NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

AGENDA

A meeting of the Trust Boards-in-Common (meeting held in Public) to be held on Thursday, 12 November 2026 at 10.00 am to 12.45 pm in the Boardroom, Diana, Princess of Wales Hospital

For the purpose of transacting the business set out below:

No.	Agenda Item	Format	Purpose	Time
1.	**CORE / STANDING BUSINESS ITEMS**			
1.1	**Welcome, Group Chair's Opening Remarks and Apologies for Absence** Alan Downey, Group Chair	Verbal	Information	**10:00**
1.2	**Staff Charter and Values** Alan Downey, Group Chair	Attached	Information	
1.3	**Patient Story** Jo Ledger, Deputy Chief Nurse	Verbal	Information	**10:05**
1.4	**Questions from the Public and Governors** Alan Downey, Group Chair	Verbal	Discussion	**10:25**
1.5	**Declarations of Interest** Alan Downey, Group Chair	Attached	Information	**10:30**
1.6	**Minutes of the Meeting held on Friday, 9 October 2026** Alan Downey, Group Chair	BIC(26)274 Attached	Approval	
1.7	**Minutes of the HUTH Annual General Meeting (AGM) on Wednesday, 14 October 2026** Alan Downey, Group Chair	BIC(26)275 Attached	Approval	
1.8	**Matters Arising** Alan Downey, Group Chair	Verbal	Discussion	
1.9	**Action Tracker** - **Public** Alan Downey, Group Chair	BIC(26)276 Attached	Assurance	
2.	**CHAIR REPORT**			
2.1	**Group Chair's Briefing** Alan Downey, Group Chair	Verbal	Information	**10:35**
2.2	**Group Chief Executive's Briefing** Lyn Simpson, Group Chief Executive	BIC(26)277 Attached	Information	**10:45**
2.3	**Integrated Improvement Plan (IIP) (including update on CQC Section 29A, Financial Recovery Plan Update & Transition Programme** Lyn Simpson, Group Chief Executive, Emma Sayner, Chief Financial Officer & Ben Smith, NHS England	BIC(26)278 Attached	Information	**10:55**
2.4	**National Reports and Guidance** Lyn Simpson, Group Chief Executive	BIC(26)281 Attached	Information	**11:10**

3.	**PATIENT SAFETY UPDATE**			
3.1	**Monthly Patient Safety Update (including Assurance Committee Update)** Mr Peter Sedman, Deputy Medical Officer & Hilda Gwilliams, Group Chief Patient Safety Officer	BIC(26)282 Attached	Assurance	**11:15**
3.2	**Marthas Rule** Hilda Gwilliams, Group Chief Patient Safety Officer & Jo Ledger, Deputy Chief Nurse	BIC(26)283 Attached	Assurance	**11:25**
3.3	**Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG and HUTH** Dr David Sulch, NED Maternity & Neonatal Safety Champion	BIC(26)284 Attached	Assurance	**11:35**
3.4	**Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH** • Maternity Incentive Scheme (MIS) Year 8 Compliance Jo Ledger, Deputy Chief Nurse & Yvonne McGrath, Group Midwifery Director	BIC(26)285 Attached	Assurance	**11:40**
3.5	**Care Quality Commission (CQC) Update** Hilda Gwilliams, Group Chief Patient Safety Officer	BIC(26)305 Attached	Assurance	**11:50**
4.	**STRATEGIC PROGRESS**			
4.1	**Public Purse (including Assurance Committee Update & Approval of Monthly Cash Drawdown)** Emma Sayner, Group Chief Financial Officer & Murray Macdonald, NED Committee Chair	BIC(26)286 Attached	Assurance / Approval	**12:00**
4.2	**National Operating Framework Report** Sam Peate, Group Chief Operating Officer	BIC(26)287 Attached	Information	**12:10**
4.3	**Performance & Accountability Framework** Sam Peate, Group Chief Operating Officer	BIC(26)288 Attached	Approval	
5.	**OTHER ITEMS FOR ASSURANCE**			
5.1	**Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report** Jane Hawkard, NED Committee Chair	BIC(26)289 Attached	Assurance	**12:20**
6.	**OTHER ITEMS FOR APPROVAL**			
6.1	**HHP Transition Programme October Report** Lyn Simpson, Group Chief Executive	BIC(26)301 Attached	Approval	**12:25**
6.2	**Governance Arrangements in Transition and Leading to Dissolution of the Humber Health Partnership** Keith Haynes, Interim Board Secretary	BIC(26)309 Attached	Approval	**12:35**
7.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**			
7.1	**Items for Information / Supporting Papers (as per Appendix A)** Alan Downey, Group Chair	Verbal	Information / Assurance	
8.	**ANY OTHER URGENT BUSINESS**			
8.1	**Any Other Urgent Business** Alan Downey, Group Chair / All	Verbal		**12:40**

9.	**MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON**			
9.1	**To agree any matters requiring referral for consideration on behalf of the Trust Boards by any of the Board Committees-in-Common** Alan Downey, Group Chair / All	Verbal	Discussion	
10.	**DATE OF THE NEXT MEETING**			
10.1	**The next meeting of the Boards-in-Common will be held on Thursday, 10 December 2026**			

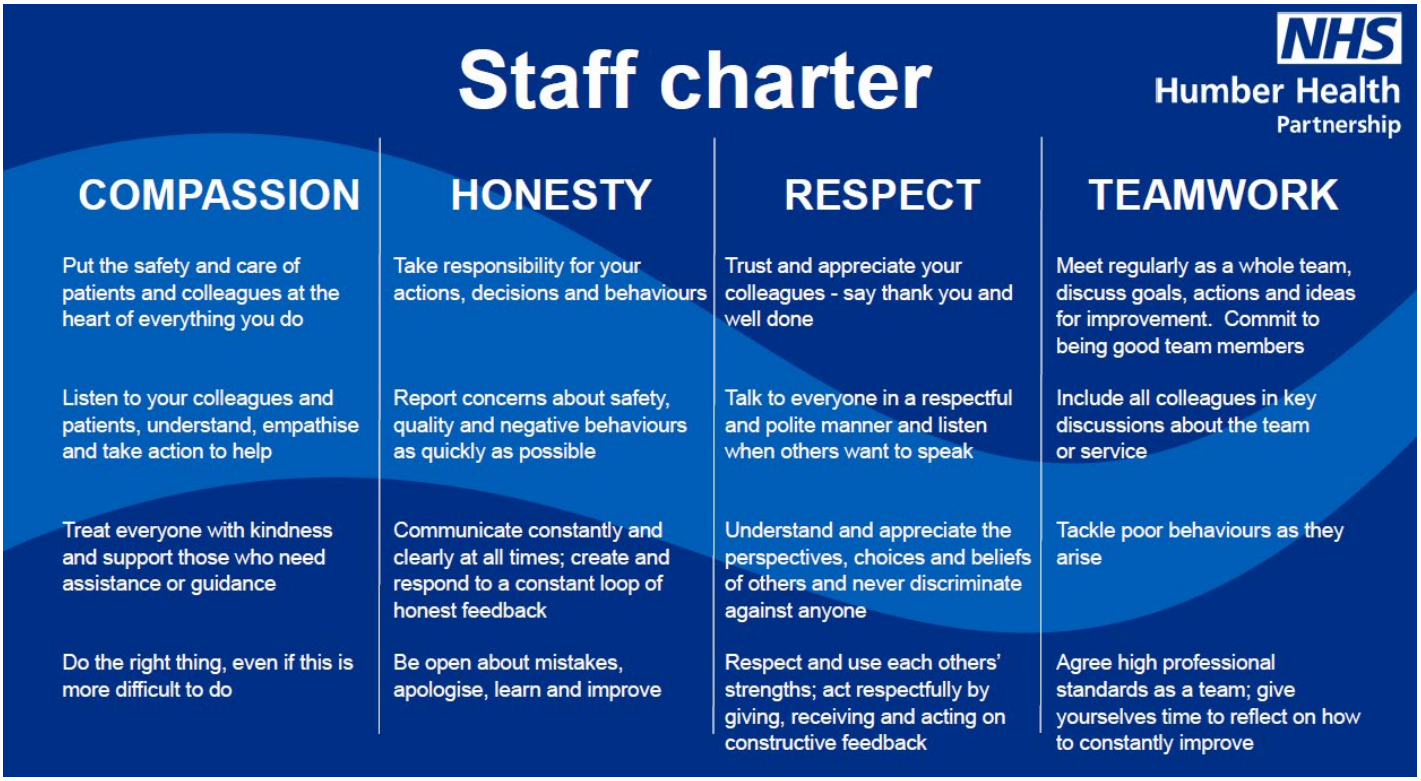
KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

7.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**	
7.1	**Quality & Safety Committees-in-Common**	
7.1.1	**Quality & Safety Committees-in-Common Minutes – September 2026** Dr David Sulch, NED Committee Chair	BIC(26)291 Attached
7.2	**Performance, Estates & Finance Committees-in-Common**	
7.2.1	**Performance, Estates & Finance Committees-in-Common Minutes – October 2026** Murray Macdonald, NED Committee Chair	BIC(26)292 Attached
7.2.2	**Finance Report – Month 6** Emma Sayner, Group Chief Financial Officer	BIC(26)293 Attached
7.3	**Workforce, Education & Culture Committees-in-Common**	
7.3.1	None	
7.4	**Audit, Risk & Governance Committees-in-Common**	
7.4.1	**Audit, Risk & Governance Committees-in-Common Minutes – July 2026** Jane Hawkard, Non-Executive Director Committee Chair	BIC(26)295 Attached
7.5	**Other**	
7.5.1	**Integrated Performance Report (IPR)** Sam Peate, Group Chief Delivery Officer	BIC(26)297 Attached

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

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



Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

DRAFT

TRUST BOARDS-IN-COMMON MEETING IN PUBLIC

Minutes of the meeting held on Friday, 9 October 2026 at 10.00 am

in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Alan Downey	Group Chair
Lyn Simpson	Group Chief Executive
Murray Macdonald	Interim Chair – NLaG
Therese Patten	Interim Chief Executive - NLaG
Jo Ledger	Deputy Chief Nurse (covering Group Chief Nurse)
Sam Peate	Group Chief Delivery Officer
Mr Peter Sedman	Deputy Chief Medical Officer (covering Group Chief Medical Officer)
Professor John Craig	Non-Executive Director (HUTH)
Joanne Gander	Group Non-Executive Director
Murray Macdonald	Group Vice Chair
Dr David Sulch	Group Non-Executive Director

In Attendance:

Dr Kieran Baker	Group Chief Digital Information Officer
Dr Paul Edmondson-Jones	Associate Group Non-Executive Director
Hilda Gwilliams	Group Chief Patient Safety Officer
Keith Haynes	Interim Board Secretary
Yvonne McGrath	Group Director of Midwifery (for item 1.3)
Helen Marks	Group Chief People Officer
John Palmer	Trust Member (attended virtually)
Ian Reekie	Lead Governor
Sarah Meggitt	Executive Assistant to the Group Chair (minute taker)

KEY

HUTH - Hull University Teaching Hospitals NHS Trust

NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

1. CORE BUSINESS ITEMS

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

Alan Downey welcomed Board members and observers to the meeting and declared the meeting open at 10.00 am.

The Board welcomed several members attending their first meeting since joining the organisation. Dr Kieran Baker had joined as Group Chief Digital Information Officer. Dr Paul Edmondson Jones had recently joined as Group Associate Non-

Executive Director (NED) and would become a HUTH NED following the dissolution of the Group. Joanne Gander, Group NED, and Dr Ekta Elston, Associate NED, had also joined the organisation and would be aligned to NLaG following the dissolution of the Group.

It was noted that Murray Macdonald had been appointed Interim Chair of NLaG and Therese Patten as Interim Chief Executive of NLaG. Therese Patten expressed her pleasure at joining the organisation and noted the warm welcome she had received from staff whom she had met to date.

Apologies for absence were received from

Julie Beilby	Group Non-Executive Director
Dr Ekta Elston	Associate Group Non-Executive Director
Jane Hawkard	Group Non-Executive Director
Emma Sayner	Group Chief Financial Officer

1.2 **Staff Charter and Values**

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

1.3 **Patient Story**

Yvonne McGrath introduced the patient story, which described the care of a child with complex care needs. The child's parents had raised concerns regarding medication management, inaccuracies in documentation, communication between the clinical team and the family, and a few other aspects of care. The family felt that, despite raising these concerns, resulting improvements had not always been evident.

A meeting had subsequently been held with the parents, and a review undertaken by the paediatric team. The review acknowledged that some of the issues and concerns raised had not always been appropriately addressed.

It was reported that improvements had since been implemented, including the introduction of nursing support during ward rounds to strengthen communication between clinicians and the family. All actions arising from the review had been completed to support learning and improve practice.

Dr David Sulch welcomed the introduction of nursing support during ward rounds, noting that this had previously been established practice but had reduced in many hospitals due to ward staffing pressures. He sought assurance that, given the complexity of the child's needs, there was consistency in consultant-led care during each hospital attendance.

Jo Ledger supported the points raised and noted that the case reinforced the importance of key worker roles in supporting patients and families. She also welcomed nursing involvement in ward rounds. While it was positive that the agreed actions had been implemented, she emphasised the importance of demonstrating that these actions were resulting in sustained improvements. Yvonne McGrath advised that assurance on the improvements would be provided through the appropriate governance processes and reported to the

relevant meetings.

Professor John Craig felt that it was important to acknowledge that the parents and carers of particular patients were often the experts of what they required due to their knowledge of the care received.

Jo Gander queried whether the introduction of Martha's law would have any impact in the future. Yvonne McGrath advised that this mainly focussed on the deterioration of patients, however, clearer guidance was expected. Often such concerns were raised whilst patients were still being cared for in hospital and such concerns were raised with the Patient Advice & Liaison Service (PALS). If concerns were raised more directly, they could be addressed at the time rather than through that route. This could potentially then avoid a poor experience for patients.

Hilda Gwilliams reflected on changes in clinical practice over recent years, noting that hospitals had moved away from a model whereby a single consultant had oversight of a particular ward. She highlighted the importance of multidisciplinary working during ward rounds and welcomed nursing involvement. She also noted the value of tools to support patients with complex needs and considered that identifying a key individual to provide continuity of support could help build relationships with patients during their care.

Murray Macdonald welcomed the action plans that had been put in place but noted that sustaining changes in behaviours and culture could be more challenging. He sought assurance on how staff would be supported to listen to and respond to patients' concerns at the point they were raised, enabling issues to be resolved wherever possible.

Yvonne McGrath emphasised the importance of relationship-based care and acknowledged that, particularly within maternity services, continuity of relationships and trust had been affected by a range of changes and initiatives. She suggested that consideration be given to how staff in non-registered roles might be utilised differently to support patients with complex needs and provide greater continuity of care.

Lyn Simpson queried whether a case conference approach could be considered for children with complex needs to identify a key worker who could provide continuity of support throughout the child's care journey, including across community and education settings. Mr Peter Sedman highlighted the importance of appropriate governance arrangements and organisational commitment to such an approach, noting the longer-term benefits for patients.

Alan Downey queried whether future patient stories could provide an opportunity for a patient or carer to share their experience directly with the Board. Yvonne McGrath agreed to explore this for future patient stories.

Action: Jo Ledger to consider patient stories being shared by patient or family member

1.3 **Questions from the Public and Governors**

Alan Downey advised that a question had been received from the public and that

the response to this would be shared in the minutes of the meeting.

Keith Haynes provided detail of the question that had been raised.

Questions raised and responses:

What are the Trust's protocols for managing patients whose consultant is absent for an extended period?

The NHS operates on the principle that patients remain under the care of a clinical service, rather than being solely dependent on an individual consultant. Where a consultant is unexpectedly absent for a prolonged period, clinical teams and operational managers review arrangements to ensure continuity of care. This may include allocating clinical responsibility to another consultant, sharing workload across the wider team, or identifying alternative clinical oversight arrangements where necessary.

Patients waiting for investigation, treatment or follow-up remain on the relevant waiting lists and continue to be managed in accordance with national NHS elective care guidance. Consultant absence does not pause a patient's waiting time or remove them from established monitoring processes.

How is this monitored to ensure patients are not being neglected or failed unnecessarily?

Patients continue to be monitored through the Trust's established waiting list management processes and operational oversight arrangements. All patients remain visible on referral-to-treatment (RTT) and patient tracking systems, which allow services to identify individuals who are waiting for care and to monitor delays.

Where a patient's condition deteriorates significantly whilst waiting for treatment or review, national guidance requires that they are reassessed and their clinical priority reviewed. This enables patients whose needs have become more urgent to be reprioritised where appropriate.

Operational and administrative teams also regularly review outstanding clinical work associated with prolonged consultant absence. This may include redistributing clinic activity, reviewing clinical correspondence, managing investigation results and ensuring appropriate clinical oversight is maintained.

Is this information recorded and reported through local, regional or national procedures, or are these patients the "forgotten ones"?

Patients affected by consultant absence are not excluded from local or national monitoring arrangements. They remain part of routine waiting list, RTT and elective care reporting processes and continue to be included in performance monitoring undertaken by the Trust and reported through NHS performance frameworks.

