Experts in health

Independent review of the Humber Health Partnership group model

Summary report to NHS England

4 September 2026

Purpose

This summary report sets out the independent review commissioned by NHS England under the Intensive Recovery Programme. It records the commission and its boundaries, how the review was conducted, the limitations that qualify its conclusions, what the review found, the outcome of the options appraisal, the review's recommendations, and the issues that no change in organisational form can resolve. The detailed appraisal evidence, domain by domain, was set out in the CF Phase 1 and Phase 2 papers provided to NHS England as commissioner. Implementation of the recommended direction is a matter for the Trusts and is not addressed here. This report was completed on 4 September 2026 and pre-dates the Trusts' own decision-making.

Commission and scope

Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire and Goole (NLAG), together operating as the Humber Health Partnership (HHP), were two of five Trusts placed into the national Intensive Recovery Programme (IRP), announced by the Secretary of State in March 2026. The IRP is a national programme established by NHS England to provide intensive, time-bounded support to the most challenged Trusts in the country. It is intended to stabilise performance, restore financial control and determine the right organisational arrangements where standard regulatory oversight has not delivered sufficient improvement.

In April 2026, NHS England commissioned CF to undertake an independent, evidence-based review of the HHP group model, to establish whether it remains the right organisational arrangement for the Trusts and, if not, what should replace it. The review ran in two phases between April and August 2026.

Phase 1: the case for change

Phase 1 examined the current group model against four questions:

- Was the original November 2022 decision to form the group underpinned by a robust case for change, credible assumptions and sufficient Board challenge?
- Has the group model delivered, or is it capable of delivering, measurable improvement across performance, financial control, leadership stability and quality oversight?
- Does the group model align with current NHS expectations and national policy for performance, quality and financial sustainability?
- Has the group model supported safe, accessible and sustainable services for the 1.5 million people it serves, and has it reduced structural inefficiency across the 5 sites?

Phase 1 found that the original 2022 evaluation had not been designed to test rigorously whether a group model was the right answer to the Trusts' challenges, particularly on financial viability, and that clinical involvement in shaping the proposals had been limited. The case for change was therefore rebuilt from the evidence and is summarised in 'What the review found' in this report. Phase 1 also produced an options framework setting out a

shortlist for appraisal in Phase 2, covering both site configuration (defined as which sites should be managed together) and legal organisational form.

Phase 2: options appraisal

Phase 2 tested alternative organisational configurations (including legal form) against the rebuilt case for change and developed a recommended direction. Its conclusions are set out from the section 'Outcome of the options appraisal' onwards.

What was, and not, within scope

The review was bounded in five respects, each agreed with the Steering Group at the outset. These boundaries matter to the reading of the conclusions.

- **No change to clinical pathways, except potentially between the Group's own sites.** Clinical pathways for specialist services are frequently defined through national or regional designation processes, such as trauma and neonatal intensive care. The review does not recommend specific clinical service changes.
- **Community providers were out of scope.** The IRP commission concerns the acute partnership. Including community provision would conflate two distinct policy questions and would draw in stakeholders who have not been engaged through the IRP process. In addition, the local community providers are community interest companies and similar non-NHS social enterprise forms, and NHS organisational form changes are only legally available between NHS bodies.
- **The review was not asked to produce a path to breakeven.** Options were evaluated on their relative financial difference to the counterfactual and on the residual deficit each leaves, being the position that cannot be resolved within three years.
- **Changes already implemented or in progress under the Humber Acute Services Review (HASR) were treated as fixed** in the counterfactual. Anything within the agreed HASR scope that is not yet implemented remains available to the options.
- **The benefit horizon is three years,** with 2026/27 as year 0. This is the period within which opportunities should be implementable and benefits realised.

All organisational forms were in scope for the acute Trusts, including dissolution of the current group model and the more structurally disruptive configurations. Vertical integration was not separately modelled as a configuration option, although future provider and commissioning arrangements may still consider greater integration for services where this supports sustainability.

