadership for the NHS. Through the NHS Long Term Plan, we promote high quality health and care for all, and support NHS organisations to work in partnership to deliver better outcomes for our patients and communities, at the best possible value for taxpayers and to continuously improve the NHS. We are working to make the NHS an employer of excellence and to enable NHS patients to benefit from worldleading research, innovation and technology

NHS Health and Care Partnership - a locally-determined coalition will bring together the NHS, local government and partners, including representatives from the wider public space, such as social care and housing.

NHSLA - NHS Litigation Authority. Handles negligence claims and works to improve risk management practices in the NHS

NHSP - NHS Professionals

NHS Providers - This is the membership organisation and trade association for all NHS provider trusts

NHSTDA – NHS Trust Development Authority

NICE - the National Institute for Health and Care Excellence is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health

NL - North Lincolnshire

NLaG - Northern Lincolnshire & Goole Hospitals NHS Foundation Trust

NMC - Nursing & Midwifery Council

NOF – National Oversight Framework

Non-Elective Admission (Emergency) - An unplanned admission to hospital at short notice because of clinical need or because alternative care is not available

NPIP – National Provider Improvement Programme

NQB - National Quality Board

NSFs – National Service Frameworks

OBC - Outline Business Case

OFT – Office of Fair Trading

OLU - Obstetric led unit

OOH - Out of Hours

OP – Outpatients

OPA – Outpatient Appointment

Operational management - Operational management concerns the day-to-day organisation and coordination of services and resources; liaison with clinical and non-clinical staff; dealing with the public and managing complaints; anticipating and resolving service delivery issues; and planning and implementing change

OSCs – Overview and Scrutiny Committees

PALS - Patient Advice and Liaison Service. All NHS Trusts have a PALS team who are there to help patients navigate and deal with the NHS. PALS can advise and help with any non-clinical matter (eg accessing treatment, information about local services, resolving problems etc)

PADR - Personal Appraisal and Development Review - The aim of a Performance Appraisal Development Review is to confirm what is required of an individual within their role, feedback on how they are progressing, to identify any learning and development needs through the use of the and to agree a Personal Development Plan

PAU – Paediatric assessment unit

PbR - Payment by Results

PCN - Primary Care Network: Groups of GP practices, working with each other and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas. Led by a clinical director who may be a GP, general

practice nurse, clinical pharmacist or other clinical profession working in general practice.

PCT – Primary Care Trust

PDC – Public Dividend Capital

PEWS - Paediatric Early Warning Score

PEF – Performance, Estates & Finance Committees-in-Common

PFI – Private Finance Initiative

PIDMAS – Patient Initiated Digital Mutual Aid System

PLACE - Patient Led Assessment of Controlled Environment are annual assessments of inpatient healthcare sites in England that have more than 10 beds. It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care, such as cleanliness, food and infection control

Place - Town or district within an ICS, which typically covers a population of 250,000 – 500,000 people. Often coterminous with a council or borough.

Place Based Working - enables NHS, councils and other organisations to collectively take responsibility for local resources and population health

PMO – Programme Management Office

Population Health Management (PHM) - A technique for using data to design new models of proactive care, delivering improvements in health and wellbeing which make best use of the collective resources. Population health aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.

PPE - Personal Protective Equipment

PPG - Patient Participation Group. Patient Participation Group is a group of people who are patients of the surgery and want to help it work as well as it can for patients, doctors and staff

PPI – Patient and Public Involvement

PRIM - Performance Review Improvement Meeting

PROMS – Patient Recorded Outcome Measures

Provider Collaborative - Arrangements between NHS organisations with similar missions (e.g., an acute collaborative). They can also be organised around a 'place', with acute, community and mental health providers forming one collaborative. It is expected that all NHS providers will need to be part of one or more provider collaborates, as part of the new legislation.

PSF - Provider Sustainability Fund

PST – Patient Suitability for Transfer

PTL – Patient Transfer List

PTS – Patient Transport Services

Putting Patients First – New ward accreditation programme rolled out on 23 March 2026. Previously known as A Commitment to Excellence (ACE) and 15 Step Reviews.

QA – Quality Accounts. A QA is a written report that providers of NHS services are required to submit to the Secretary of State and publish on the NHS Choices website each June summarising the quality of their services during the previous financial year **or** Quality Assurance

QGAF – Quality governance assurance framework

QI – Quality Improvement

QIA – Quality Impact Assessment

QIPP – Quality Innovation, Productivity and Prevention. QIPP is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS

QOF – Quality and Outcomes Framework. The Quality and Outcomes Framework is a system designed to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. It is a fundamental part of the General Medical Services (GMS) Contract, introduced in 2004.