The Trust does not regard such patients as "forgotten". Whilst prolonged staff absence can sometimes create challenges and may contribute to delays in specific circumstances, services are expected to put arrangements in place to

maintain oversight of affected patients and to ensure that care continues to be delivered according to clinical need. Patients whose condition worsens are encouraged to seek further medical advice so that their circumstances can be reviewed and, where necessary, their priority reassessed.

In summary, patients remain the responsibility of the clinical service throughout their care pathway. Robust waiting list management processes, clinical review mechanisms and team-based models of care are intended to ensure that patients continue to be monitored and managed safely, even during periods of prolonged consultant absence.

Alan Downey acknowledged that a response would be provided to the individual that had raised the query, however, he requested that when the response was provided to them a query is raised as to whether they could provide any further detail in relation to their care.

Post Meeting Note:
The patient who had raised the question was contacted in respect of the queries raised and these were being reviewed further.

1.4 **Declarations of Interest**

Alan Downey sought declarations of interest from Board members.

Murray Macdonald advised that he had been appointed as the Interim Chair of NLaG.

Jo Gander advised that she held an additional NED role at Doncaster and Bassetlaw NHS Trust which would be declared.

1.5 **To approve the minutes of the Trust Boards-in-Common meeting held on Thursday, 9 September 2026 – BIC(26)232**

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

1.6 **Matters Arising**

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

1.7 **Action Tracker – Public – BIC(26)233**

Alan Downey referred to the action tracker and sought updates from Board members, he reminded Board members to ensure they met target dates for actions when they are set.

- Item 5.1, 12 February 2026 meeting, Nursing Establishment Paper - risk register score to be reviewed. Jo Ledger advised that this risk was reviewed on a monthly basis. The risk related to HUTH and investment had been supported by Board members the previous year. She added that newly qualified nurses were now in place, she hoped, therefore, that this could then

be updated in terms of the risk. It was explained that this was also measured within the Integrated Performance Report (IPR).

- Item 5.2, 9 April 2026 meeting, Establishment Review of Safer Staffing. Jo Ledger advised that she had met with Murray Macdonald to review the current report. Once this had been updated it would first be shared with the Executive Team and then with Board members at the November 2026 meeting.

- Item 1.3, 14 May 2026 meeting, Patient Story - Safeguarding Capacity Update. Jo Ledger advised that there had been a safeguarding review of the service. She added that from a compliance perspective both NLaG and HUTH were compliant in respect of staffing. However, the review was intended to look at opportunities for changes in roles, the lead nurse was undertaking this piece of work.

- Item 3.1, 14 May 2026 meeting, Monthly Patient Safety Update - Complex Cases Presentation. Hilda Gwilliams advised that this item could now be closed due to the patient story being shared that day. She added that a register of patient stories was held on Bridget to allow staff to access them for reference, she agreed to ensure that complex case patient stories were also included within that. She agreed to discuss this with Myles Howell to ensure complex patient stories were included on the register. It was agreed this action could therefore, be closed.

  Action: Hilda Gwilliams to discuss complex case patient stories being included on the register with Myles Howell

- Item 3.1, 11 June 2026 meeting, Monthly Patient Safety Update (including Assurance Committee Update) - Corridor Care Session in respect of changes and the impact of this. Jo Ledger advised this related to Temporary Escalation Spaces (TES) and the point of prevalence. She added there had been a positive impact in respect of this for staff. It was agreed the data for this would be shared within the Integrated Performance Report (IPR) at the November 2026 meeting and that it would be included within required audits. It was agreed this item could be closed.

- Item 3.1.2, 11 June 2026 meeting, Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH - Birth Rate Plus. Yvonne McGrath advised this would be included within the reports due to be shared at the November 2026 meeting. It was agreed this action could be closed.

- Item 3.1.2, 11 June 2026 meeting, Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH - update on progress following investment. Yvonne McGrath advised that this related to recruitment within the service. It was explained that this referred to specialist posts and profiles for new roles. It was agreed this action could be closed.

- Item 2.2, 9 July 2026 meeting, Group Chief Executive's Briefing - Communication options to be shared with Public. Myles Howell advised that various alternatives had been considered in addition to sharing information through social media. It was agreed this action could be closed.

- Item 3.2.2, 10 September 2026 meeting, Maternity & Neonatal Assurance Reports - NLaG & HUTH (including MIS Year 7, PMRT) - Ultrasound and C-Sections. Yvonne McGrath advised that this would be included within the November 2026 reporting and that it would be overseen by the Quality & Safety Committees-in-Common. She added that there would also be support through Grant Thornton in respect of this item. It was agreed this action could be closed.

- Item 4.1, 10 September 2026 meeting, Public Purse (including Assurance Committee Update). Keith Haynes advised that discussions had taken place in respect of this item and that it had been agreed that current arrangements would remain in place. It was agreed this action could be closed.

2. GROUP CHIEF EXECUTIVE & CHAIR REPORT

2.1 Group Chair's Report – BIC(26)234

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

Alan Downey advised that the Group was in a period of transition and emphasised the importance of maintaining focus throughout this period to ensure continued improvement.

He reflected on the decision made by the Trust Boards-in-Common on 10 September 2026 to dissolve the Humber Health Partnership (HHP), noting that this was considered the right decision to enable both Trusts to move forward positively and support their future success.

A number of staff roadshows had subsequently taken place. Feedback received during these sessions had included concerns regarding the recruitment pause, which had since been lifted. Alan Downey emphasised the importance of listening and responding to the issues raised by staff during this period of change.

Alan Downey also reflected on a recent visit to the neonatal unit at Hull Royal Infirmary (HRI), a Level 3 neonatal unit providing care for babies born from 22 weeks' gestation. He commended Francesca Matthews and the wider neonatal team for the care provided and acknowledged their dedication. He added that a family he had spoken with during the visit had also spoken positively about the care they had received.

2.2 Group Chief Executive's Briefing – BIC(26)35

Lyn Simpson referred to the report and highlighted that HUTH had improved its position in the National Oversight Framework (NOF) ratings from 134 to 128. She acknowledged that this improvement reflected the hard work and commitment of staff.

It was noted that Sir Jim Mackey, NHS Chief Executive, had visited Hull Royal Infirmary (HRI) on 10 September 2026. During the visit, he had met with Board members at their monthly private meeting and visited the maternity service. It was hoped that there would be a further opportunity to welcome him back in the future.

Lyn Simpson also reported that Dame Diana Johnson had recently visited Castle Hill Hospital (CHH). The visit had provided an important opportunity to demonstrate the improvements made since her previous visit.

Lyn Simpson advised that she had recently attended the North Lincolnshire Council Health and Wellbeing Board. It was noted that Therese Patten, Interim Chief Executive of NLaG, would attend these meetings going forward.

Lyn Simpson also reported that she had attended a recent Anchor Institution meeting hosted by the University of Hull and acknowledged the positive work being undertaken.

In respect of the transitional organisational arrangements, it was reported that work was progressing and that maintaining momentum was important. However, it was equally important to ensure that any changes were implemented safely and supported by appropriate governance arrangements. A Programme Delivery Group (PDG) had been established to oversee the transition, with representation from key stakeholders, including trade unions and local authorities.

Lyn Simpson noted thanks to staff who had supported the recent event at CHH for robotic surgery, this had been a well organised event.

It was reported that issues with infection control continued and that processes for improvements were being reviewed to ensure this was addressed.

Lyn Simpson advised that she had been pleased to recently visit the new sensory garden at the Child Development Centre (CDC), Diana, Princess of Wales Hospital (DPoWH) following recent funding through the Charity for improvements to be made to that area.

Board members were reminded that the NHS Staff Survey had commenced on 1 October 2026. The response rate remained relatively low, and alternative ways of enabling and encouraging staff to complete the survey were being considered.

Lyn Simpson also drew the Board's attention to the Chief Executive Dashboard included within the report for information.

Jo Gander referred to the staff survey and asked if there had been consideration for staff focus groups to highlight why staff were not contributing to completing this with further sessions being held for staff to attend to complete the survey. Lyn Simpson acknowledged the point made and advised that staff were being encouraged to complete the surveys at recent staff roadshows. She felt further consideration could be looked at in respect of other roadshow events to allow staff access to complete the survey and identify why they were not doing this.

Action: Consideration of further sessions to allow staff to complete staff surveys and identify reasons for none completion

2.3 **Integrated Improvement Plan (IIP) (including update on CQC Section 29A Actions & Financial Recovery Plan) – BIC(26)237**

Ben Smith referred to the report and explained that this had now moved into the delivery phase.

During September 2026, all Senior Responsible Officers (SROs) had presented updates on their respective domains, highlighting key delivery risks. It was noted that no issues had required immediate escalation to the Board for intervention.

The programme was beginning to demonstrate positive impact in some areas. However, this was not consistent across all areas and further review was underway to identify and address areas requiring additional focus.

It was reported that the financial recovery programme was now fully established, with relevant workstreams aligned to minimise duplication. Governance and visibility across the IIP had strengthened, although greater focus was required on delivery and achieving the intended outcomes.

Hilda Gwilliams referred to the Care Quality Commission (CQC) Section 29A letters and advised that, following their receipt, a gap analysis had been undertaken against the IIP to ensure that the four themes identified within the recommendations were reflected within the programme deliverables. The CQC had advised that a further visit would take place in April 2027 to reassess both Trusts.

Initial improvements had been made, as detailed within the report. The Board Assurance Framework (BAF) had also been redesigned to strengthen oversight of risks and ensure appropriate assurance to the Boards.

It was noted that concerns had previously been raised regarding harm-related incidents and the response to patients and families following such incidents. Learning had been identified and improvements implemented. A significant reduction in the backlog of investigations had also been achieved, with further improvements planned by December 2026 to support the evidence required ahead of the CQC's next visit.

The Duty of Candour position was very low when the base line assessment was undertaken, however, this had improved significantly with the organisation being 100% compliant for CQC.

Dr David Sulch referred to the table on page six, which he found helpful, and queried whether the ratings reflected the assurance provided by the relevant committees. He highlighted sepsis as an example, noting that the rating had improved from red to amber, although the Quality & Safety Committees-in-Common had not considered that sufficient assurance had been received to demonstrate improvement. He emphasised the importance of ensuring that the ratings accurately reflected the assurance position and progress being made.

Ben Smith advised that this matter had been identified through the Oversight Groups. A paper was due to be presented to the Committee the following week to review the position further with the SROs and ensure that the information reported was accurate.

Murray Macdonald expressed concern that Committee oversight was not yet operating as effectively as required, and welcomed further discussion to ensure that reporting was appropriately triangulated and aligned across the governance structure. He noted that the current reports did not appear fully aligned. He also

considered that the snapshot page could be simplified to provide greater clarity on the areas of concern and those requiring further attention.

Murray Macdonald also suggested that the CQC Well-Led element could be presented more clearly to emphasise the improvements required. He queried the inclusion of the people and finance elements within the Financial Recovery Plan rather than being brought together through the IIP. Where these elements needed to be reflected across separate programmes, he considered that the rationale and interdependencies should be clear and appropriately understood.

Helen Marks advised that in the interim the information in respect of people would be shared through the Workforce, Education & Culture Committees-in-Common to ensure there was oversight.

Hilda Gwilliams clarified that there had been no decision to separate the information for the purposes of Board reporting; rather, it had been presented separately due to the volume of detail. Ben Smith advised that this had been recognised and that future Board reporting would bring the information together from the following month.

Lyn Simpson acknowledged the points raised and agreed that it was important for Board members to be able to access the relevant information in one place. She noted that further work was required to achieve this.

Helen Marks advised that, in the interim, information relating to people would continue to be reported through the Workforce, Education & Culture Committees-in-Common to maintain appropriate oversight.

Therese Patten referred to the Well-Led element within the diagram on page six, noting that it was shown as closed. She emphasised that Well-Led principles should remain integral to the wider improvement work. Lyn Simpson agreed that the presentation could be reviewed to provide greater clarity and reflect the continued importance of Well-Led across the improvement programme.

Hilda Gwilliams advised that the Boards had previously agreed that the Section 29A actions would be subject to a deep dive at the Quality & Safety Committees-in-Common, including a review of the associated metrics.

Alan Downey queried the timeframe for delivery of the required improvements, noting that this was longer than would normally be expected. Hilda Gwilliams advised that she had requested a meeting with the CQC to clarify expectations ahead of its next visit, particularly in light of the planned dissolution of the Group. She noted that some actions related to the development of joint arrangements, including policies, which might no longer be applicable following dissolution.

Alan Downey thanked Ben Smith and Hilda Gwilliams for the work undertaken in respect of the IIP as it was acknowledged this had meant considerable work.

2.4 **National Reports and Guidance - BIC(26)238**

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

It was reported that when correspondence was received it was shared with relevant staff to ensure required actions were taken. This had meant there were now improvements in this process.

Murray Macdonald referred to the issue of staff accessing patient information and queried whether the expectations and associated learning were understood by both clinical and non-clinical staff. Mr Peter Sedman advised that the organisation had taken a robust approach to this issue over the previous two years following a number of identified cases. He emphasised that inappropriate access to patient information was unacceptable in all circumstances.

In respect of the Emergency Care Emergency Department (ED) Report, Murray Macdonald queried whether any learning had been identified, noting that no specific actions for the organisation had been highlighted. Jo Ledger agreed to review the report and advised that a complaint relating to this issue had been received on the South Bank. Work was underway to identify improvements for patients presenting with mental health needs, including consideration of whether assessments should be undertaken consistently across all relevant areas.

Jo Ledger added that further consideration would be given to how patient information was updated as individuals progressed through their care pathway. A Mental Health Task and Finish Group had been established to consider these matters and progress any identified requirements.

Jo Gander reported that the Acorn Centre was due to launch more facilities one being on the South Bank. This would provide support on a 24/7 basis for anyone that required mental health support. It was hoped this would mean patients being directed to that facility rather than it being provided through ED.

Dr David Sulch referred to the mandatory information governance training in relation to staff accessing patient records and expressed concern that it did not sufficiently highlight the potential consequences of inappropriate access, including dismissal.

In respect of Martha's Rule, Dr Sulch queried whether any national work was being undertaken to review concerns raised through this route and identify learning to support improvements in the quality of patient care. Lyn Simpson advised that she was not aware of any specific national review of the impact of Martha's Rule. Mr Peter Sedman noted that this was due to be considered at a future National Medical Directors' meeting. He added that he was aware of cases where processes had been changed following concerns raised through Martha's Rule, with positive outcomes for patients.

Helen Marks advised that the information governance training was delivered through a national training module and that the point raised regarding its content could be escalated. She added that, locally, the seriousness of inappropriate access to patient records had been reinforced through communications to staff and that the relevant policy had been updated.

Jo Gander advised that there was evidence of Martha's Rule being used and monitored to identify its impact and support learning. She noted that patient videos had also been introduced to support staff learning.

Sam Peate advised that further work would be undertaken within the ED on the North Bank, supported by funding received to improve care for patients with mental health needs.

Alan Downey noted that papers on the agenda were generally described as being presented for assurance, whereas some were provided for information. He requested that future agendas clearly identify the purpose for which each paper was being presented to the Board.

3. PATIENT SAFETY UPDATE

3.1 Monthly Patient Safety Update (including Assurance Committee Update) – BIC(26)239

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

Hilda Gwilliams advised that incident reporting remained consistent across all sites. A Never Event had been reported on 31 August 2026 and an investigation had commenced. Immediate learning had been identified and actions implemented, with further learning expected to emerge following completion of the investigation.

Hilda Gwilliams provided assurance to the Trust Boards-in-Common that the Improvement Programme had now progressed to Phase Two.

Alan Downey referred to the three recent Never Events, noting that one had occurred outside theatres and two within theatres, following a six-month period in which no Never Events had been reported. He sought assurance as to whether the appropriate safety checks had been followed and whether the incidents had been avoidable. Hilda Gwilliams confirmed that the themes identified related to compliance with safety checks and that the incidents should therefore have been avoidable.

Alan Downey sought further assurance on the extent to which learning from the Never Events had been embedded into practice and whether there was any evidence of staff deviating from established processes. Mr Peter Sedman advised that regular theatre audits were undertaken, with compliance reported at 90%. He acknowledged that further learning could be identified from such incidents but advised that processes were in place to share learning with staff and ensure awareness following incidents.

Professor John Craig queried why the investigation had not yet concluded. Hilda Gwilliams explained that the process included an immediate tabletop review to establish the known facts surrounding the event. However, the subsequent gathering of statements from staff involved required additional time. She added that the immediate review of a Never Event would normally take place the day following the incident.

Professor John Craig expressed concern that delays in speaking with staff following an incident could affect the clarity and accuracy of their recollection. He therefore queried whether discussions with those directly involved could be prioritised as part of the immediate response.

Mr Peter Sedman advised that a meeting was held with the relevant team the following day to reflect on the incident and determine whether it met the criteria for a Never Event.

Jo Gander sought assurance on the arrangements in place where staff were not adhering to established policies and procedures, noting that this could indicate that learning had not been fully embedded. Hilda Gwilliams advised that a performance and accountability framework had been developed to address behaviours or practices requiring improvement. It was also noted that, despite the recent Never Events, the organisation did not appear on the National Never Event List.