How the review was conducted

Governance and assurance of the evidence

The review was overseen by a Steering Group with senior representatives of NHSE IRP, NHSE North East and Yorkshire, the Humber and North Yorkshire ICB, and HHP. The evaluation process was undertaken independently by CF and then confirmed by the Steering Group.

Financial assumptions were confirmed separately by the Finance and Operations Steering Group, which includes representatives from HHP, the ICB and the NHSE regional team.

Evidence was confirmed as accurate with subject matter experts from the Group before it was used in the appraisal, and the evidence base as a whole was reviewed for factual accuracy by those experts and by the Steering Group. Where an item of evidence could not be confirmed, it was not relied upon.

Sources of evidence

Four sources of evidence underpin the review.

- **Quantitative data analysis** covering activity, workforce, productivity, patient flow, population demographics, service fragmentation and travel time. Data was drawn from Hospital Episode Statistics (HES), Model Hospital, the Office for National Statistics, the TravelTime API and Trust returns. The analysis was benchmarked against peer Trusts and, where relevant, national averages.
- **Financial modelling** built from the Trusts' Medium Term Plans, Provider Finance Returns and SLAM activity data, with assumptions confirmed by the Finance and Operations Steering Group.
- **Document review** of over 75 documents, covering the November 2022 case for change Board papers, group governance documentation, internal audit findings, HASR outputs and the NPIP evidence base.
- **Stakeholder engagement,** comprising clinical and wider stakeholder interviews alongside site visits to Hull Royal Infirmary, Castle Hill Hospital and Goole and District Hospital. Clinical engagement was undertaken through structured sessions with 8 of the 14 cross-HHP care groups, being those identified as potentially affected by changes to organisational form. Wider engagement involved interviews across Trust leadership, the ICB, NHSE, community providers, NLAG consultants and governors, local council leadership, and patient and VCSE representatives.

Engagement was deliberately scoped as targeted evidence-gathering for this review rather than as a comprehensive consultation. It is expected that the Trusts will lead further engagement as appropriate through the implementation process.

Analytical domains

The quantitative analysis was structured across 11 analytical domains. Where data allowed, metrics were tracked over recent years and benchmarked against peer Trusts and, where relevant, national averages. Peer groups for each Trust were identified using the NHS Model Hospital tool and a peer benchmarking tool, which match Trusts on measures including size and source of income, service type and site structure. The 11 domains were analysed as follows.

- **Population demographics:** age distribution, ethnicity, deprivation, life expectancy and general practice provision per head of population across each Trust's catchment.

- **Patient flows:** the activity within local authority districts and the Trust sites it flows to, and the activity at HUTH and NLAG and the local authority districts it flows from.
- **Service fragmentation:** services that are sub-scale, and where there may be an opportunity to consolidate provision running across multiple sites.
- **Activity:** how outpatient, emergency department, elective (day case and overnight) and non-elective activity levels have changed over time relative to peers.
- **Workforce:** substantive and bank and agency whole-time-equivalent staffing, vacancy, turnover and sickness absence rates.
- **Performance:** outpatient and inpatient standards in 2025/26, benchmarked against peers.
- **Quality and safety:** mortality, safety reports, readmissions, timely care metrics and CQC ratings.
- **Financial performance:** adjusted financial performance, the underlying position, bank and agency costs, cost improvement programme delivery and cost per weighted activity unit, benchmarked against peers where possible.
- **Travel time:** access to each site by car and public transport at LSOA level, the site closest to each population compared with the site it actually uses, and how travel times and patient flows would change under alternative site configurations for focus services, including the effect on Core20 populations.
- **Productivity opportunities:** baseline opportunities that exist regardless of organisational form, being admissions per population, length of stay, elective outpatient activity, high volume low complexity consolidation and repatriation of private sector activity, which are applied uniformly across all options to reset the activity baseline; and option-differential opportunities, being care group restructuring, bank and agency, and clinical workforce productivity, which depend on the governance and structural conditions of a given option and therefore create the financial gap between them.
- **Financial modelling:** a counterfactual is built for each Trust, adjusting current plans for at-risk savings, and aggregated to a group view to show the position if nothing changes. Each shortlisted option is then overlaid onto that baseline with its opportunities, disbenefits and transition costs, producing a net position per option that is stress-tested for sensitivity and affordability.