QRP – Quality & Risk Profile

Q&SC – Quality & Safety Committees-in-Common

QSIR – Quality & Service Improvement Report

R&D – Research & Development

RAG – Red, Amber, Green classifications

RCA – Root Cause Analysis

RCGP – Royal College of General Practitioners

RCN – Royal College of Nursing

RCP – Royal College of Physicians

RCPSYCH – Royal College of Psychiatrists

RCS – Royal College of Surgeons

RGN – Registered General Nurse

RIDDOR – Reporting of Injuries, Diseases, Dangerous Occurrences Regulation. Regulates the statutory obligation to report deaths, injuries, diseases and "dangerous occurrences", including near misses, that take place at work or in connection with work

Risk Assessment Framework – The Risk Assessment Framework replaced the Compliance Framework during 2013/14 in the areas of financial oversight of providers of key NHS services – not just NHS Foundation Trusts – and the governance of NHS Foundation Trusts

RoI – Register of Interests

RoI – Return on Investment

RTT – Referrals to Treatment

SaLT - Speech and Language Therapy

SDEC – Same day emergency care

Secondary Care - NHS trusts and NHS Foundation Trusts are the organisations responsible for running hospitals and providing secondary care. Patients must first be referred into secondary care by a primary care provider, such as a GP

Serious Incident/event (**SI) -** An incident that occurred during NHS funded healthcare which resulted in serious harm, a never event, or another form of serious negative activity

Service User/s - People who need health and social care for mental health problems. They may live in their own home, stay in care, or be cared for in hospital

SGH – Scunthorpe General Hospital

SHCA – Senior Health Care Assistant

SHMI - Summary Hospital-level Mortality Indicator

SI - Serious Incident: An out of the ordinary or unexpected event (not exclusively clinical issues) that occurs on NHS premises or in the provision of an NHS or a commissioned service, with the potential to cause serious harm

SIB - System Improvement Board

SID - Senior Independent Director - One of the non-executive directors should be appointed as the SID by the Board of Directors, in consultation with the Council of Governors. The SID should act as the point of contact with the Board of Directors if Governors have concerns which approaches through normal channels have failed to resolve or for which such normal approaches are inappropriate. The SID may also act as the point of contact with the Board of Directors for Governors when they discuss, for example, the chair's performance appraisal and his or her remuneration and other allowances. More detail can be found in the Code of Governance

SJR - Structured Judgement Review

SLA – Service Level Agreement

SLM/R – Service Line Management/Reporting

SNCT - Safer Nursing Care Tool

Social Care - This term refers to care services which are provided by local authorities to their residents

SPA – Single Point of Access

SoS – Secretary of State

SSA – Same Sex Accommodation

Strategic Management - Strategic management involves setting objectives for the organisation and managing people, resource and budgets towards reaching these goals

Statutory Requirement - A requirement prescribed by legislation

SUI – Serious untoward incident/event: An incident that occurred during NHS funded healthcare which resulted in serious harm, a never event, or another form of serious negative activity

T&C – Terms and Conditions

TCI – To Come In

Terms of Authorisation - Previously, when an NHS Foundation Trust was authorised, Monitor set out a number of terms with which the trust had to comply. The terms of authorisation have now been replaced by the NHS provider licence, and NHS Foundation Trusts must comply with the conditions of the licence

TMB - Trust Management Board

Third Sector - Also known as voluntary sector/ non-profit sector or "not-for-profit" sector. These organisations are non-governmental

ToR – Terms of Reference

Trauma - The effect on the body of a wound or violent impact

Triage - A system which sorts medical cases in order of urgency to determine how quickly patients receive treatment, for instance in accident and emergency departments

TTO – To Take Out

ULHT – United Lincolnshire Hospital NHS Trust

ULYSSES - Risk Management System to report Incidents and Risk (Replaced DATIX in 2023)

UTC - Urgent Treatment Centre

Voluntary Sector - Also known as third sector/non-profit sector or "not-for-profit" sector. These organisations are non-governmental

Vote of No Confidence - A motion put before the Board which, if passed, weakens the position of the individual concerned

VTE – Venous Thromboembolism

WEC – Workforce, Education & Culture Committee-in-Common

WRES - Workforce Race Equality Standards

WDES - Workforce Disability Equality Standards

WTE - Whole time equivalent

YTD - Year to date