Therese Patten referred to the reporting of pressure ulcers resulting in harm and queried why pressure ulcers that had not occurred during a hospital admission were not included within the reported data. Jo Ledger clarified that community-acquired pressure ulcers were not included; however, any deterioration following admission to hospital would be captured within the reporting.

Therese Patten also welcomed the planned Patient Safety Conference and queried whether the programme could include patient and family stories to provide staff with an opportunity to hear directly about their experiences. Hilda Gwilliams agreed that this could be considered as part of the programme.

Alan Downey asked that the Board's concern regarding the increase in Never Events over recent weeks be formally recorded. He confirmed that this would remain an area of focus and continue to be discussed by the Board.

Dr David Sulch reported that the Quality & Safety Committees-in-Common had raised concerns regarding mandatory training compliance, noting deterioration in some areas, particularly within paediatric services. It was noted that there had also been technical challenges relating to job planning and that a joint Job Planning Policy had not yet been agreed.

An update on Infection Prevention and Control (IPC) had also been received by the Committees. Positive work undertaken by the teams was acknowledged, although concern remained regarding current infection levels. The Committees considered that the teams had a good understanding of the issues and clear plans were in place to address them; however, the impact of this work was not yet reflected in the reported infection data.

It was noted that further consideration could be given to alternative ward configurations, together with the impact of overcrowding within the ED at peak times.

Jo Ledger advised that IPC remained challenging across the organisation. She reported that a competency assessment framework had been introduced to support staff training and compliance. It was noted that NHS England and the Integrated Care Board (ICB) had recently undertaken an IPC visit on the North Bank. From a HUTH perspective, emphasis had been placed on IPC being the responsibility of all staff, rather than solely the IPC team. Staff were expected to understand their individual responsibilities for compliance, together with the actions that could be taken where required standards were not met.

Jo Ledger reported that a case of bacteraemia had been identified at HUTH and was subject to review. Looking ahead to the winter period, an increase in norovirus was anticipated and increased testing would be undertaken. She emphasised the importance of managing infection risks effectively, including reducing corridor care, which was recognised as contributing to an increased risk of infection.

Mr Peter Sedman provided assurance that standards continued to be monitored and maintained on the wards through appropriate check and challenge arrangements.

Jo Ledger advised that progress had been made in addressing the backlog of Patient Advice and Liaison Service (PALS) concerns, with the number of outstanding cases having reduced. Concerns were now referred directly to the relevant Care Group for action and closure once resolved. She also welcomed the planned opening of a front-facing PALS office at HUTH. In respect of complaints, a revised process had been agreed to reduce delays in responding. The Integrated Performance Report (IPR) provided further detail on the improvement work, with response times having improved over recent months.

3.2 **Maternity 10 Point Plan – BIC(26)241**

Jo Ledger advised that the Boards had delegated authority to the Quality & Safety Committees-in-Common to approve the Maternity 10 Point Plan submission ahead of the deadline of 24 September 2026. Prior to submission, the Plan had been considered through the appropriate governance forums.

Yvonne McGrath referred to the report and highlighted the key areas of progress. In respect of Martha's Rule, she confirmed that the organisation had met the requirement to attend the relevant webinar. For those actions assessed as partially compliant, further work remained outstanding; however, the team understood the requirements and the actions needed to achieve full compliance.

It was noted that the Terms of Reference would require approval by the Boards to ensure that appropriate accountability arrangements were in place. Yvonne McGrath provided detail in respect of the other points required in the paper. Highlighting where the organisation was partially complaint and providing the detail of what was to be put in place.

It was reported that the assurance exercise had been completed and submitted to the regional team within the required timeframe. Feedback was awaited, and the evidence supporting the submission was detailed within the report. The next submission was due by 31 December 2026.

In respect of the NOF requirements for induction of labour, concerns were noted regarding the accuracy and quality of the data submitted. Further work would be undertaken to improve data quality and ensure the accuracy of future submissions. Dr David Sulch confirmed that the Quality & Safety Committees-in-Common had reviewed the submission and were content for it to be submitted.

3.3 **Briefing on Thirlwall Report & Recommendations – BIC(26)242**

Jo Ledger referred to paper and asked that it be taken as read.

Following a review of the recommendations, the evidence required to demonstrate compliance had been identified and was detailed within the report. Correspondence received from Duncan Burton and Sarah-Jane Marsh on 21 September 2026 had identified five key elements requiring action, some of which had already been achieved.

Assurance was provided to the Boards that appropriate arrangements were in place to respond to the sudden collapse of a baby receiving neonatal care or a paediatric patient. In respect of the installation of CCTV in areas where insulin was stored, this was currently being scoped at NLaG, while HUTH was reported as compliant. Further review would also be undertaken across other areas providing care to paediatric patients.

It was noted that further work remained outstanding against some of the identified elements, as detailed within the report, and progress would continue to be monitored through the appropriate governance arrangements.

Jo Ledger advised that an active listening event had been put in place to reinforce the need for staff to confidently speak up when required. She added that national templates letters had been shared with parents to highlight any concerns from a clinical perspective and who that should be escalated to.

Jo Ledger advised that a Programme Board would be established, with agreed SROs, and that a gap analysis would be undertaken. Appropriate governance arrangements would be put in place to oversee the work. It was considered that the required actions should be incorporated within the Integrated Improvement Plan IIP to provide assurance to the Boards on progress and delivery.

Jo Ledger emphasised the importance of providing assurance to the Boards that appropriate safeguards were in place to mitigate the risk of similar events occurring within the organisation. She highlighted the availability and appropriate sharing of perinatal data, together with established Freedom to Speak Up arrangements and active listening events. The introduction of Martha's Rule and strong leadership arrangements would provide further support. While these measures provided assurance, she emphasised the continuing importance of staff feeling able to speak up and raise concerns.

Yvonne McGrath advised that a number of small clusters had been identified through the available data. She considered this positive evidence that emerging trends were being recognised, with deep-dive reviews undertaken where appropriate.

Dr David Sulch advised that the Quality & Safety Committees-in-Common were well sighted on the neonatal data and would continue to maintain oversight. He queried whether Medical Examiner scrutiny would identify any concerns regarding the quality of care provided and whether there was a national panel responsible for reviewing neonatal deaths, rather than reviews being undertaken solely at organisational level.

Mr Peter Sedman advised that, locally, neonatal deaths were reviewed by a Medical Examiner with paediatric expertise. He was not aware whether an equivalent national panel was in place.

Hilda Gwilliams advised that learning was being shared through the Chief Nurse Network. She noted that concerns had been raised regarding the volume of metrics and reporting requirements placed on organisations. These concerns had been recognised, and work was underway nationally to streamline reporting and recommendations to ensure that key issues were communicated to organisations more effectively.

Therese Patten emphasised the importance of this work and considered that the learning should be considered alongside other improvement activity across the organisation, ensuring that relevant learning was applied more widely and not limited to maternity services. Yvonne McGrath agreed, noting that this approach had been reflected in recent work and was recognised as a positive way forward.

Alan Downey sought approval from the recommendations in the paper. The Trust Boards-in-Common agreed to those recommendations.

4. STRATEGIC PROGRESS

4.1 Patients – Performance (including Assurance Committee Update) – BIC(26)243

Sam Peate referred to the report and provided an overview of the performance position across the Group. In respect of ambulance handovers, he advised that NLaG would commence implementation of the continuous flow model the following week, acknowledging that this would be a challenging period. Overall performance during September 2026 had been more challenging than in August 2026 due to a range of operational pressures.

The Frailty Same Day Emergency Care (SDEC) service at Hull Royal Infirmary (HRI) had opened four bed spaces, with plans to expand to eight. Sam Peate advised that the Performance, Estates & Finance Committees-in-Common had undertaken a deep dive into RTT performance. Following this, teams were reviewing existing processes and opportunities to work differently to support improvement in identified areas of pressure. A gap between HUTH's activity plan and the level of activity required to deliver the RTT performance plan had been identified as a risk.

In respect of cancer performance, improvement had been seen against the 31-day standard across the Group, driven largely by improved performance at HUTH. A Cancer Turnaround Director had joined the organisation to support further improvement, and initial sessions had been held with key colleagues to share feedback and identify areas of focus.

Diagnostic performance had also improved in relation to patients being seen. In respect of outpatient improvement, implementation of the national Single Point of Access had been slightly delayed due to software issues.

Theatre utilisation continued to improve across all sites, with South Bank sites having achieved accreditation. The annual planning cycle had been presented to the Committee, where it had been agreed that more frequent updates would be provided over the coming months.

Philippa Russell reported that the year-to-date financial position remained off plan, with a Group deficit of £50.5 million, representing an adverse variance of £16.4 million against plan. She noted that no improvement had been achieved and further recovery was required.

The Board was advised that a cash support request of £12 million had been submitted, of which £10 million had been received. A further cash request for November 2026, comprising £8.26 million for HUTH and £3.55 million for NLaG, was due for submission. Philippa Russell sought Board approval for the request, noting that approval was now required from Board members rather than the previous delegated arrangement.

Board colleagues approved the cash submission for November 2026.

Lyn Simpson explained that performance delivery would need to be revisited in respect of the financial delivery, it was felt this would be discussed at Board level as required.

Dr David Sulch referred to the report, which indicated that 48% of patients at NLaG had waited in the ED for more than 12 hours before admission to a bed. He noted that mortality at NLaG remained relatively low and queried whether this could indicate that some patients were being admitted who might otherwise have been managed through alternative pathways.

Alan Downey queried whether it would be beneficial to invite Dr Anwer Qureshi to a future Board meeting to provide further detail on the position. Therese Patten advised that the teams understood the specific issues and the actions required to address them, including where support from system partners was needed.

Action: Dr Anwer Qureshi to be invited to future Board meeting to provide further detail on issues

Murray Macdonald referred to the report from the Performance, Estates & Finance Committees-in-Common and highlighted two strategic risks relating to digital. The first related to the Electronic Patient Record (EPR) programme, where the risk profile had increased. The Boards were asked to acknowledge the increased strategic risk and endorse the revised risk position, as recommended.

The second related to the impact of the separation of the two Trusts on the digital team's capacity to deliver planned clinical and non-clinical priorities over the coming months. The Boards were asked to recognise this as a strategic risk for both Trusts and note the additional work arising from the transition. Murray Macdonald also highlighted the need for clear principles to guide the digital team's decision-making and prioritisation, noting that guidance had not yet been provided on which areas of work should be paused or deferred.

Alan Downey sought the Boards' approval of the proposed increase in the strategic risk. Lyn Simpson requested that the position be noted at this stage, pending further consideration at the Board Development Session later that day. It was agreed that the position would be confirmed during that session.

Therese Patten queried whether a separate risk register was being developed for the organisational transition. Lyn Simpson confirmed that this was being developed as part of the transition programme.

Post Meeting Note:
The Trust Boards-in -Common subsequently considered the EPR implementation programme in a Board "Deep Dive" session and agreed that the risks identified should be noted on the Board Assurance Framework and a further update be provided to the Board.

4.2 People (only Assurance Committee Update) – BIC(26)244

D Dr David Sulch referred to the report and highlighted a number of key areas considered by the Workforce, Education & Culture Committees-in-Common. The Committees remained concerned regarding the experience of trainee doctors at NLaG, which had been an ongoing area of concern.

He also highlighted previous concerns regarding the allocation of appropriate time for consultants undertaking specific educational responsibilities and noted that improvements had since been made.

On a positive note, the Committees had received assurance from Finance regarding medical education funding and its planned use. A new report had also been considered which brought together workforce and financial data to support greater alignment and oversight.

Therese Patten advised she was due to meet with the Director of Education and would address NLaG issues with them.

4.2.1 Freedom to Speak Up Guardian (FTSUG) Report – Quarter One – NLaG & HUTH – BIC(26)245

Fran Moverley referred to the HUTH report and highlighted an increase in the number of staff raising concerns who had requested that their identity be protected, particularly in relation to worker safety and psychological safety.

She advised that Freedom to Speak Up Champions at HUTH had organised REACT mental health training to support more structured conversations with staff. Learning from concerns had also identified instances where earlier escalation to senior colleagues may have enabled issues to be resolved more promptly.

Fran Moverley advised that the National Guardian's Office was no longer in place and that reporting arrangements were now directly to NHS England.

In the absence of Liz Houchin, Fran Moverley presented the NLaG report and highlighted the key areas. She advised that NLaG remained below the national average for anonymous concerns. Worker safety was the most frequently reported area of concern, with issues relating particularly to psychological safety and inappropriate behaviours.

Helen Marks thanked both Freedom to Speak Up Guardians and acknowledged the work undertaken to review learning from concerns and identify opportunities for improvement. She queried whether any specific concerns had been raised in relation to the organisational transition. Fran Moverley advised that no such

concerns had been raised by HUTH staff, although some concerns had been raised at NLaG.

Alan Downey advised that he had previously met with both the HUTH and NLaG Guardians. Going forward, Murray Macdonald, as Interim Chair of NLaG, would meet with the NLaG Guardian, while Alan Downey would continue to meet with Fran Moverley. Julie Beilby would continue in the NED Champion role across the organisation, with a HUTH NED providing support to the HUTH Guardian in the future.

Lyn Simpson acknowledged the ongoing work of the Guardians to improve the ways in which staff could raise concerns. However, she noted that some staff remained reluctant to speak up and queried whether previous approaches that had been effective could be reconsidered. It was agreed that this would be explored further.

Action: Further discussion in respect of options for staff to speak up to be considered

Fran Moverley advised that NLaG staff had previously been able to raise concerns through a staff app, which was no longer available. Online reporting arrangements were now in place across both Trusts, improving the ability for staff to raise concerns anonymously. It was agreed that staff should continue to have access to a clear and accessible route for anonymous reporting. Fran Moverley added that, in light of wider NHS changes, the contact details for the Freedom to Speak Up Guardians were required to be available on the organisations' external websites to ensure staff could continue to access the appropriate reporting routes.

Alan Downey thanked Fran Moverley for sharing the report.

4.3 Workforce Disability Equality Standard (WDES) – BIC(26)246

Lucy Vere referred to the report and provided key highlights. She added that the report had also been shared with the Workforce, Education & Culture Committees-in-Common. It was reported that particular themes had been identified as detailed within the report.

The Trust Boards-in-Common noted the recommendations.

It was acknowledged that there was work still to be undertaken in respect of staff with disabilities having the same opportunities within the organisation.

4.4 Workforce Race Equality Standard (WRES) – BIC(26)247

Lucy Vere referred to the report and asked it be taken as read.

Lucy Vere referred to the report and provided key highlights. She added that the report had also been shared with the Workforce, Education & Culture Committees-in-Common. It was reported that particular themes had been identified as detailed within the report.

She added that the aim was to have zero tolerance in place in respect of racism due to the improvements made at the organisation.

Helen Marks agreed positive work was being undertaken, however, it was acknowledged this did need to be enhanced.

The Trust Boards-in-Common noted the recommendations.

It was acknowledged that there was work still to be undertaken in respect of staff having the same opportunities within the organisation.

4.5 NHS Equality Delivery System (EDS) – Six Monthly Update – BIC(26)248

Lucy Vere referred to the report and asked it be taken as read.

Lucy Vere provided key highlights and advised that the organisation was due to reset the quality objectives as detailed within the report.

Lucy Vere wanted to thank Jo Ledger for attending the Equality & Diversity Improvement (EDI) Steering Group as this had been well received by staff.

It was noted that further discussion would take place regarding opportunities for the two organisations to continue working collaboratively. The staff networks were highlighted as an area where effective joint working was already well established. Lyn Simpson emphasised the importance of retaining collaborative arrangements where these continued to provide benefit.

Lucy Vere advised that work was progressing towards the submission in March 2027. The report outlined the current position and identified a number of areas where further improvement could be made ahead of the submission.

It was anticipated that the overall rating would remain unchanged for the following year, although improvements were expected in a number of individual areas.

Helen Marks thanked the Networks for the work undertaken in respect of this.

5. OTHER ITEMS FOR ASSURANCE

5.1 There were no items of assurance to be shared at the meeting.

6. OTHER ITEMS FOR APPROVAL

6.1 **Linen & Laundry Contract Award – BIC(26)250**

Phillipa Russell referred to the report and highlighted the key points, noting that it had been approved by the Performance, Estates & Finance Committees-in-Common. She drew attention to the agreed costings, which represented a significant increase for both Trusts, particularly HUTH. It was understood that this increase reflected the fact that the costings had been fixed during the previous period.

Murray Macdonald advised that the Performance, Estates & Finance Committees-in-Common had considered the costings in detail at its previous meeting.

The Trust Boards-in-Common approved the Linen & Laundry Contract Award.

6.2 **Trust Constitution – BIC(26)252**

Keith Haynes referred to the report and provided details on the updates included within the report. It was noted that the updates had been approved by the Council of Governors (CoG) at the August 2026 meeting.

The NLaG Trust Board approved the Trust Constitution.

7. ITEMS FOR INFORMATION / SUPPORTING PAPERS

7.1 **Items for Information / Supporting Papers**

The following items for information were shared.