Approach to the options appraisal

A conventional approach to provider collaboration moves from partner identification to organisational form, and then to the evaluation of synergies, including those arising from site configuration. For HUTH and NLAG, the review found that this order does not hold. Site configuration is a binding constraint that determines which clinical and financial synergies are viable, and the organisational form that follows should be the lightest-touch arrangement capable of delivering the chosen configuration. The appraisal therefore proceeded in the order of site configuration first, organisational form second.

A four-stage evaluation framework was applied, with stages 1 and 2 undertaken in Phase 1 of the review and stages 3 and 4 in Phase 2:

- **Stage 1, fixed points:** whether any fixed points in clinical pathways, current estates, consultations, national guidance or national designations constrain the option set.
- **Stage 2, deliverability filter:** whether each site configuration is financially viable, clinically viable, accessible for patients and deliverable by outside partners. At this stage only options that were not viable were discounted.
- **Stage 3, preferred site configuration:** which viable site configuration performs best across seven evaluation criteria (domains) drawn from the re-built case for change.
- **Stage 4, organisational form:** which legally available organisational form best delivers the preferred configuration, assessed across the same seven domains.

The deliverability filter was applied to a longlist of 10 configurations covering the full range of arrangements involving HUTH, NLAG and potential external partners across the wider region. It established that no individual site is financially viable on a standalone basis; that Hull Royal Infirmary and Castle Hill Hospital must be managed together; that Scunthorpe General Hospital and Diana, Princess of Wales Hospital must be managed together, because of their shared clinical services; and that there is no suitable external partner. Doncaster and Bassetlaw Teaching Hospitals, United Lincolnshire Hospitals and York and Scarborough Teaching Hospitals each refer their own specialist activity to Sheffield, Nottingham and Leeds respectively, each faces its own financial challenge, and travel times and administrative boundaries work against closer working. Three viable site configurations remained, which were then mapped to the three legally available organisational forms to produce a shortlist of eight options.

Stages 3 and 4 were an evidence-based, qualitative evaluation against seven domains, each supported by key lines of enquiry and a defined evidence base. The domains are patient needs, leadership and positive culture, clinical sustainability, financial sustainability, operational performance and grip, feasibility to implement, and research and education. Each was weighted high, medium or low, and options were assessed across all domains with the pros and cons of each weighed across them. The assessment was throughout a relative comparison between options rather than a judgement on current performance at either Trust.

The domain-by-domain evidence and evaluation was documented in the CF Phase 2 papers provided to NHS England as commissioner, and the evidence base was assured as described in 'Governance and assurance of the evidence' above.

Limitations

The review was conducted at pace to meet the requirements of the IRP programme, and its conclusions should be read with the following limitations in mind.

- Clinical engagement usually spans months to enable holistic coverage of stakeholders. Engagement for this review was completed over a six-week period, which limited the ability to engage with multidisciplinary clinical colleagues below care group lead level.

- Time constraints limited the scope of the analysis. A full productivity or cost improvement programme plan was not in scope.
- In some cases external work was relied upon, including the use of the Medium Term Plan assumptions as the baseline for the financial model. These were validated where possible, but not rebuilt.
- Detailed financial modelling was not undertaken for the alignment of Goole and District Hospital. The non-recurrent cost of potentially disaggregating the site from NLAG's financial, contracting and corporate arrangements under a HUTH-aligned option has not been quantified at this stage.

None of these limitations changes the direction of the review's conclusions. They do mean that the appraisal should be treated as a directional comparison between structural choices, and that further work will be required on service-level and financial detail as implementation proceeds.

What the review found

The Group was established to address leadership retention, clinical sustainability issues and financial pressure across HUTH and NLAG. The review found that many of these challenges remain, that some have worsened since group formation, and that further challenges have emerged.

- **The Group configuration does not support local focus and partnership to deliver the left shift and reduce acute activity.** Most acute activity flows to the nearest hospital, the geographical barrier of the Humber estuary makes travel difficult, there are material differences in the demographics of the HUTH and NLAG populations, the administrative boundaries of partner organisations divide along the Humber, and local partnerships have deteriorated since group formation.
- **The Trusts are not delivering national standards on the majority of headline measures.** This includes 53.8% performance in February 2026 at Hull Royal Infirmary against the four-hour emergency standard of 78%, and 59.6% performance in 2025/26 at NLAG against the 92% referral to treatment standard. Many of these challenges pre-date the Group model, but it has not led to improvement.
- **Workforce engagement and cultural challenges at NLAG are longstanding and pre-date the Group.** National Staff Survey results have been consistently weak over several years, both before and since the Group was formed, indicating that these are not issues created by the current arrangements, although they have not yet been resolved by them. NLAG consultants have consistently raised objections to the Group model since 2022, escalating to a recent formal vote of no confidence in the current operating model.
- **The scope of the Group executive role, spanning two highly challenged organisations, has created demands beyond what any leadership team could realistically sustain.** Board departures since the group decision have been around seven times the pre-decision rate, which has been a barrier to improvement.

- **Many clinical services remain sub-scale across both Trusts,** although many of the constraints on resolving them sit outside the Group's control. There are some examples of clinical workforce sharing, but these mostly predate group formation.
- **The current group operating model is not fit for purpose and does not provide the clarity of accountability or grip** required to resolve clinical, performance and financial challenges. Accountability is separated from authority within the Trusts, and the absence of a coherent accountability framework below Chief Executive and Board reporting results in an insufficient basis for assurance.
- **The longstanding underlying financial position remains unsustainable** and has deteriorated further in recent years, with an underlying financial deficit of £128m in 2025/26 and the identification of only £15m of cost improvement initiatives as at March 2026 against a target of £98m in 2026/27.

These challenges are multifactorial. The review found that they will not be resolved simply by changes to organisational form, or by the two organisations acting alone.

What the organisational form has to support

HHP does not have an agreed clinical strategy for individual or groups of services, other than the aims set out in the Humber Acute Services Review from 2019 and the high-level Clinical Services Strategy agreed in October 2025. Service-level decisions on fragile services and the tertiary portfolio remain to be taken. The organisational form must therefore be one that can support whatever configuration of services ultimately emerges from those decisions.

Stakeholders and clinicians interviewed through the review expressed a consistent set of aims for the organisational form: that services meet the needs of populations and reduce inequalities between them; that patients receive high quality, safe care to the same standard across the Humber; that care is accessible and delivered as close to home as possible; and that the clinical model is financially sustainable.

To deliver those aims, the review found that the operating model needs to provide visible, accountable leadership at every site with authority matched to responsibility, a coherent accountability framework, and sufficient bandwidth to support partnership working to deliver care closer to home.

Outcome of the options appraisal

The appraisal produced three conclusions, taken in sequence. The summary evaluation for each is set out below. The domain-by-domain evidence was documented in the CF Phase 2 options appraisal papers provided to NHS England as commissioner.

Site configuration: a split-site configuration

Three site configurations were viable following the deliverability filter: five sites operating as a single configuration (Option 1); a split-site configuration with Goole and District Hospital (GDH) aligned to NLAG (Option 2); and a split-site configuration with GDH aligned to HUTH (Option 3). The review recommends moving towards a split-site configuration, each with

distinct leadership and clear local accountability, with the organisational form required to deliver this assessed separately.

Two of the three most heavily weighted domains, patient needs and leadership and positive culture, support a split configuration, and the third, feasibility to implement, shows no significant difference. The only domain favouring a five-site configuration is research and education, which carries the lowest weighting. The remaining four domains show no significant difference.