- Quality & Safety CiC Minutes – July 2026
- Infection Control Annual Report
- Performance, Estates & Finance CiC Minutes – September 2026
- Finance Report – Month 5
- Fire Annual Report & Work Plan
- Group Annual Security Report
- Workforce, Education & Culture CiC Minutes – May & July 2026
- Trust Boards & Committees Meeting Cycle – 2026
- Documents Signed Under Seal
- Provider Capability Assessment 2026

8. ANY OTHER URGENT BUSINESS

Alan Downey sought any other urgent business items; no items were raised.

9. MATTERS FOR REFERRAL TO COMMITTEES-IN-COMMON

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

10. DATE AND TIME OF THE NEXT MEETING

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

Thursday, 12 November 2026 at 10.00 am in the Boardroom, Diana, Princess of Wales Hospital.

The meeting closed at 1.04 pm.

Cumulative Record of Board Director's Attendance 2026/27

Name	Possible	Actual	Name	Possible	Actual
Alan Downey	6	5	Jo Ledger	6	5
Lyn Simpson	6	6	Murray Macdonald	6	6
Kieran Baker	1	1	Helen Marks	2	2
Julie Beilby	6	6	Therese Patten	1	1

Paul Bunyan	4	4	Sam Peate	6	6
John Craig	3	2	Alastair Pickering	5	5
Paul Edmondson-Jones	1	1	Emma Sayner	5	5
Ekta Elston	1	0	Peter Sedman	6	6
Joanne Gander	1	1	David Sharif	4	2
Hilda Gwilliams	6	6	David Sulch	6	5
Keith Haynes	3	3	Kate Wood	4	0
Jane Hawkard	6	5			

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

BIC(26)276

BOARDS-IN-COMMON - PUBLIC
ACTION TRACKER - PUBLIC

2026 / 27

ACTION TRACKER - CURRENT ACTIONS - 12 NOVEMBER 2026

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
Boards-in-Common ACTION									
5.1	12.02.26	Nursing Establishment Paper - risk register score to be reviewed		Jo Ledger to review risk register score for staffing due to investment being approved	Jo Ledger	November 2026	To be reviewed In November once new recruits have commenced employment with organisation Risk register has been reviewed & 2 separate risks created; one for registered nurses, 1 for non registered at HUTH.		
5.2	09.04.26	Establishment Review of Safe Staffing		Safer Staffing paper to be shared with Boards in August 2026, to be shared six monthly thereafter	Hilda Gwilliams / Jo Ledger	December 2026	Paper to be shared at the December 2026 meeting.		
1.3	14.05.26	Patient Story - safeguarding capacity update		Report on safeguarding capacity to be shared with the Trust Boards-in-Common by Jo Ledger once the review had been undertaken	Jo Ledger	November 2026	Full service review being undertaken by Tracy Campell, Site Nursing Director and will be shared with Trust Board in November 2026. Annual report presented at Oct QSCIC with a reivew of current staffing & associated risks; further analysis to be completed. Review of other organisation's safeguarding workforce structures of similar size to be undertaken & presented by to QSCIC in January.		
3.1	14.05.26	Monthly Patient Safety Update - More detailed information to be added to front sheets		communicate to report authors details to be included on front sheets including prior approval	TBC	November 2026	Update to be provided at November 2026 meeting. Progressed through Governance workstream and Board Governance Manual.		
3.1	14.05.26	Monthly Patient Safety Update - Complex Cases Presentation		Complex cases presentation to be shared with Board members	Hilda Gwilliams / Wendy Page	November 2026	Complex case Patient Story shared at October 2026 meeting. Hilda Gwilliams to update whether discussion taken place with Myles Howell on register of stories		
4.2	14.05.26	Public Purse - Triple A Report		Further discussion to take place regarding how the Triple A report highlights concerns requiring escalation to the Boards	Keith Haynes	November 2026	Update to be provided at November 2026 meeting. Progressed through Governance workstream and Board Goverance Manual.		
3.1	11.06.26	Monthly Patient Safety Update (including Assurance Committee Update) - Corridor Care Session in respect of changes and the impact of this		Session to be held with the Boards on changes made in respect of corridor care and how this had positively impacted patients and staff	Jo Ledger	October 2026	Session to be held at December 2026 Board Deep Dive Details added to Monthly Patient Safety Update.		October 2026 meeting minutes
3.1.2	11.06.26	Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH - Birth Rate Plus		Birth rate plus target dates to be added to the report to highlight progress being made	Yvonne McGrath	September 2026	Update provided at October 2026 meeting, information to be included within November 2026 report.		
3.1.2	11.06.26	Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH - update on progress following investment		Summary of successes within Maternity Service and progress made following the recent investment to include any current concerns that needed to be highlighted within the current reporting	Yvonne McGrath	September 2026	Update provided at October 2026 meeting, information to be included within November 2026 report.		
2.2	09.07.26	Group Chief Executive's Briefing - Communication options to be shared with Public		Myles Howell to review further options for communication in addition to those being shared on social media	Myles Howell	September 2026	Update provided at October 2026 meeting, various alternatives have now been conidered.		October 2026 meeting minutes
3.2.2	10.09.26	Maternity & Neonatal Assurance Reports - NLaG & HUTH (including MIS Year 7, PMRT) - Rag Rating Detail		Yvonne McGrath to provide the rag rating detail within the report for the fill rates	Yvonne McGrath	October 2026	Update provided at October 2026 meeting.		October 2026 meeting minutes
3.2.2	10.09.26	Maternity & Neonatal Assurance Reports - NLaG & HUTH (including MIS Year 7, PMRT) - Ultrasound and C-Sections		Discussion to be held with Jo Ledger, Yvonne McGrath and Dr David Sulch outside of the meeting the concerns raised in respect of ultrasounds and the increase in Caesarean sections	Jo Ledger, Yvonne McGrath & David Sulch	October 2026	Ultrasound capacity work ongoing.		
4.1	10.09.26	Public Purse (including Assurance Committee Update)		Keith Haynes to provide an update on whether digital business should be with one Committee-in-Common or if this should remain separated across the two	Keith Haynes	October 2026	Agreed that current arrangements would remain in place		
1.2	09.10.26	Patient Story - sharing of stories by patient or family member		Consider patient stories being shared by patient or family member	Jo Ledger	November 2026	Update to be provided at November 2026 meeting.		
2.2	09.10.26	Group Chief Executive's Briefing - Staff Survey Completion		Consideration of further sessions to allow staff to complete staff surveys and identify reasons for none completion	Myles Howell	November 2026	Update to be provided at November 2026 meeting.		
4.1	09.10.26	Patients - Performance - waiting times in ED		Dr Anwer Qureshi to be invited to future Board meeting to provide further detail on issues	Sam Peate	December 2026	Dr Anwer Qureshi invited to Board Deep Dive in December 2026		
4.2.1	09.10.26	Freedom to Speak Up Guardian Quarter One Report - further consideration to allow staff to speak up		Further discussion in respect of options for staff to speak up to be considered	Fran Moverley / Liz Houchin	November 2026	Report on barriers to speaking up provided to LS, Group CEO for consideration. Confirmed that FTSU online reporting forms with option to report anonymously (to remove barriers to speak up) are now live and being utilised. FTSUG contact details live on the external NLAG and HUTH websites in line with the new NHSE guidance to promote speaking up and accessibility of the FTSUG role.		

Key:

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

ACTION TRACKER - CLOSED ACTIONS

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

M nute Re	Da e Month of Me ting	Subjec	Action Ref if d fferent	Ac on Point	Lead Off cer	Target Date	Progress	Status	Ev dence
Boards-in-Common ACTION									
1.4	09.04.26	Questions from the Public & Governors - Response to be provided to questions asked		Updated response to question following meeting between Sam Peate and John Palmer to be provided at May 2026 meeting	David Sharif / Sam Peate	May 2026	Sam Peate met with John Palmer on the 15 April 2026		
1.4	09.04.26	Questions from the Public & Governors - Sam Peate to meet with John Palmer to discuss points raised		Sam Peate to arrange to meet with John Palmer	Sam Peate	April 2026	Sam Peate met with John Palmer on the 15 April 2026		
2.2	09.04.26	Group Chief Executive's Briefing - Board Development Session		Board Development Session on 247 staffing provision to include holiday periods and weekend cover	Paul Bunyan	May 2026	Item added to Board Development Sessions - date to be agreed		
2.3	09.04.26	National Reports & Guidance - Lead added to report for initiatives		Lead to be added to report to highlight who was overseeing initiatives	Lyn Simpson	May 2026	Update to be provided at May 2026 meeting		Sharepoint system introduced for all correspondence to be added to including lead executive, reports to continue being shared with the Boards
3.1	09.04.26	Monthly Patient Safety Update -Further detail included within report		Infection control and corridor care to be included within future patient safety reporting	Hilda Gwilliams / Jo Ledger	May 2026	Update to be provided at May 2026 meeting		Report now included in Patient Safety Report, to then be included in IPR future report.
5.1	09.04.26	Briefing on Ward Accreditation Programme - Indicators to be added		Appendix of indicators to be included within future reports	Hilda Gwilliams / Jo Ledger	May 2026	Update to be provided at May 2026 meeting		Information included in future reports
5.1	09.04.26	Briefing on Ward Accreditation Programme - Session with colleagues at organisation to be scheduled on system		Sam Peate to schedule session on ward accreditation programme with colleagues using the system from previous organisation	Sam Peate	May 2026	Session scheduled with colleagues at South Tees Hospital.		
6.1	09.04.26	Quality Priorities - further detail within front sheets of reports on approval process		Report authors to include required detail within reports in respect of prior approval process, using the front sheet as a minimum	Executives (David Sharif)	May 2026	Reminders issued. Will also form part of the guidance to accompany the AAA reporting across the Group.		
5.1	12.02.26	Nursing Establishment Paper - how investment would be managed on staffing		Executive report to be shared at the Workforce, Education & Culture Committees-in-Common on how the staffing investment would be managed in respect of reducing bank and agency staffing in areas where investment had been made	Executives (Jo Ledger)	June 2026	Paper presented to Workforce, Education & Culture Committees-in-Common in May 2026.		
5.3	09.04.26	The Value Circle Report		Value Circle Priorities to be clarified	David Sharif	June 2026	Item discussed at the May 2026 meeting, Value Circle to undertake a further session with the Boards in June 2026		
4.1	14.05.26	Monthly Patient Survey Results - Review other organisations in same tiering		Paul Bunyan to review staff survey results from comparator organisations within the same tier and report findings to the Boards	Paul Bunyan	June 2026	Data for the NOF 5 trusts has been isolated and benchmarked against the national average as well as the trusts in the NEY region. Information shared with Board members.		
7.1	14.05.26	Items for Information - CiC to move to virtual meetings		Committees-in-Common Meetings to be held virtually, amended diary invites to be circulated	David Sharif	June 2026	Administrators for the CiC updated meeting invites to virtual meetings		
4.1	12.03.26	Public Purse - model hospital data shared at PEF CiC		Model Hospital data to be included within reports to the Performance, Estates & Finance Committees-in-Common for oversight	Sam Peate	July 2026	Item to be discussed at the PEF CiC in June 2026; item on agenda for sharing		
1.4	09.04.26	Questions from the Public & Governors - review of administrative function to be undertaken		Performance, Estates & Finance Committees-in-Common to review administrative functions to provide assurance to the Trust Boards-in-Common	NED Chair, TBC / Sam Peate	July 2026	Item to be discussed at the PEF CiC in June 2026; item on agenda for sharing		
5.1	09.04.26	Briefing on Ward Accreditation Programme - Schedule of Dates		Hilda Gwilliams to share accreditation programme of dates with NED and governor colleagues	Hilda Gwilliams	June 2026	Dates were provided to the NEDs in June 2026		
6.1	09.04.26	Quality Priorities - insulin safe practice		Jo Ledger to review current position for insulin safe practice and incorporate into the Quality Priorities	Jo Ledger	June 2026	Reported that there has been a 20% reduction of incidents causing harm from insulin prescribing and medication errors.		
3.1	14.05.26	Monthly Patient Safety Update - PALS Concerns Update		Jo Ledger to provide an update on the success of the amnesty process for PALS concerns	Jo Ledger	June 2026	294 PALS concerns had been reviewed and that 237 of those had been closed following review. The process was to be reviewed for PALS concerns including additional capacity to continue sustainable change and improvements.		
5.1	14.05.26	Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report - Review of policies and procedures		Hilda Gwilliams and David Sharif to review policies and procedures that were outstanding to ensure they did not relate to patient safety	Hilda Gwilliams & David Sharif	July 2026	Review of overdue policy documents completed by Sarah McDougall, email sent to relevant SRO (Executive or Chief of Staff) including key information. Oversight and assurance to be tracked in GERAC.		
7.1	14.05.26	Items for Information - WEC CiC frequency		Further discussion required as to whether the Workforce, Education & Cultures Committees-in-Common continues to be held on a bi-monthly basis	David Sharif	July 2026	It has been agreed the WEC CiC would move to bi-monthly sequencing		
3.1	11.06.26	Monthly Patient Safety Update (including Assurance Committee Update) - Corridor Care query		Jo Ledger to review whether the zero target for corridor care was in respect of all areas or if this excluded ED	Jo Ledger	July 2026	Corridor care reduction programme includes all areas where care is carried out in non -designated clinical space. This includes Emergency Departments. There are two reporting metrics one for ED and one is for G&A beds which excludes ED. The ED data runs midnight to midnight and is the number in total of individual patients who exceed a 45 minute corridor care time in this attendance episode. The G&A bed data return is a snapshot of occupied corridor care spaces at 8am in the morning . This should read as 0 from July as there are no chairs in use in our corridors in our wards or assessment units. HHP Corridor Care slides circulated to Board members 7 July 2026.		
3.1	11.06.26	Monthly Patient Safety Update (including Assurance Committee Update) - TES achievement to be included within report for each hospital		Jo Ledger to provide details in reference to each hospital and the TES achievement against each within the report in the future	Jo Ledger	July 2026	Updated presentation circulated to NEDS including the trajectory and actual achievement of reduction against trajectory for end of June		
4.1	11.06.26	Patient – Performance (including Assurance Committee Update) - IQIG Reporting		Agreement of IQIG report to be shared with Board members until IPR had been updated	Sam Peate / Emma Sayner	July 2026	IQIG papers shared with Board Members.		
4.1	11.06.26	Patient – Performance (including Assurance Committee Update) - Harm Reviews being undertaken		Sam Peate to review whether harm reviews were being undertaken in relation to patients that were delayed for diagnostic testing	Sam Peate	July 2026	Any patients who have delay to treatment in line with the clinical harm process will be reviewed on completion of their Cancer or RTT pathway and any issues relating to delayed diagnostics would be picked up in these reviews. There is not a standalone process for diagnostics as all picked up via this route		
4.2	11.06.26	People (including Assurance Committee Update - IQIG Information - workforce		Paul Bunyan to circulate slides in respect of workforce from the IQIG meeting	Paul Bunyan	July 2026	Slides shared with Board members on 30 June 2026 and due to be presented to NHSE regional team on 3 July 2026.		
4.2	11.06.26	People (including Assurance Committee Update) - Lead CiC for CIP		Further consideration required in respect of which Committee-in-Common would be the lead for triagulation of performance, workforce and finance in respect of CIP	Emma Sayner	July 2026	Recommend PEF undertakes this role on triangulation.		
1.3	11.06.26	Patient Story - Library of patient stories		Hilda Gwilliams to review a process for a library of patient stories for reference	Hilda Gwilliams	July 2026	Electronic library developed in Bridget.		
3.1	09.04.26	Monthly Patient Safety Update - IPR update shared		IPR to be shared with Boards once it had been redesigned	David Sharif	September 2026	New IPR in place shared at September 2026 Trust Board meeting		
1.3	11.06.26	Patient Story - Sharing of Stories with staff		Myles Howell to work with the patient experience team to improve the sharing of patient stories with staff through communications	Myles Howell	July 2026	Library of patient stories now shared on Bridget, stories also to be shared more widely through the Learning Improvement Safety Academy (LISA)		
3.1	11.06.26	Monthly Patient Safety Update (including Assurance Committee Update) - Sepsis Six		Mr Peter Sedman to circulate Sepsis Six documentation to Board members	Peter Sedman	July 2026	Information has been shared with Board members.		
3.1.2	11.06.26	Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH - Ultrasound capacity		Jo Ledger to provide update on concerns raised in respect of Ultrasound within future reporting	Jo Ledger	September 2026	Meeting held with Grant Thornton project scope agreed and reported through MNAG and Quality CIC.		
4.1	11.06.26	Patient – Performance (including Assurance Committee Update) - CDC Activity		Sam Peate to provide information in respect of the CDC activity currently being used and how this was impacting on organisational activity	Sam Peate	September 2026	Information provided by email to Board members on 14.09.26		
4.2.1	11.06.26	Freedom to Speak Up (FTSU) Guardian Report – Quarter Four & Annual Report		Jo Ledger to provide information to the FTSUGs on the EQIA	Jo Ledger	July 2026	Information shared with the FTSUGs with a meeting arranged to discuss.		
1.6	09.07.26	Fit & Proper Persons Test: Annual Declaration		Keith Haynes to confirm required details within the report and ensure this was updated	Keith Haynes	September 2026	The TBC register of interests entry has now been completed and register updated.		
5.1	09.07.26	Audit, Risk & Governance CiC Highlight / Escalation - Issues raised during meeting - further discussion		Board members to address how issues raised would be addressed, further discussion to be held in private	Murray Macdonald	September 2026	It was agreed to bring forward the November 2026 meeting to October 2026.		
6.2	09.04.26	Capital Plan - planning cycle to include plan		Sam Peate and David Sharif to include Capital planning within the Boards timetable	Emma Sayner	October 2026	Updates have been incorporated into the planning timetable for 2026/27		
4.2	14.05.26	Public Purse - Finance Strategy - milestones		Emma Sayner to share milestones relating to the Finance Strategy with the Performance, Estates & Finance Committees-in-Common	Emma Sayner	September 2026	Update to be provided to PEF in September 2026.		
6.2	11.06.26	NHS Equality Delivery System (EDS) Submission		Session to be scheduled for the EDS mid-point submission during the year	Lucy Vere	October 2026	Session scheduled for October 2026 meeting.		
3.1	09.07.26	Monthly Patient Safety Update (including Assurance Committee Update) - Patient Experience Model Update		NLaG Governors to be considered as part of the engagement work in respect of the patient experience model	Hilda Gwilliams / Jo Ledger	October 2026	Governors have been included as part of this. One Governor attends the Steering Group and the Council of Governors are updated on a quarterly basis.		