The recommended configuration is underpinned by structured collaboration and is not a return to the position before the Group. HUTH and NLAG remain interdependent, and the arrangements that currently work across them should be sustained rather than dismantled. Cross-site cover in cardiology, anaesthetics, critical care, urology and therapies can continue under contracted arrangements. Collaboration could be sustained or built further in shared corporate, support and enabling functions, digital infrastructure, workforce arrangements, research and education, and formally commissioned specialist services.

Goole and District Hospital: alignment to NLAG

Once a split-site configuration was recommended, the review considered whether Goole and District Hospital (GDH) should continue to be part of NLAG or transfer to HUTH. Both options were assessed across the same seven domains.

Alignment to NLAG is supported by leadership and positive culture, clinical sustainability, operational performance and grip, and feasibility to implement, which include two of the three most heavily weighted domains. No domain supports alignment to HUTH. Patient needs, financial sustainability and research and education show no significant difference between the options.

The review therefore recommends that GDH remains part of NLAG, although decisions about future service provision at the site will remain commissioner-led. This reflects the strong clinical and corporate links to NLAG and the NLAG focus of local care. Moving GDH to HUTH would be disruptive, would take time and focus, and would most likely require a statutory transfer scheme, which rests on NHS England discretion and is therefore outside the Trusts' control. Services at GDH will continue to be delivered and developed by both NLAG and HUTH, and the review recommends that:

- HUTH continues to deliver elective work at GDH, with a commissioner-led review of how high volume, low complexity work is delivered across the Humber, including opportunities for developing the site.
- NLAG continues to deliver community services at GDH, with opportunities for streamlined working across HUTH and NLAG explored as part of the work on setting up provider collaboration agreements, and subject to any commissioner-led wider review of community service provision.
- Complex neuro-rehabilitation remains with NLAG, subject to any commissioner-led wider review of highly specialist services.

Organisational form: dissolution of the Group

Organisational form was assessed following site configuration and the alignment of GDH, because the form chosen is that which best supports delivery of the recommended site configuration. Three forms are legally available: a committee in common group with aligned membership (Form A), a single foundation trust via acquisition by NLAG (Form B), and dissolution of the Group (Form C).

A single board across two statutory entities is not legally possible, because certain corporate governance and regulatory functions are non-delegable and must be discharged by each Trust's own Board. A merger of equals into a new foundation trust is also not available: HUTH is an NHS Trust at Segment 5 of the NHS Oversight Framework and cannot access a current authorisation route to foundation trust status within IRP timescales, and the traditional route has been effectively dormant since 2015. Acquisition by NLAG is therefore the only practically accessible single-entity route.

Form A is the current arrangement and was ruled out on the basis of the case for change, which shows that it has not addressed the challenges it was established to resolve, with the financial position worsening since group formation and further challenges emerging. Forms B and C were appraised against the seven domains. All three domains weighted as high support Form C.

- **Patient needs.** The same statutory relationships exist under either form. Under Form B a single board holds all of them; under Form C each Trust holds only the relationships for its own geography, allowing greater focus on each locality. Patient access, pathways and clinical quality are unaffected by legal form.
- **Leadership and positive culture.** Form C aligns accountability with responsibility, giving each Trust a board answerable for its own performance, finances and workforce. A single foundation trust would still require bank-based leadership operating with delegated rather than statutory authority across a dispersed geography. Opposition to a joint organisation runs across the NLAG consultant body and its governors, and the developmental governance review found a cultural divide that a merger would be more likely to compound than resolve.
- **Feasibility to implement.** The differentiator is complexity rather than pace. A single foundation trust requires a formal merger business case and Secretary of State approval, so it cannot be delivered by the Trusts alone, whereas dissolution requires no external consent and keeps the work within the Trusts' own control. Neither form is materially faster.

Clinical sustainability shows a marginal advantage to Form B on workforce flexibility, because joint appointments and cross-site cover operate under a single employer, but this is medium-weighted and the review did not find the difference material. The remaining three domains show no significant difference.

The recommended direction

The review therefore recommends a split-site configuration, with GDH aligned to NLAG, and dissolution of the HHP Group.

This would result in two independent statutory entities, with collaboration agreements and no shared Group governance structure. The recommended option depends on and is underpinned by structured collaboration. HUTH and NLAG remain interdependent. Where particular specialties need greater scale to support recruitment, retention and sustainable care, services may be commissioned to support workforce retention and address service fragility, and there are opportunities for support and corporate services to continue to be delivered once across both Trusts.

The review did not reach this conclusion on financial grounds. Financial sustainability showed no significant difference between options at every stage of the appraisal. The recommended option delivers £9.0m of net recurrent benefit at full-year effect against one-off costs of £1.7m, which is immaterial against a combined risk-adjusted deficit (the Counter-factual position) of £74.7m in 2029/30. The benefits and costs also fall unevenly: the clinical productivity benefits arising from more focused local accountability are available only to NLAG, while the recurrent corporate costs fall on both Trusts, so HUTH's position deteriorates by £2.1m against the counterfactual while NLAG's improves by £9.6m. No commissioner contribution to the costs of organisational separation or transition is assumed, and none is included in the modelled position; the source of funding for these one-off costs has not been agreed and remains a decision for the Trusts, the ICB and NHS England.

The financial opportunity of greatest consequence is place-based rather than configuration-dependent. Five baseline productivity opportunities - admissions avoidance, reduced length of stay, outpatient transformation, and two further schemes - are available regardless of site configuration or organisational form, and carry an indicative gross range of £37.1m to £106.7m at full-year impact. Closing the deficit position rests on two levers, recurrent productivity improvement and potential commissioner-led decisions on sub-scale services, neither of which depends on the direction recommended here, though the recommended direction may better enable delivery.

Recommendations

The review makes the following recommendations, split into two subsections. The first set of recommendations includes the direction itself and the actions required to protect its success - without them, the benefits set out above are put at risk. The second subsection includes recommendations that would be relevant for any of the options. Organisational form does not, on its own, resolve every challenge facing the Trusts, and these recommendations set out the action still needed elsewhere. Each is addressed to the body that holds it.

Recommendations that protect the recommended direction

1. **To the Boards in Common: adopt a split-site configuration, with GDH aligned to NLAG, and dissolution of the HHP Group.** The case rests on two findings: each Trust

would plan services around a single population with a consistent set of out of hospital partners, and the scope of senior leadership posts would come within a range that can realistically be filled and held. On balance, across the assessment, this direction holds up against the alternatives; the trade-offs, including the costs set out above, are real but do not change the recommendation.

2. **To the Boards in Common: run a shadow appointment process during the transition period, so that executive leadership is not left to default to a single Trust by virtue of current employment.** Because current Group executives are employed by HUTH, they would remain HUTH employees at dissolution unless they apply for and are appointed to a role at NLAG; without a managed cross-Trust shadow process, NLAG is at significant risk of starting the post-dissolution period with little to no incumbent executive leadership. The recommended direction rests on each Trust having a board and executive able to hold its side of the collaboration agreements recommended below, and either Trust reaching dissolution without that leadership, or without the working relationships that currently sustain cross-Trust arrangements, would undermine those agreements however well they are documented. An NLAG designate chief executive should therefore be appointed early through that shadow process. The Boards should also consider appointing wider designate Trust executive roles early, especially for medical, to lead the clinical work of the transition and hold the cross-Trust clinical arrangements through it.
3. **To the Boards in Common: put the interdependencies that currently work into formal collaboration agreements before dissolution rather than after.** The principal risk to the recommendation is that arrangements which currently operate on management instruction and goodwill become discretionary once the Trusts are sovereign. Cross-site cover in cardiology, anaesthetics, critical care, urology and therapies, shared corporate and digital arrangements, and research and education links should each carry a named owner, a service level and an exit route. Responsibility for these arrangements rests with HUTH and NLAG. They are provider-to-provider arrangements, made and maintained between the two Trusts. Commissioner contracting is the mechanism only where a service needs to be secured as a commissioned model, as set out in the recommendations below.
4. **To NHS England: confirm the legal route to each Trust's continuing statutory form, and run both statutory Board appointment routes to a shared timetable.** Recruitment and retention in two Segment 5 Trusts is the most significant delivery risk to the recommendation, and differing appointment lead times at the two Trusts would compound it. NHS England's own assurance process should also track delivery of the executive shadow appointment process set out above, given the risk that NLAG could otherwise exit dissolution without incumbent executive leadership.
5. **To NHS England: confirm the governance, assurance, legal and approval process that applies through mobilisation and separation, including the gateways, decision points and organisational responsibilities at each.** NHS England should work with all