KEY	
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Trust Boards-in-Common

Agenda Item No: BIC(26)277

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 November 2026
Director Lead	Lyn Simpson, Hull University Teaching Hospitals NHS Trust and Group Chief Executive
Contact Officer / Author	Lyn Simpson, Hull University Teaching Hospitals NHS Trust and Group Chief Executive
Title of Report	**Group Chief Executive update**
Executive Summary	This report provides an update on key developments and activities since the previous meeting of the Trust Boards-in-Common. It covers progress with the clinically led Integrated Improvement Plan; an update on the organisational transition programme following the Boards' decision in September; preparations for winter and engagement with system partners; regional NHS developments; and recent examples of clinical innovation, collaboration and achievement across the Partnership. The report also highlights the revised timetable for extending Urgent Treatment Centre provision at Hull Royal Infirmary, together with ongoing work with local authority partners to improve patient flow and discharge arrangements.
Background Information and/or Supporting Document(s) (if applicable)	The report forms part of the Chief Executive's regular update to the Boards.
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	There are no specific financial implications arising directly from this report. Any financial implications relating to individual programmes or initiatives are considered through the relevant governance and approval processes.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	There are no specific new equality, diversity or health inequality implications arising directly from this report. Relevant implications are considered through the appropriate governance arrangements for individual programmes and initiatives.
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

TRUST BOARDS-IN-COMMON – PUBLIC
12 November 2026

GROUP CHIEF EXECUTIVE UPDATE

1. Introduction

The past month has seen continued progress with our clinically led improvement programme, alongside important work to prepare for winter and develop the arrangements through which Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) will operate separately in future.

Our focus remains on delivering safer, more reliable care for patients, improving operational performance and addressing the longstanding challenges facing both organisations.

2. Organisational transition programme

Following the Boards' decision on 10 September to move towards separate organisational arrangements for HUTH and NLAG, work is progressing to establish the detailed arrangements needed to support a safe and orderly transition.

A programme governance structure has been established, with work progressing across the key areas of strategy, people, operating models, governance, communications, quality and safety, and finance. The protection of existing patient pathways remain central to this work.

Our priority is to ensure that both organisations have the local arrangements needed to focus effectively on their respective populations and local health and care systems, while preserving and strengthening collaboration where this benefits patients.

There are no immediate changes to how patients access services as a consequence of the Boards' decision.

3. Integrated Improvement Plan

Work to deliver our clinically led Integrated Improvement Plan (IIP), *Listening to Clinicians, Learning for Patients*, continues across both Trusts.

The programme is focused on strengthening patient safety, improving access and operational performance, supporting our clinical teams and establishing the foundations for sustainable improvement.

We are beginning to see encouraging progress in a number of areas. At HUTH, improvements in patient flow have contributed to a 44% reduction in lost bed days, alongside stronger ambulance handover performance.

At NLAG, the introduction of the Rapid Assessment and Treatment model is supporting improvements in urgent and emergency care (UEC), while the two-hour community response standard has been maintained.

Cancer performance is another area in which progress is being made. Recent improvement shows year-on-year improvements in Faster Diagnosis Standard performance of 20% at HUTH and 6.8% at NLAG. This is encouraging progress in an area that matters enormously to patients, and we must continue to build on it.

We are also seeing developments in diagnostic services. Community Diagnostic Centre activity has expanded, digital pathology reporting at NLAG has reached 70%, and histology turnaround times at HUTH are improving. Further work is focused on increasing magnetic resonance imaging (MRI) and audiology capacity, redesigning pathways and making more effective use of diagnostic facilities.

I remain grateful to our Chiefs of Service, clinical leaders and colleagues across both organisations for their commitment to this work.

4. Our approach to service improvement

Alongside delivery of the IIP, we are developing a more consistent and sustainable approach to service improvement across our organisations.

This work, known as *Our Improvement Way*, will bring together our existing approaches to quality improvement, patient safety, organisational learning, leadership development and staff engagement within a single overarching framework.

The intention is not to introduce another improvement methodology, but to build on the expertise and good practice already in place, creating a common language and shared expectations for how we identify, deliver and sustain improvements. This will help reduce duplication, strengthen local ownership and ensure that improvement becomes an integral part of everyday working, from Board to ward.

Importantly, the framework recognises the close relationship between quality, patient safety, productivity, patient experience and workforce wellbeing. By strengthening improvement capability and supporting teams to identify and implement change, we want to create an environment in which continuous learning and improvement are everyone's responsibility, rather than something led solely by specialist improvement teams.

A more detailed paper setting out the proposed framework and approach to implementation will be presented to the public Board meeting in December. This will be followed by a Board development session in the New Year to explore the underpinning methodology, leadership expectations, organisational culture and the arrangements needed to embed continuous improvement across our organisations.

5. Winter preparedness and urgent and emergency care

Preparing for winter remains a priority, particularly given the continuing pressures on UEC services.

At Hull Royal Infirmary (HRI), an important element of our winter planning has been the proposed extension of the Urgent Treatment Centre (UTC), delivered by City Health Care Partnership (CHCP), to provide a 24-hour service.

We had anticipated that the extended provision would become available during October. The current timetable indicates that 24-hour operation will now commence on 8 February 2027.

The additional provision was expected to support the management of overnight demand, with an estimated 50 patients each night potentially benefiting from an alternative pathway to the emergency department (ED).

The revised timetable means that we will need to continue managing this demand within existing arrangements during the winter period, with potential implications for patient flow and our ability to sustain improvements in emergency care performance.

We are working constructively with CHCP and the Humber and North Yorkshire Integrated Care Board (ICB) to explore what additional support can be provided in the intervening period. This includes consideration of enhanced community provision and alternative overnight General Practitioner (GP) - supported assessment and streaming arrangements at HRI.

I welcome the engagement of our partners and the shared commitment to finding practical solutions. Our collective priority is to ensure that patients continue to receive timely and appropriate care, while making the best possible use of the services and resources available across the local health system.

We will continue to work closely with the ICB and CHCP to explore all available options, including opportunities to strengthen the support available to HRI ahead of the planned extension of the UTC service.

The implications of the revised timetable are being considered as part of our wider winter preparedness and operational risk management arrangements, with the Boards continuing to receive assurance through established reporting mechanisms.

6. Working with local authorities and system partners

Effective partnership working will be particularly important over the winter period, especially in supporting timely discharge, reducing avoidable hospital admissions and improving care for vulnerable patients.

I continue to maintain regular engagement with Local Authority (LA) Chief Executives (CEs) across the Humber. Our most recent meeting took place on 29 September and provided a further opportunity to maintain dialogue on the challenges facing our health and care services.

Building on this engagement, I have also sought a more focused discussion with the CEs of Hull City Council and East Riding of Yorkshire Council, involving their Directors of Adult Social Care and our senior clinical and operational leadership.

The intention is to identify practical opportunities to continue to strengthen joint working ahead of winter, with particular attention to frailty pathways, homelessness, discharge arrangements and the wider support available to patients whose needs span health and social care services.

These are issues that require a coordinated response across health and social care. Better working across organisational boundaries is essential if we are to improve patient experience, reduce avoidable admissions and support people to return home safely and promptly when they no longer require hospital care.

7. Engagement with Members of Parliament

I held my latest regular engagement meeting with local Members of Parliament (MPs) on 30 September.

Maintaining an open and constructive dialogue with our elected representatives remains an important part of our approach to transparency and accountability, particularly as we work through the implementation of the organisational review and continue our improvement journey.

These meetings provide an opportunity to share information, hear the perspectives of MPs and the communities they represent, and ensure that elected representatives remain informed about significant developments affecting local NHS services.

We will continue this regular engagement as the transition programme progresses.

8. Freedom to Speak Up

The Group CE has recently held regular one to one meetings with the two Freedom to Speak Up Guardians (FTSUGs) where the importance of when a concern is raised with a line manager or leader, the information is taken seriously, listened to, acted upon in a timely manner and appropriate feedback given to the individual to close the loop, was discussed. Across the Group and through the FTSUGs, several positive examples have been given where this has happened, but sadly there are also examples

of where this has not been the case. An environment must be created where colleagues feel able to speak up and receive an outcome.

9. NHS England North East and Yorkshire regional developments

On 8 October, I attended the NHS England (NHSE) North East and Yorkshire Regional CE and Chairs' network meeting in Newcastle.

The meeting provided an opportunity to consider the region's performance and improvement priorities, discuss the changing relationship between providers, ICBs and NHSE, and share learning from organisations undertaking significant improvement programmes.

The regional mid-year review highlighted the continuing challenges facing NHS organisations in relation to financial sustainability, workforce, UEC and planned care performance.

These are challenges which are particularly relevant to our own organisations and reinforce the importance of maintaining a clear focus on delivery, productivity and sustainable improvement.

An important item was the introduction of the North East and Yorkshire Operating Framework, which sets out a shared understanding of the respective roles of providers, ICBs and NHSE.

The framework emphasises local accountability, clear responsibilities, transparency, shared learning and proportionate oversight. It also seeks to simplify relationships between organisations, reduce duplication and establish a more coordinated approach to improvement and assurance.

These principles are particularly relevant as we develop the future arrangements for HUTH and NLAG and continue to strengthen our relationships with local commissioners and system partners.

The meeting also included valuable discussion about organisational learning, patient safety and the importance of leadership and culture in achieving sustained improvement. Learning from the Aubrey report at County Durham and Darlington NHS Foundation Trust was highlighted, with organisations encouraged to reflect on its implications for their own services and governance arrangements.

There was also a strong emphasis on sharing successful improvement approaches between organisations, rather than seeking to address common challenges in isolation.

Finally, the regional public health update reinforced the importance of winter preparedness and staff flu vaccination, both in protecting vulnerable patients and in supporting workforce resilience through the winter months.

10. Celebrating clinical excellence, research and innovation

Alongside the considerable improvement work underway, it is important that we continue to recognise the outstanding commitment and achievements of our clinical teams.

Recent examples demonstrate the quality of expertise across our organisations and the benefits of collaboration, innovation and research.

- ***Hull cardiac surgery team's contribution to national research***

The Cardiac Surgery team at Castle Hill Hospital (CHH) is playing a leading role in the national AFFECT research trial, which is examining the most effective blood-thinning treatment for patients following mitral valve repair surgery.

The study, funded by the National Institute for Health and Care Research, involves more than 30 centres across the UK, with Hull among the leading sites for patient recruitment.

This is an excellent example of how our clinical teams are contributing to nationally significant research while offering local patients opportunities to participate in studies that may improve future treatments.

- ***National accreditation for regional allergy service***

The East Yorkshire Regional Adult Immunology and Allergy Unit at CHH has achieved national Improving Quality in Allergy Services accreditation.

The accreditation recognises the service's achievement of national standards relating to clinical care, patient experience and workforce.

Assessors highlighted the team's clinical leadership, teamwork and commitment to patient engagement and continuous improvement.

This builds on the unit's previous national accreditation for immunology services and is a significant achievement for everyone involved.

- ***Award-winning collaboration to improve liver cancer surveillance***

The Humber and North Yorkshire Hepatocellular Carcinoma Surveillance Team has received the Better Together (Collaboration) award at the Cancer Alliance conference.

Working across HUTH, NLAG and York and Scarborough Teaching Hospitals, the team supports patients with advanced chronic liver disease who are at increased risk of developing liver cancer.

More than 2,600 patients have been enrolled in the surveillance programme, with approximately 1,000 additional patients receiving regular ultrasound surveillance since the programme began in 2025.

The initiative is helping to identify cancer earlier and reduce barriers to accessing surveillance, particularly for patients who may otherwise struggle to engage with services.

It is a strong example of the benefits that effective clinical collaboration across organisational boundaries can deliver.

I would like to congratulate all the colleagues involved in these achievements. They illustrate the expertise, innovation and commitment to patient care that exist across our hospitals and services.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)278

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**12 November 2026**
Director Lead	Lyn Simpson, HHP CEO
Contact Officer / Author	Ben Smith – NHSE Programme Lead supporting the Improvement Programmes
Title of Report	HHP Integrated Improvement, Financial Recovery and Transition Assurance Report
Executive Summary	Humber Health Partnership (HHP) continues to operate within a challenging regulatory, operational and financial environment. The Partnership remains subject to the highest level of NHS oversight, with significant improvement required to deliver its regulatory undertakings, respond to the CQC Section 29A Warning Notices and establish a sustainable financial and operational position. The Partnership's three principal programmes — the Integrated Improvement Plan (IIP), Financial Recovery Programme (FRP) and Transition Programme — provide the overarching framework for coordinating delivery, strengthening accountability and ensuring that improvement and recovery remain central to the transition towards two sovereign organisations. **Integrated Improvement Plan** The IIP continues to strengthen governance, delivery grip and regulatory assurance. October reporting covered 209 deliverables, of which 29 (13%) were rated Off Track/Escalate and 23 were completed and closed with supporting evidence. Tangible or emerging operational and patient benefits are evident, including improvements in governance and leadership, complaints and PALS backlogs, Duty of Candour, data quality and quality reporting. However, benefits evidence and delivery maturity remain inconsistent across workstreams, requiring continued focus on recovery trajectories, KPI baselines, risk management and benefits realisation. **Financial Recovery Programme** The Financial Recovery Programme continues to strengthen financial governance, delivery oversight and accountability across the Partnership. Cost improvement delivery has increased during the year, demonstrating improved momentum, although further progress is required to support delivery of a sustainable financial position. The next phase will focus on sustaining delivery, strengthening expenditure management, accelerating recurrent savings and

	progressing further productivity opportunities. Financial recovery measures will continue to be implemented with appropriate consideration of patient safety, quality, operational performance, access and workforce sustainability. **Transition Programme** The Transition Programme has moved from mobilisation into delivery, with governance arrangements established and all seven workstreams progressing. Key dependencies remain around safe-landing assurance, the Recovery Compact, decision rights, operating models and the continuity of improvement and financial recovery delivery. The transition will be readiness-led, with existing HHP governance and collaborative operating arrangements continuing until formally changed through the agreed transition governance. The appointment of separate Trust executives does not itself constitute organisational separation. Formal dissolution should proceed only following the agreed go/no-go process and assurance that the safe-landing conditions have been met. A coordinated approach is therefore required to protect existing regulatory, improvement and financial commitments while establishing sustainable improvement, transformation and programme management capability within both Trusts. **Overall assurance and priorities** HHP continues to face a significant financial challenge and delivery of a sustainable financial position remains a key organisational priority. The Financial Recovery Programme is strengthening financial governance, delivery oversight and accountability, with improving cost improvement delivery during the year. The focus for the remainder of 2026/27 will be on maintaining delivery momentum, increasing recurrent savings, strengthening expenditure management and progressing further productivity opportunities. Financial recovery actions will continue to be assessed alongside their potential impact on quality, patient safety, operational performance and workforce sustainability. Any additional programme management or transition resource requirements will remain subject to appropriate financial scrutiny and approval.
Background Information and/or Supporting Document(s) (if applicable)	• Appendix A – Listening to Clinicians, Learning from Patients: October 2026 IIP Board Report. • Financial Recovery Programme Board Progress Report: position to 3 November 2026. • Transition Programme Progress Update: October 2026.
Prior Approval Process	
Financial Implication(s) (if applicable)	HHP began 2026/27 with an underlying deficit of £123.6m and a planned deficit of £63.1m. At the end-September position, the

	forecast outturn deficit was approximately £118m. Against the £119.1m CIP target, £70.2m has been identified, £65.5m is risk-adjusted and £56.5m is in delivery, leaving an identified gap of £48.9m and a risk-adjusted gap of £53.6m. CIP delivery has increased from £2.7m in April to £7.4m in October, with £31.4m delivered during the first seven months. While October delivery exceeded the £6.8m monthly rate required to achieve the current £65.5m forecast, reducing the forecast deficit below £100m would require approximately a further £18m of improvement beyond the current forecast, equivalent to approximately £10.4m per month over the remaining five months. Delivery of the full £119.1m CIP target would require approximately £17.5m per month and is not supported by the current delivery trajectory. The strengthened financial recovery approach will therefore focus on sustaining delivery momentum, accelerating recurrent savings, strengthening workforce and variable-pay controls and progressing further cross-cutting productivity opportunities. Any additional programme management or transition resource requirements will remain subject to appropriate financial scrutiny and approval.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Equality, diversity and health inequalities considerations will remain integral to all three programmes. Material workforce and financial control decisions will be subject to appropriate Quality Impact Assessments and Equality Impact Assessments, ensuring that financial recovery and organisational transition do not adversely affect patient safety, access to services or safe staffing.
Recommended action(s) required	✓ Approval ✓ Information ✓ Assurance ☐ Other – please detail below:

1. Background

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

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

Alongside operational pressures, the Partnership continues to face a significant financial challenge. The Financial Recovery Programme provides the framework for strengthening financial

governance, progressing cost improvement opportunities and supporting a more sustainable financial position.