parties to agree the actions that follow from this review, through the IRP Recovery Compact. The Compact should be signed by both Trusts, the ICB and NHS England regionally and nationally, so that each party is committed to the actions it owns rather than the Trusts being left to hold the structure alone.

6. **To NHS England: accept a dissolution date recommended against tested conditions rather than fixed in advance.** Clinical continuity, corporate and regulatory readiness, and governance and people should each be tested and signed off before a dissolution date is set.

Recommendations that address what organisational form does not resolve

7. **To the Boards: state explicitly what dissolution is and is not expected to deliver.** The recommended direction addresses accountability, leadership span and local partnership. It does not resolve the underlying financial position, sub-scale services or the estates backlog. Recording this now protects the decision from later being judged against outcomes it was never designed to achieve.
8. **To the ICB: lead the commissioning decisions on which the model depends, and publish a decision schedule with a named senior lead held through the ICB's own restructuring.** The reviews required are set out in the following section 'What no organisational form can resolve, and the reviews that must follow'. Without a different commissioning and service strategy for the Humber, the structural change will not deliver the clinical, performance or financial outcomes expected of it, and neither Trust will reach a sustainable position. The review recommends the commissioning actions required; it does not define the programme through which the ICB takes them. The scope, governance, prioritisation, affordability and resourcing of any resulting commissioner work programme are for the ICB to agree separately, through its own governance.
9. **To the ICB: where the commissioning reviews conclude that a service needs to operate at greater scale across sites, the mechanism for delivering that collaboration is a formal commissioner-led contractual arrangement rather than shared organisational form.** This may include services where one Trust takes clinical responsibility across both banks while continuing to deliver on more than one site, so that scale is achieved in the service rather than by moving activity to fewer sites. The review has not determined which services require this, nor which Trust should lead; those questions sit with the reviews themselves. Where such arrangements are put in place, clarity over the activity each Trust delivers, and on which site, is likely to determine whether they succeed.
10. **To NHS England: maintain IRP sponsorship through the transition, and resolve deficit support and the rejected 2026/27 plans.** The recommendation assumes continued national attention and an agreed financial trajectory to which each Trust is held.

What no organisational form can resolve, and the reviews that must follow

Several constraints persist under every option considered. The recommendation is presented on that basis rather than as a resolution of them. The recommended direction is necessary but not sufficient.

Constraints that persist under every option

- **The largest financial opportunities sit outside the Trusts' control.** Delivery depends on working in partnership with out-of-hospital and primary care partners to shift activity closer to home. The two largest baseline opportunities identified, reducing non-elective admissions and reducing elective outpatient activity, both depend on care being delivered outside hospital rather than on how the Trusts are structured. This is a commissioning and place-based collaboration question rather than a matter of provider form.
- **Sub-scale services remain unresolved on both banks.** Cross-Humber consolidation is often not viable, consolidation may not close the gap to the national median, and any change would require further statutory processes regardless of the organisational form adopted. These issues may be addressed through commissioner-led single-provider contractual arrangements for specialist services.
- **Community and primary care fragility persists.** The area has a low number of GPs per head of population, and community partners told the review that their relationships with Group members have largely deteriorated. Rebuilding them sits outside the scope of organisational form.
- **Estates pressures are structural.** Although not a focus of this review, stakeholders noted significant estates challenges. The five sites carry a combined backlog maintenance requirement of around £159m, of which around £103m is high or significant risk. Estates and facilities cost per square metre has deteriorated at both Trusts, in absolute terms and against peers, since formation.
- **A residual structural deficit is likely to persist regardless of organisational form.** The recommended option leaves a combined risk-adjusted deficit of £74.7m in 2029/30, widening to £79.5m after prudent sensitivities. The distance between the best and worst performing options, measured cumulatively across the 4 years, is £17.8m. None of these figures closes the deficit. Two earlier reviews support a structural deficit specific to NLAG's two-site configuration: A review in 2018 estimated around £12.2m,[1] equivalent to approximately £17.5m at current prices, and a different review in 2026 estimated £22.6m attributable to running services across two sites.[2] Financial sustainability depends less on site configuration or legal form than on the Trusts' ability to deliver

[1] NLAG, Review of the 2017/18 structural deficit, June 2018.
[2] PA Consulting, HHP – Barriers and Limitations to Improvement, July 2026.

recurrent productivity improvements, and this is a limitation of the appraisal's scope rather than a gap in delivery.

The reviews that must follow

The following decisions are commissioner-led. The review has not pre-judged their prioritisation, timing or outcome, and the recommended organisational form does not depend on any particular outcome from them. Without them, however, the structural change will not deliver the clinical, performance or financial outcomes expected of it, as set out in recommendation 8 above. Future commissioning decisions, service models, provider roles and contractual arrangements remain matters for separate ICB consideration and approval, through the ICB's own evidence, engagement, equality and statutory governance processes.

Taken together, the recommended reviews constitute a commissioning programme of substantial scale, running alongside the transition programme rather than within it. Several of these decisions are politically sensitive, including the future of fragile services and the sustainability of two-site provision, and will require sustained national support if they are to be taken rather than deferred.

1. **High volume, low complexity planned care across the Humber.** How this work is delivered across the five sites, including the role of GDH and the opportunity to develop the site further. Owner: Humber and North Yorkshire ICB, with the Trusts.
2. **How the Goole population is best served.** The range of services provided at GDH, given that patients are routinely sent elsewhere for procedures that could be undertaken there, and the use of the wider GDH estate for community provision. Owner: Humber and North Yorkshire ICB, with the Trusts.
3. **The sustainability of NLAG's 2-site district general hospital provision.** This is only partly addressed by the Humber Acute Services Review, and two separate earlier reviews identified a structural deficit at NLAG associated with running services across two sites. Owner: Humber and North Yorkshire ICB, with NHSE.
4. **Fragile services, in particular maternity and paediatrics.** The configuration questions identified but not resolved through HASR and the Group's Clinical Services Strategy. Owner: Humber and North Yorkshire ICB.
5. **Sub-scale specialised services where the answer is regional.** Where the required scale is not available within the Humber, the review is a regional one, including consideration of a lead provider role for HUTH across the Humber for specialist services. Owner: NHS England, regional commissioners.
6. **Out of hospital capacity and the shift of activity closer to home.** The capacity in community, primary and social care on which the largest financial opportunities depend, and the development of neighbourhood teams around each Trust's population. Owner: Humber and North Yorkshire ICB, with local authorities and community providers.

The review recommends that the Boards, the ICB and NHS England each record which of these they own, and by when, at the point the direction is agreed, captured in the IRP

Recovery Compact recommended above. This is a recommendation to inform future planning, not a condition attached to the organisational form, and it does not predetermine or commit the ICB or NHS England to any of the listed decisions in advance of its own governance process. Their absence would not invalidate the recommended organisational form, but the Trusts would be left holding a structure without the accompanying commissioning decisions that the review's analysis suggests are needed to realise the improvement fully. On the review's analysis, without a different commissioning and service strategy for the Humber neither Trust reaches a sustainable position. The residual structural deficit described above is likely to persist unless the sustainability of NLAG's two-site provision is separately resolved and the Trusts are able to deliver recurrent productivity improvements; neither is something any organisational form can deliver on its own, and neither is committed to by this review.