Leadership instability, the complexity of the current group governance model and workforce and cultural challenges have further constrained organisational effectiveness and the pace of improvement. National Staff Survey results remain below the national average across all People Promise domains, reinforcing the need for sustained improvement in leadership visibility, accountability and staff experience.

In May 2026, work commenced to refresh the Integrated Improvement Plan, Listening to Clinicians, Learning from Patients, ensuring it reflected the priorities identified through patient and staff feedback, regulatory assessments, external reviews and organisational performance.

The refreshed IIP provides an integrated framework for improvement across leadership, clinical governance, quality and safety, medical and clinical models, operational performance and people. In July 2026, the Boards-in-Common approved the strategic intent of the refreshed programme, with Executive Senior Responsible Officers accountable for delivery through dedicated workstreams.

The scale and urgency of the financial challenge subsequently resulted in the establishment of a dedicated Financial Recovery Programme, with separate governance and reporting arrangements. While finance is no longer a standalone IIP domain, the FRP remains closely aligned to the broader improvement agenda.

The CQC completed Well-Led assessments at HUTH and NLaG in June 2026 and issued Section 29A Warning Notices on 28 July 2026, identifying areas requiring significant improvement.

Following the Carnall Farrar Organisational Form Review, the Partnership also established a Transition Programme to support the move towards two separate sovereign organisations.

The IIP, FRP and Transition Programme now represent the Partnership's three principal programmes. While each has distinct governance and delivery requirements, they share significant dependencies relating to leadership, workforce, operational performance, financial sustainability, patient safety and regulatory assurance.

It is therefore essential that these programmes are managed through a coordinated approach, ensuring that financial recovery and organisational transition support, rather than undermine, the delivery of sustained improvement and existing regulatory commitments.

2. Regulatory Oversight

To progress from the highest level of NHS oversight, the Partnership must demonstrate continual and sustainable improvement against its regulatory undertakings, the Medium-Term Plan and the requirements of the NHS Oversight Framework.

This includes delivering credible recovery trajectories across quality, finance and operational performance, addressing findings from external reviews and regulatory assessments, and providing sufficient assurance to NHS England that improvements are robust and sustainable.

The refreshed NHS Oversight Framework 2026/27 reinforces expectations relating to quality, productivity, financial sustainability, organisational capability and improvement.

The IIP remains the Partnership's principal framework for coordinating and evidencing progress against regulatory and improvement requirements. This is supported by the FRP, which provides the framework for financial recovery and sustainability, and the Transition Programme, which supports continuity of accountability, governance and delivery through organisational change.

A consistent approach to assurance is being maintained across the three programmes, with an increasing focus on measurable outcomes, clear Executive accountability, validated evidence and timely escalation of delivery risks.

3. Integrated Programme Progress

3.1 Integrated Improvement Plan – October 2026

The IIP is providing an increasingly robust framework for tracking and evidencing progress against the Partnership's regulatory undertakings, CQC Section 29A requirements and wider improvement priorities, while strengthening visibility of the overall assurance position to NHS England.

During October, 209 deliverables were monitored. Of these, 29 (13%) were rated Off Track/Escalate, reflecting target dates missed by more than one month. Six are pending closure subject to final evidence, while the remaining deliverables require focused recovery action. A further 23 deliverables were completed and closed with supporting evidence, an increase of 14 from September.

Progress and emerging benefits during October included:

- strengthening governance and leadership through the Board Assurance Framework refresh, governance manuals and recruitment to key leadership roles;
- strengthening assessment and tracking of regulatory undertakings, Value Circle recommendations and CQC Section 29A requirements;
- revision of the PSIRF policy and improved Duty of Candour compliance;
- closure of the HUTH PALS backlog and significant reduction in the complaints backlog;
- improved data quality, quality reporting and dashboard development; and
- improved identification of workstreams where delivery is not gaining sufficient traction or governance is duplicative, supporting earlier intervention and escalation.

Delivery grip and regulatory assurance continue to strengthen, with tangible or emerging evidence of operational and patient benefit. However, benefits are not yet consistently evidenced across all workstreams and further development is required around KPI baselines, delivery trajectories, risk management and benefits realisation. A small number of workstream components also remain under development, including Care Group Recovery and Tertiary, while the Maternity Plan on a Page is due for ratification in November.

The next phase will focus on strengthening recovery plans where delivery remains off trajectory, improving risk and assurance maturity, evidencing benefits against NHS Oversight Framework and CQC requirements and protecting continuity of IIP delivery throughout organisational transition.

Full workstream-level assurance is provided in Appendix A.

3.2 Financial Recovery Programme – position to 3 November 2026

The Financial Recovery Programme has moved into delivery, supported by strengthened governance, reporting and Executive accountability. These arrangements are improving visibility of delivery and supporting the identification and implementation of further cost improvement opportunities.

CIP delivery has strengthened during the year, with £31.4m delivered between April and October, including £7.4m in October. This represents improved delivery momentum, although further progress is required to support a sustainable financial position.

The next phase will focus on sustaining delivery momentum, accelerating recurrent savings, strengthening expenditure management and progressing productivity opportunities across the organisation.

Overall assurance remains Red/Amber, reflecting improving delivery alongside the continuing scale of the financial recovery requirement.

Detailed financial trajectories, delivery risks and individual recovery actions will continue to be considered through established FRP governance and, where appropriate, the private Board session.

3.3 Financial Recovery Programme: strengthened delivery

The next phase of financial recovery will focus on sustaining improved delivery, strengthening expenditure management, accelerating recurrent savings and progressing further productivity opportunities.

Key areas of focus will include:

- stronger management of vacancies and workforce expenditure;
- continued reduction in reliance on premium staffing;
- improved workforce planning and deployment;
- strengthened management of non-pay expenditure and procurement;
- acceleration of recurrent productivity opportunities; and
- clear Executive accountability for delivery.

The Boards will receive regular assurance on financial recovery progress and whether strengthened arrangements are translating into sustainable financial improvement.

All material financial recovery actions will be implemented with appropriate clinical, quality, equality, workforce and operational safeguards to ensure that patient safety, access, safe staffing and essential services are protected.

3.4 Transition Programme – October 2026

Programme mobilisation and workstream delivery are progressing, but material dissolution dependencies remain, including safe-landing assurance, the Recovery Compact, decision rights, operating models and continuity arrangements.

Key achievements during October included:

- Establishing weekly Programme Delivery Group meetings and formal programme governance.
- Agreeing transition principles and progressing safe-landing conditions.
- Developing the draft timeline to dissolution and workstream delivery arrangements.
- Issuing clinical inventory templates to 10 of 14 care groups and corporate inventory templates to 3 of 7 corporate directorates.
- Work continues to clarify the governance, accountability and decision-rights arrangements required during transition, supported by appropriate legal and regulatory advice.
- Establishing the approach to clinical engagement and the Clinical Reference Group.

- Developing the IRP Recovery Compact framework with NHS England input.
- Aligning transition deliverables with the IIP and FRP.

The immediate focus is on completing and validating inventories, finalising the programme budget, clarifying decision rights and governance arrangements, and developing the safe-landing assurance framework.

Until dissolution, HHP's existing joint governance, operating and collaborative arrangements will remain in place unless formally changed through the agreed transition governance. The appointment of executives to future HUTH or NLaG roles does not of itself change existing HHP-wide governance or accountabilities, which will remain in place until formally changed through the agreed transition process.. Executive leaders will therefore continue to work collectively through the agreed HHP governance and decision-rights framework to protect patient safety, operational delivery, financial recovery, improvement delivery, shared services and regulatory commitments.

Dissolution will be readiness-led rather than driven solely by a target date. Formal separation should proceed only following the agreed go/no-go process and assurance that the approved safe-landing conditions have been satisfied. The transition must provide a controlled and evidenced transfer of accountability so that no regulatory, financial, operational or improvement responsibility is fragmented, duplicated or lost as accountability moves from the existing HHP arrangements to the two sovereign organisations.

3.5 Alignment Across the Three Programmes

The IIP, FRP and Transition Programme have distinct delivery responsibilities but share significant dependencies.

The IIP provides the framework for regulatory and organisational improvement. The FRP is responsible for delivering financial recovery and recurrent cost reduction. The Transition Programme must establish the governance, operating models and organisational arrangements necessary for two sustainable sovereign organisations.

Strong alignment is required to ensure that financial controls support sustainable service delivery, that organisational change does not disrupt existing improvement commitments, and that programme ownership and accountability remain clear throughout transition.

A consistent approach to performance, risk, benefits and assurance reporting will be maintained, with particular attention to the impact of financial recovery measures on quality, safety and operational delivery.

Decisions which materially affect the future organisations will continue to be considered through the agreed Transition Programme governance, with appropriate consideration of workforce, service, financial, legal and regulatory implications before implementation.

4. Integrated Programme Risks and Required Decisions

4.1 Key programme risks

The IIP Oversight Group, FRP governance arrangements and Transition Programme have identified a number of significant risks requiring coordinated Executive oversight and continued Board attention.

Failure to maintain integrated control across IIP, FRP and Transition could result in competing priorities, duplicated activity, fragmented accountability and deterioration in quality, operational or financial recovery during organisational separation.

Financial recovery and sustainability

Financial recovery remains a significant organisational priority. Although delivery momentum has improved, further progress is required to strengthen recurrent savings and support a sustainable financial position.

Recovery activity will continue to focus on stronger expenditure management, workforce productivity and delivery of recurrent efficiencies, supported by regular Executive and Board assurance.

Quality, safety and operational delivery

There is a risk that financial recovery actions could have unintended consequences for service delivery if not appropriately managed. Material changes will therefore be supported by appropriate clinical, quality, workforce, operational and equality assessment, with escalation where required.

Premature organisational separation

There is a risk that organisational arrangements evolve ahead of the formal dissolution gateway in ways that create ambiguity in accountability or fragment existing Partnership-wide arrangements. This risk will be managed through the agreed transition principles, decision-rights framework and safe-landing assurance process.

Existing HHP-wide accountabilities and governance arrangements will therefore remain in place until formally changed through the agreed transition process.

Organisational transition and delivery continuity

The transition towards separate sovereign organisations presents a material risk to the continuity of IIP and FRP delivery and regulatory assurance.

There is a risk that dividing existing programme management capacity across two organisations without an assessment of future requirements could create gaps in delivery, governance and oversight.

Clear transition arrangements, defined responsibilities and sufficient improvement and programme management capacity will be required to protect existing commitments.

Electronic Patient Record (EPR)

EPR delivery remains a significant programme risk, with further assurance required regarding readiness, implementation planning and data migration ahead of go-live

Operational performance

Assurance requires strengthening across planned and unplanned care. Reporting will be aligned through a consistent evidence base, with priority metrics, refreshed deliverables, risks and escalation thresholds agreed through existing governance arrangements.

Workforce and clinical ownership

Delivery capacity and capability remain variable, with several workstreams dependent on sustained clinical leadership and specialist workforce capacity.

The transition creates additional uncertainty regarding future roles, structures and accountabilities. Clear leadership ownership and proactive staff engagement will be essential to maintain delivery momentum.

Data, KPI and benefits maturity

Incomplete baselines, variable KPI quality, limited business intelligence capacity and inconsistent benefits evidence continue to restrict the ability to demonstrate measurable and sustained improvement.

A more integrated reporting approach is required, linking programme activity to realised financial, workforce, quality and operational outcomes.

Risk and assurance maturity

Risk management remains variable across workstreams. Executive SRO confirm-and-challenge arrangements will continue to strengthen validation of risk scoring, controls, mitigations and evidence of delivery.

4.2 Transition capacity and programme management requirements

The transition to two sovereign organisations will require both Trusts to have sufficient improvement, transformation and programme management capability to discharge their regulatory, financial and operational responsibilities.

Current capability is unevenly distributed across HHP and remains substantially committed to existing improvement, recovery and transition priorities. A structured assessment is therefore required to determine the capability and capacity needed within each organisation and the transitional arrangements necessary to maintain continuity.

Detailed resource, establishment and financial implications will be considered through the appropriate private governance arrangements.

4.3 Proposed approach and Board decision

The Trust Boards-in-Common are asked to agree the following approach:

1. Recognise the requirement to establish sufficient overall improvement, transformation and programme management capability within both organisations.
2. Commission a rapid assessment of existing improvement, transformation and programme management capability across HUTH and NLaG, including current commitments and capacity.
3. Define the capability required within each organisation to support delivery of its improvement, financial recovery, transition and regulatory responsibilities.
4. Identify any material capability or capacity gaps and develop options to address these.
5. Consider the detailed resource, establishment, financial and interim delivery arrangements through the appropriate governance route

This approach will support a controlled transition of programme responsibilities, protect delivery of existing commitments and ensure that both organisations are appropriately equipped to meet their improvement and regulatory obligations.

5. Integrated Assurance and Next Steps

5.1 Overall assurance position

The three principal programmes continue to strengthen the Partnership's governance, oversight and delivery arrangements. However, the level of assurance differs across programmes.

Programme	Assurance position	Key message
Integrated Improvement Plan	Developing, variable by workstream	Governance, delivery grip and regulatory assurance are strengthening, with tangible or emerging patient and operational benefits, but benefits evidence and delivery maturity remain inconsistent across workstreams.
Financial Recovery Programme	Red/Amber	Delivery momentum is improving and financial governance has strengthened, although further progress is required to support a sustainable financial position.
Transition Programme	Developing assurance	Mobilisation is progressing, but safe-landing readiness, capacity and delivery dependencies require continued scrutiny.

The overarching challenge is to translate strengthened programme governance into sustained and measurable improvements in organisational performance, financial sustainability, quality and patient outcomes.

5.2 Immediate priorities

The immediate priorities for November and December 2026 will be to:

- Sustain financial recovery, with continued focus on recurrent savings, expenditure management, productivity and appropriate safeguards for quality, patient safety and operational delivery.
- Ensure that further financial recovery measures are safe and sustainable, supported by appropriate assessment of clinical, operational, workforce and equality implications.
- Progress Transition Programme readiness, including completion of inventories, safe-landing assurance, the Recovery Compact, decision rights, operating models and the assessment of future improvement and programme capability.

- Maintain delivery of IIP, CQC Section 29A and regulatory commitments throughout transition, strengthen recovery plans where workstreams remain off trajectory and improve evidence of benefits realisation against relevant NHS Oversight Framework measures.

5.3 Integrated reporting and accountability

The Boards will require a consistent and aligned view of progress across the three programmes, supported by clear Executive accountability and robust evidence of delivery.

Board reporting will continue to provide an integrated view across the three programmes, increasingly focused on outcomes, material risks, benefits realised, financial sustainability and Executive accountability, rather than activity alone.

Particular emphasis will be placed on ensuring that improvements in programme governance translate into demonstrable benefits and that the move towards separate organisations does not create gaps in ownership, delivery or assurance.

6.0 Summary

The IIP, FRP and Transition Programme provide HHP with an integrated framework for regulatory improvement, financial recovery and safe organisational transition. Governance and programme grip are strengthening and financial recovery delivery has improved, although significant challenges remain.

The next phase will focus on translating improved programme control into measurable and sustainable outcomes, maintaining financial recovery momentum and protecting delivery of existing regulatory and improvement commitments throughout transition.

7. Recommendations

The Trust Boards-in-Common are invited to:

- Note the integrated assurance position across the IIP, FRP and Transition Programme.
- Note improvement in financial recovery delivery while recognising the significant remaining challenge.
- Endorse the continued strengthening of financial recovery, with appropriate quality, clinical, workforce and equality safeguards.
- Note progress with the Transition Programme and confirm that organisational separation remains readiness-led.
- Confirm that existing HHP governance and accountability arrangements remain in place until formally changed through the agreed transition process.
- Endorse the principle that both organisations require sufficient improvement, transformation and programme management capability to discharge their future responsibilities.
- Commission an assessment of future capability requirements, with detailed resource and financial implications to return through the appropriate governance route.

Transition programme progress update

Reporting period: October 2026

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4	Workstream progress update
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Transition office progress update: October 2026

NHS Humber Health Partnership

In October, the programme moved from set-up into delivery. Governance is in place, the transition principles are agreed and the safe landing conditions and, clinical and corporate inventories are under way.

Delivered in October
(1 to 31 October)

- Programme Delivery Group meeting weekly from 1 October, with its terms of reference approved by the Transition Steering Group
- Programme governance and Transition Steering Group terms of reference taken to the Boards in Common (9 October)
- Transition principles endorsed and shared with staff, and the revised safe landing conditions developed
- Draft timeline to dissolution and workstream charters developed, with highlight reporting in place
- Inventory templates handed over to 10 of 14 care groups and 3 of 7 corporate directorates
- Clinical engagement approach tested at SLT, and the Clinical Reference Group approved by the Programme Delivery Group
- IRP Recovery Compact framework developed with NHS England input, and first draft budget completed

In progress now
(as at the end of October)

- Collecting and reviewing the clinical and corporate inventories, with the transition office supporting leads
- Finalising the workstream charters, milestones and the PID for sign-off
- Agreeing decision rights and Board governance, informed by legal advice
- Setting up the Clinical Reference Group, including its terms of reference, chair and members
- Reviewing the draft programme budget with both Chief Executives and the Group Chief Financial Officer
- Aligning deliverables across the transition, financial recovery and integrated improvement programmes

Priorities for November
(ahead of the Boards in Common on 10 December)

- Hold the Board development session (4 November) and present to the Boards in Common (12 November)
- Finalise and agree the IRP Recovery Compact
- Develop and test the safe landing assurance framework
- Test the detailed dissolution timeline with workstream leads and design shadow running
- Agree the programme budget and the appointment routes
- Complete the inventories and set the timeline for drafting and approving the collaboration agreements
- Test the decision rights framework with the Trusts, the ICB and NHS England

Workstream progress update

NHS Humber Health Partnership

In October, all seven workstreams mobilised and are on track. Inventory completion and staff uncertainty about care group arrangements are the main areas to watch.

Workstream	Status	Progress in October
1. Strategy	On track	Mobilised with Lyn Simpson and Therese Patten as co-leads, and the business case for developing the strategies submitted to NHS England. Scope is being refined ahead of the Clinical Policy Group on 5 November.
2. People and Leadership	On track	Interim Chief Executive and Chair appointed at NLaG, with interim and HUTH substantive executive recruitment under way. Uncertainty about care group structures is concerning staff in group roles.
3. Operating Models and ICB Commissioning	On track	Business case for developing the target operating models submitted to NHS England, and the ICB has shared its high-level view of commissioning implications. Sequencing of commissioning reviews is being set out.
4. Governance, Board and Legal	On track	Draft Board governance manuals developed for both Trusts, and legal advice received on the memorandum of understanding and accountable officers. Next steps on decision rights and NED recruitment are being agreed.
5. Communications and Engagement	On track	Communications and engagement plan developed across the three programmes, and the transition principles circulated Trust-wide. Staff are asking for clarity on the timeline, with no dedicated comms resource yet.
6. Quality, Safety and Clinical Continuity	On track	Chiefs of Service engaged, and the clinical inventory template pre-populated and handed over to 10 of the 14 care groups. Clinician capacity to complete and validate the inventory is the main risk.
7. Finance and Resources	On track	Workstream charter drafted, corporate inventory process agreed and the template handed over to 3 of the 7 corporate directorates. Meetings with the remaining directorate leads are being arranged.

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Workstream highlight reports

Highlight report: assurance

NHS Humber Health Partnership

RAG key: Green: on track | Amber: at risk, mitigations in place | Red: off track, action needed

Workstream 1: Strategy	Start date: 14/09/2026 End date: Dissolution date (TBC)	Reporting week: 19–23 October 2026	

SRO	Lyn Simpson, Group Chief Executive, and Therese Patten, Interim NLAG Chief Executive	**Workstream Lead**	Lyn Simpson (HUTH) and Therese Patten (NLAG), co-leads	**Clinical Lead**	N/A
PMO Support	Transition Office (CF), Jacqueline Roberts and Daniel Huntley	**Other Key Individuals**	N/A – workstream mobilisation still underway		

ASSURE: Inform Programme Delivery Group (PDG) where positive assurance has been achieved

- Submitted proposal and business case approval to NHSE on developing the clinical strategies

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- Working through the establishment of a Clinical Reference Group and potentially independent Senate which would support the review of clinical inventories and development of the strategies for the Trusts
- Preparing for the Clinical Policy Group meeting on 5 November to discuss clinical design principles and what makes an effective clinical strategy
- In the process of further scoping the strategy workstream, including its objectives, requirements and approach

ALERT: Alert to matters that require the Programme Delivery Group (PDG) attention or action

- No items for escalation this week.

Key Issues / Risks	Recommended Actions	Likelihood	Impact	Score	Status	Latest Update
The engagement approach is not fit for purpose and leads to delays in the workstream or disengagement	Identify and test the engagement requirements early for the strategy workstream, and ensure there is regular communications and engagement	2	3	6	Open	
The clinical inventories are delayed which is a key input into the clinical strategies	Actively monitor progress with the inventories to identify, escalate and resolve any potential delays	2	4	8	Open	
Commissioner decisions, and the commissioning arrangements needed to support the clinical strategies are delayed	Work with the ICB to map out the commissioning reviews and actions needed, including the sequencing and dependencies to establish timelines	2	4	8	Open	

Highlight report: assurance

NHS Humber Health Partnership

RAG key: Green: on track | Amber: at risk, mitigations in place | Red: off track, action needed

SRO		**Workstream Lead**	Helen Marks, Group CPO and Paul Bunyan, Deputy CPO	**Clinical Lead**	N/A
PMO Support		**Other Key Individuals**	Anne Lloyd, Regional Director of Workforce, Learning and Education; Lucy Vere, OD Director; Mel Bunyan, Recruitment Lead; Claire Rix, Senior Operational HR Lead		

ASSURE: Inform Programme Delivery Group (PDG) where positive assurance has been achieved

- Interim and substantive executive recruitment underway; Interim CEO and Chair appointed at NLAG, other interim posts out to recruitment at NLAG, substantive exec recruitment underway at HUTH
- OD workstream stood up with OD Lead assigned and interim OD plan in development

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- Recruitment to Interim posts at NLAG and substantive vacancies in HUTH is ongoing; updates to be provided to PDG as roles are filled and NLAG interim execs will become workstream co-leads
- Budget is due to be submitted to cover external HR advisory costs, executive search support, and interim transition support

ALERT: Alert to matters that require the Programme Delivery Group (PDG) attention or action

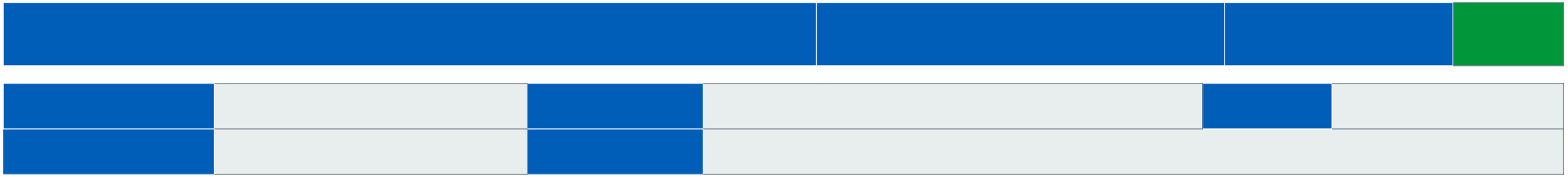
- Uncertainty over the care group structure is causing concern among staff in group roles. A balanced stakeholder group is needed for co-creation to ensure that we are staying true to our transition principles. Next steps: agree the process and timelines, and communicate with staff when possible. Taken to PDG for noting.

Key Issues / Risks	Recommended Actions	Likelihood	Impact	Score	Status	Latest Update
Most Group executives are employed by HUTH, so NLAG is left with a new team or without senior leaders	Plan appointments across both Trusts; appoint NLAG's interim leaders early	2	4	8	Open	Interim CEO and Chair appointed at NLAG, recruitment to additional interim posts begun.
Care group leads remain uncertain about their roles until the care group layer is designed and they are confirmed in role, leading to disengagement or departures.	Engage care group leads early, with a named sponsor and a route to raise concerns (deliverable 8), timed with the care group design in the Operating Models and ICB Commissioning workstream.	2	4	8	Open	Staff in group roles have raised many questions; comms on next steps and timelines will follow once confirmed. Clinical engagement groups being confirmed to maintain clinician involvement.

Highlight report: assurance

NHS Humber Health Partnership

RAG key: Green: on track Amber: at risk, mitigations in place Red: off track, action needed



ASSURE: Inform Programme Delivery Group (PDG) where positive assurance has been achieved

- Submitted proposal and business case approval to NHSE on developing the Target Operating Models (TOM)
- Received high level assessment of commissioning implications from the ICB and whether work is underway

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- Sam and Anja met in relation to the commissioning aspects and agreed to meet again with Alex Seale and Shaun Jones from the ICB once all of the information had been received from the Chiefs of Service
- Establishing the sequencing of activities and engagement needed on developing the TOM, including commissioning reviews and actions

Key Issues / Risks	Recommended Actions	Likelihood	Impact	Score	Status	Latest Update
Winter pressures may test accountabilities during the Transition Programme	Develop a winter pressures framework to establish accountabilities across services	2	4	8	Open	
The operating model and care group layer design depends on the inventories, strategic direction and engagement processes	Set out the sequence of activities needed to develop the TOM and informs the care group layer and roles	2	3	6	Open	
Commissioner decisions, and the commissioning arrangements needed to support the operating models are critical and may be subject to delay	Work with the ICB to map out the commissioning reviews and actions needed, including the sequencing and dependencies to establish timelines	2	3	6	Open	

Highlight report: assurance

NHS Humber Health Partnership

RAG key: Green: on track | Amber: at risk, mitigations in place | Red: off track, action needed

Workstream 4: Governance, Board and Legal	Start date: 14/09/2026 End date: Dissolution date (TBC)	Reporting week: 19–23 October 2026	

SRO	Keith Haynes, Group Board Secretary	**Workstream Lead**	Keith Haynes, Group Board Secretary	**Clinical Lead**	N/A
PMO Support	Transition Office (CF), Jacqueline Roberts and Daniel Huntley	**Other Key Individuals**	Alison Hurley, Deputy Director of Assurance		

ASSURE: Inform Programme Delivery Group (PDG) where positive assurance has been achieved

- Draft Board Governance Manuals developed for HUTH and NLAG setting out authoritative bodies, governance and assurance framework, internal control systems, independent control systems and regulation, and behaviours and standards
- Received legal advice on amending the Memorandum of Understanding for accountable officers and dissolution date

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- Review legal advice and determine next steps for the Memorandum of Understanding, accountable officers, decisions rights and approach to dissolution for the Boards
- Recruitment approach for NEDS in discussion and whether previous pool of applicants should be used as a starting point

ALERT: Alert to matters that require the Programme Delivery Group (PDG) attention or action

- No items for escalation this week

Key Issues / Risks	Recommended Actions	Likelihood	Impact	Score	Status	Latest Update
NED and Exec appointments take longer than planned, delaying the HUTH and NLAG Boards being at quorate.	Confirm the lead times and process for recruitment early. Work with the Chairs to confirm approach for NEDs and the People and Leadership workstream for Execs.	2	4	8	Open	
Limited clarity on accountable officers, decision rights, and shadow running of Boards.	Seek legal advice on the Memorandum of Understanding to establish the position and sequencing of milestones and dependencies to dissolution	2	4	8	Open	Initial legal advice has been sought 20/10/2026

Highlight report: assurance

NHS Humber Health Partnership

RAG key: Green: on track | Amber: at risk, mitigations in place | Red: off track, action needed

Workstream 5: Communications and Engagement	Start date: 10/09/2026 End date: Post-dissolution (date TBC)	Reporting week: 19–23 October 2026	

SRO	Group Director of Communications	**Workstream Lead**	Myles Howell, Group Director of Communications and Ade Beddow, Head of Engagement	**Clinical Lead**	N/A
PMO Support	Ellie Langton, Carnall Farrar	**Other Key Individuals**	Band 6 Communication Support (vacancy)		

ASSURE: Inform Programme Delivery Group (PDG) where positive assurance has been achieved

- Developed communications and engagement plan for the three programmes: financial recovery, integrated improvement, and dissolution
- Transition principles circulated trust-wide; the safe landing conditions and high-level timeline will be circulated once approved at the appropriate forums.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- External stakeholder map being updated to identify key relationship holders at each Trust; plan in place to refresh it as interim and substantive appointments are made
- Safe landing conditions and high-level timeline to dissolution will be communicated to staff once approved at PDG, TSG and the Boards in Common
- Capacity: there is no dedicated communications resource for the transition, it is being handled by Myles and Ade, and when needed other members of the team, alongside their busy day jobs. Comms resourcing in the programme budget is still being scoped, and the number of forums and channels it updates keeps growing.
- Communications on dissolution: staff across the Trust are increasingly asking for clarity on the dissolution, including the sequence of activities, the timeline and future care group arrangements. The workstream will work with the Transition Officer and other relevant workstreams to confirm when this can be shared. PDG is asked to note this escalation.

ALERT: Alert to matters that require the Programme Delivery Group (PDG) attention or action

- No items for escalation this week.

Key Issues / Risks	Recommended Actions	Likelihood	Impact	Score	Status	Latest Update
Capacity: no dedication communications resource for the transition; managed by Myles and Ade and other team members as needed alongside BAU and other priorities.	Scope the resourcing requirements for the programme budget (e.g., Band 6 post); develop one set of key messages to use across most forums	3	3	9	Open	New risk raised this week; to add to the programme risk log
Timeline and delays: a timeline is developed and expectations are set amongst staff, which is then not achieved due to unforeseen delays, causing anxiety amongst staff.	Track each deliverable against the milestone it supports; hold dates in the forward plan; review at PDG; communicate early to staff where there are unforeseen delays	2	4	8	Open	

Highlight report: assurance

NHS Humber Health Partnership

RAG key: Green: on track | Amber: at risk, mitigations in place | Red: off track, action needed

Workstream 6: Quality, Safety and Clinical Continuity	Start date: 14/09/2026 End date: Dissolution date (TBC)	Reporting week: 19–23 October 2026	

SRO	Peter Sedman, Deputy Chief Medical Officer, and Joanne Ledger, Deputy Chief Nurse	**Workstream Lead**	Peter Sedman and Joanne Ledger	**Clinical Lead**	N/A
PMO Support	Transition Office (CF), Daniel Huntley and Anna Lashley	**Other Key Individuals**	N/A		

ASSURE: Inform Programme Delivery Group (PDG) where positive assurance has been achieved

- Workstream charter drafted, setting out key deliverables and dependencies with six other workstreams, risks and transition programme resourcing requirements.
- The Chiefs of Service have been engaged about the transition programme, and clinicians more widely will be engaged in the Clinical Policy Group on the 5th November.
- The Chiefs of Service have shared initial data for the clinical inventory, which has been used to pre-populate the template where applicable ahead of further data gathering with the triumvirates.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- The inventory template has been drafted to develop a validated record of clinical services across HUTH and NLAG, showing where the two Trusts work together today and what holds each arrangement in place. The agreed process was presented to the Chiefs of Service, with handover meetings being arranged with the triumvirates so they can begin populating the template for their care groups.
- Clinician capacity: clinicians have limited time to complete and validate the inventory alongside their day-to-day roles. The Transition Office (CF) is supporting care groups to complete the template.

ALERT: Alert to matters that require the Programme Delivery Group (PDG) attention or action

- No items for escalation this week.

Key Issues / Risks	Recommended Actions	Likelihood	Impact	Score	Status	Latest Update
The clinical inventory is not completed and validated in time, because clinicians have limited time alongside recovery and winter pressures, or because the two Trusts disagree on entries.	Escalate disagreements to the appropriate clinical group in a timely manner. Utilise all members of the triumvirate to support with completion of the collaboration inventory template	3	4	12	Open	
Workstream leadership capacity may become stretched as the deliverables progress, as there is no dedicated support below the workstream leads to delegate to.	Progress monitored against deliverable dates, and resourcing revisited if a milestone slips.	2	4	8	Open	

Highlight report: assurance

NHS Humber Health Partnership

RAG key: Green: on track | Amber: at risk, mitigations in place | Red: off track, action needed

Workstream 7: Finance and Resources	Start date: 14/09/2026 End date: Dissolution date (TBC)	Reporting week: 19–23 October 2026	

SRO	Emma Sayner, Group Chief Finance Officer	**Workstream Lead**	Emma Sayner, Group Chief Finance Officer	**Clinical Lead**	N/A
PMO Support	Transition Office (CF), Daniel Huntley and Pooja Murali	**Other Key Individuals**	Philippa Russell; Brian Shipley		

ASSURE: Inform Programme Delivery Group (PDG) where positive assurance has been achieved

- Workstream charter drafted, setting out key deliverables and dependencies with six other workstreams, risks and transition programme resourcing requirements.
- Key individuals of the workstream have been engaged about the transition programme and inventory
- Collaboration inventory template handed over to the first corporate directorate (finance) on Thursday 22 October.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- Following communications to the corporate directorate leads on the corporate inventory process, we meetings are being arranged with each lead so that the inventory template can be shared with their services for completion.

ALERT: Alert to matters that require the Programme Delivery Group (PDG) attention or action

- No items for escalation this week

Key Issues / Risks	Recommended Actions	Likelihood	Impact	Score	Status	Latest Update
Limited availability of directorate and service leads delays the handover of the corporate inventory template and delays the completion timeline	Hand over the template at existing forums and set a return date with them. Provide drop-in sessions for any questions or issues with gathering the data	2	3	6	Open	
Shared services or arrangements that don't sit exactly under corporate structures are left off the inventory, so collaboration arrangements aren't formally developed for these services	Validate all services that sit under each directorate before proceeding with the data collection. Ask about any arrangements or services that leads are aware of and not reflected in the template	2	4	8	Open	

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Listening to Clinicians Learning from Patients

Our Improvement Plan – Delivery Progress October 26

Report for Trust Boards-in-Common November 2026

Introduction

This report provides the Humber Health Partnership Boards-in-Common with an update on progress in delivering the Integrated Improvement Plan (IIP), *Listening to Clinicians, Learning from Patients*, during October 2026. It provides an overview of programme delivery and impact, including progress against National Oversight Framework (NOF) metrics, CQC Section 29A Warning Notices and Value Circle recommendations. It also sets out workstream progress, including executive assurance ratings and impact against key workstream KPIs, together with the most significant risks to delivery and associated mitigating actions.

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

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

Overarching workstream RAG definitions are;

- Minimal
- Limited
- Reasonable
- Significant

Executive Summary

Delivery and organisational grip continue to strengthen through the IIP, with clearer regulatory assurance and emerging operational benefits; the key test now is translating progress into sustained, measurable impact while maintaining continuity through transition.

- The IIP, Financial Recovery Programme (FRP) and Transition Programme remain the Partnership's principal programmes. Strong cross-programme alignment is being maintained as HUTH and NLaG progress towards separate sovereign organisations, ensuring delivery remains coordinated and priorities, dependencies and risks are actively managed.
- The IIP is providing an increasingly robust framework for tracking and evidencing progress against the Partnership's regulatory undertakings, strengthening visibility of the overall assurance position to Region.
- The focus for the coming months will be to continue translating delivery progress into measurable and sustained improvement, with the IIP Oversight Group and workstream delivery groups strengthening performance, risk and benefits management.
- October reporting covered 209 deliverables. 29 deliverables (13%) are rated Off Track/Escalate, reflecting target dates missed by more than one month. Of these, six are pending closure subject to final evidence, while the remaining deliverables require focused recovery action to return delivery to plan, where achievable. 23 (+14 from Sept) deliverables are complete with full evidenced and closed.
- Key benefits of the IIP during October include:
    - Identifying workstreams or deliverables where delivery is not gaining sufficient traction, progress is falling behind plan or governance arrangements are duplicative enabling targeted intervention.
    - Clearer assessment of regulatory undertakings, Value Circle recommendations and CCQ 29A.
    - Good evidence of governance and leadership being strengthened including BAF refresh, governance manual and recruitment of leadership roles.
    - Revision of PISRF policy, closure of the HUTH PALS backlog, significant reduction in complaints backlog and improvement in duty of candour.
    - Improvements to data quality/focus and dashboard development particularly for quality agenda.
- The IIP Oversight Group has identified and reviewed the following key programme risks during the month, which are highlighted to the Board for visibility and continued oversight;
    - **Organisation transition:** The move towards separate organisations presents a material risk to continuity of IIP delivery and assurance. As workstreams begin to transition, limited capacity increases the risk of fragmented ownership, duplicated activity and loss of oversight, requiring clear transition controls to protect delivery and assurance against existing commitments. **The Board-in-Common is asked to consider the options set out on slide 4 and agree the proposed way forward.**
    - **EPR:** Delivery of the EPR, particularly in relation to product functionality for go-live, delays to the Delivery Implementation Plan and uncertainty regarding data migration. Mitigating actions require further definition and continued Executive oversight to provide assurance on readiness and delivery.
    - **Operational Performance:** Assurance requires strengthening for Planned and Unplanned care reporting which will be aligned through one evidence base, with priority metrics, refreshed deliverables, risks and escalation thresholds agreed through existing governance.
    - **Workforce and clinical ownership:** Delivery capacity and capability remain variable, with several workstreams dependent on sustained clinical leadership and specialist workforce capacity.
    - **Data, KPI and benefits maturity:** There still remains incomplete baselines, variable KPI quality, limited BI capacity and inconsistent benefits evidence restrict the ability to demonstrate improvement.
    - **Risk and assurance maturity:** Risk management remains variable across workstreams. SRO confirm-and-challenge will need to continue to improve validation of risk scoring, controls and mitigations.

PMO capacity: current position, future requirements and decision

The transition to separate organisations presents a material risk to continuity of IIP delivery and assurance. Current PMO capacity cannot be divided across two organisations without creating gaps in delivery, governance and oversight, increasing the risk of fragmented ownership and duplicated activity. Clear transition arrangements and sufficient programme capacity are therefore required to protect existing improvement and regulatory commitments.

CURRENT CAPACITY

8 **core PMO posts**

7 currently aligned to NLaG

1 currently aligned to HUTH

Fully committed

1 FUTURE DELIVERY REQUIREMENT

Each organisation requires a minimum core PMO capability for:

- Programme and project leadership
- Delivery of IIP and FRP priorities
- Transition and separation activity
- Operational and corporate improvement support
- Integrated planning and dependency management
- Risk, issue and assurance management
- Benefits, performance and outcome reporting
- Board, regulatory and external assurance

Plus time-limited shared transition support

2 CAPACITY GAP AND DELIVERY RISK

NLaG

- Most established PMO capacity is currently based at NLaG
- A significant proportion is already committed to existing HHP-wide programmes
- Transition arrangements must protect delivery while confirming retained NLaG capacity

HUTH

- Improvement capability exists but is dispersed across the organisation
- Available capacity and existing commitments are not yet fully understood
- Dedicated or aligned resource is likely to be required for HUTH's IIP, FRP, transition and wider improvement responsibilities

Risk to ownership, reporting and assurance

3 DECISION REQUIRED

The Board is asked to:

1. **Recognise** the issue is overall improvement and programme capability, not simply a predetermined PMO size.
2. **Commission** a rapid mapping of existing PMO, improvement and transformation resource across NLaG and HUTH.
3. **Define** the minimum capability and resource needed to deliver IIP, FRP, transition responsibilities and wider improvement.
4. **Prioritise** identification, alignment or recruitment of additional capacity where gaps are confirmed, particularly across HUTH.
5. **Approve** interim shared or time-limited arrangements to maintain continuity until sustainable arrangements are established.

Decision required

BOARD DECISION REQUIRED:

Commission a capability and resource assessment across both organisations, followed by a plan to secure sufficient improvement and programme capacity for the IIP, FRP, Transition Programme and wider priorities, with particular focus on closing gaps across HUTH to ensure that both organisations are supported to ensure that regulatory requirements are met.

Demonstrating the Impact of the IIP

1. Regulatory Undertakings
2. CQC 29A Warning Notices
3. Value Circle Recommendations
4. National Oversight Framework (NOF)

Progress against Regulatory Undertakings (1)

1 Board Governance

The independent Board and governance review has been completed, and we have incorporated its recommendations into the IIP, with Executive ownership and clear Board assurance routes in place.

We are progressing implementation through the governance reset, refreshed BAF, strengthened accountability framework and Board and Executive development programme, with continued support from Value Circle.

We are also using the Transition Programme to ensure governance, accountabilities and decision rights are clearly defined for HUTH and NLaG as they move towards separate sovereign organisations.

The next phase is focused on embedding these arrangements and evidencing their impact.

We recognise that assurance will increasingly need to demonstrate not simply that the required structures and processes are in place, but that they are driving sustained improvements in Board effectiveness, accountability, risk management and decision-making.

Reasonable Assurance, progressing positively

2 Operational Recovery

The IIP is established as our principal framework for operational recovery, with dedicated UEC, planned care and Care Group recovery workstreams, clear Executive ownership and strengthened oversight.

We recognise that performance across UEC, elective and cancer remains below the required standards and that further improvement is required in the quality of our recovery plans, particularly around baselines, trajectories, data quality, risks and evidence of impact.

While there are emerging improvements, our priority is to convert these into sustained and measurable recovery against agreed trajectories.

In parallel, we are explicitly addressing the leadership, operational management and cultural requirements within the undertakings, including the normalisation of ED overcrowding, with clear actions, ownership and timescales.

Limited Assurance

3 Financial Recovery

We have materially strengthened our financial recovery arrangements through the dedicated Financial Recovery Programme, Financial Improvement Director, enhanced governance and stronger grip and control processes.

CIP governance, scheme validation, change control, workforce controls and financial reporting have all been strengthened. We recognise that the key test is now translating this improved grip into sustained recurrent financial improvement.

The underlying deficit and scale of the 2026/27 CIP requirement remain significant, and achieving longer-term financial sustainability will require wider workforce, service and system transformation alongside delivery of efficiencies.

Our priority is to reduce the underlying run-rate, increase recurrent savings and establish a credible trajectory towards financial sustainability, while protecting quality, safety and operational delivery.

Strengthened grip and control, but limited assurance on recurrent delivery and sustainability

Progress against Regulatory Undertakings (2)

4 Funding & Spending controls

We have incorporated funding conditions and spending approval requirements into our regulatory and financial governance arrangements, supported by the Financial Recovery Programme and Board assurance routes.

Our focus is now on consolidating the evidence against each element of the undertaking, providing a clear line of sight across funding conditions, NHS England reporting requirements and required spending approvals.

This will enable us to demonstrate compliance more explicitly and ensure that any outstanding requirements are clearly identified, owned and managed.

Limited assurance pending further evidence

5 Delivery of Undertakings

We have substantially strengthened the governance arrangements supporting delivery of our regulatory undertakings, with the IIP providing a clear route from workstream delivery and Executive SRO accountability through CEO-led oversight to Board assurance.

The IIP Oversight Group is established and providing increased Executive challenge and visibility of delivery, risks, dependencies and areas requiring intervention.

We recognise that the assurance framework must continue to mature, particularly around risk management, data quality, baselines, trajectories and evidence of impact.

Our focus is now moving beyond demonstrating that governance is in place to evidencing how it drives accountability, timely intervention, effective risk mitigation and sustained improvement.

Reasonable/ developing assurance

6 Meetings and reports

We continue to engage fully with NHS England through the established oversight arrangements and provide regular reporting across our regulatory, improvement and recovery programmes.

The Integrated Oversight Board provides a formal route for oversight of the undertakings and IRP, supported by exception-based reporting covering performance, trajectories, risks, mitigations, accountable leads, actions and evidence of impact.

Our focus is on maintaining timely and consistent reporting while continuing to strengthen its quality and outcome focus, ensuring our Boards and NHS England have a clear and aligned view of progress, risks and areas requiring intervention or support.

Reasonable assurance

Progress against CQC 29A Warning Notices

01 Leadership: Board reset

- Transition plan in place to maintain stability, effective governance and patient safety.
- HUTH recruitment progressing for the Chief Medical Officer, Chief Nurse and Corporate Secretary.
- NLAG Chief Executive and Chair appointed, with wider Board recruitment planned for Q3.

02 Governance

- Separate Governance Manuals are being developed for HUTH and NLAG.
- Risk Strategy and Performance & Accountability Framework are progressing through ratification.
- BAF refreshed due for board ratification.
- Triple AAA reporting rolled out across committees and executive forums.

03 Clinical governance

- PSIRF Policy reviewed and updated to strengthen learning from patient safety incidents.
- Duty of Candour compliance has improved to 100%.
- Overdue PSIRF investigations are recovering in line with the December 2026 trajectory.

04 Quality & safety

- Historical complaints backlog continues to reduce toward December 2026 completion.
- PALS backlog reduced by 80%; complaints answered within agreed timescales increased by 50%.
- Gram-negative bloodstream infection (GNBSI) improvement activity is progressing, including the revised catheter policy, TWOC pathway and baseline peripheral cannula audits.
    - HUTH improvement in performance include Ecoli, MRSA and MSSA
    - NLAG improvements in performance include Klebsiella and MSSA

05 Culture

- OD programme established to support transition to two sovereign organisations.
- Leadership development, behavioural expectations and values are being aligned from Board to frontline.
- Dedicated culture workstream strengthens staff and patient voice, psychological safety and leadership visibility.

Value Circle Recommendation Progress

The Value Circle shared 44 core recommendations associated across 6 themes;

- Board Assurance Framework
- Risk Management
- Quality & Safety
- Assurance & Reporting
- Role, Responsibilities and Accountabilities
- Strategy & Shared Direction

There are a further 8 recommendations within the appendices across 5 themes;

- Non-Executive Directors
- Focus of the Board
- HHP Board Sub-Committees
- Assurance
- Board Development

All Value Circle recommendations were aligned to the relevant IIP workstreams and translated into clearly defined deliverables with agreed actions, ownership and target dates to support a structured and prioritised approach to implementation.

Given the scale and complexity of the recommendations, many of which span multiple themes and workstreams, achievement cannot always be evidenced through completion of a single deliverable. In many instances, multiple interconnected deliverables are required before a recommendation can be considered fully implemented and sustainable.

Total number of recommendations	Completed	Expected completion October	Expected completion November	Remaining to progress past November
52	13	4	9	26

Key Developments to date:

- BAF refresh, systematic process development
- AAA reporting successfully piloted and rolled out
- Development of Governance Manuals and Performance Accountability Framework
- Care Group triumvirates are now routinely represented at SLT meetings
- Appointment of NEDs
- Executive portfolios and job descriptions reviewed
- Board level of quality & safety strengthened, rebalance of portfolios for quality governance
- All Never Events reviewed confirming status and ownership
- Risk register cleanse
- Stocktake of PSIRF arrangements
- Strengthened quality & safety reporting
- IPR refresh continues with performance complete, quality, workforce and finance now progressing
- Stocktake of strategy development
- Executive-led review process is in place for all CQC Improvement Plans.

Work is now progressing to:

- Continue monthly review and forecasting of progress, dependencies and delivery risks.
- PMO and SRO continuous review of opportunities to accelerate delivery and address barriers through workstream delivery / steering groups.
- Formal closure and evidence review process for recommendations ready for completion through IIP Oversight Group
- Expanded benefits realisation and KPI monitoring (where applicable) to evidence the impact of completed recommendations on governance, assurance, accountability, decision-making and organisational performance.

The IIPs Impact to NOF (1)
Data pulled from Power BI Group IRP 20.10.26

Group summary (Access to Services) - Alert:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
A&E - 4 Hour Standard (All - Footprint)	Sep-26	68.6%	-2.4%	≥ 75.9%	≥ 78.9%				Alert
A&E - 4 Hour Standard (All)	Sep-26	62.4%	-2.7%	≥ 71.0%	≥ 74.6%	≥ 82.0%			Alert
A&E - Total Time in A&E (Admitted)	Sep-26	652	101			≤ 180			Alert
Cancer - 62 Day All Referral Sources	Aug-26	54.2%	-0.8%	≥ 56.3%	≥ 69.9%	≥ 80.0%			Alert
RTT - 78+ Week Waits	Sep-26	17	7			≤ 0			Alert
RTT - Annual Change in Waiting List Size	Sep-26	7.4%	-0.5%			≤ 10.0%			Alert
RTT - Incomplete 18 Week Standard	Sep-26	56.0%	-0.4%	≥ 59.9%	≥ 65.3%	≥ 92.0%			Alert
RTT - Patients waiting 52+ weeks for Community Services	Sep-26	17.0%	0.3%						Alert
RTT - Percentage of 52+ Week Waits	Sep-26	4.0%	0.1%	≤ 3.9%	≤ 3.6%	≤ 1.0%			Alert
A&E - Conversion Rate (under 18s)	Sep-26	15.7%	0.7%						
RTT - Difference between actual and planned 18 week performance	Sep-26	-3.9%	-2.0%						

Group summary (Access to Services) - Advise:

A&E - 4 Hour Standard (Type 1)	Sep-26	46.8%	-3.0%	≥ 54.5%	≥ 59.3%				Advise
A&E - Ambulance Average Handover Time	Sep-26	28.9	-0.1	≤ 23.0	≤ 20.0				Advise
A&E - Ambulance Handovers within 45 minutes	Sep-26	88.2%	-0.1%	≥ 93.1%	≥ 93.9%				Advise
A&E - Time to Initial Assessment	Sep-26	31	0			≤ 15			Advise
A&E - Total Time in A&E (Patients >=65 years)	Sep-26	484	58			≤ 160			Advise

Group summary (Access to Services) - Assure:

A&E - Conversion Rate (over 65s)	Sep-26	35.7%	-2.3%						Assure
A&E - Corridor Care in Dept	Sep-26	36	2						Assure
A&E - Patients Waiting > 12 hours in Department	Sep-26	15.1%	2.7%	≤ 15.3%	≤ 14.6%	≤ 0.0%			Assure
Cancer - 28 Day Faster Diagnosis Standard	Aug-26	72.3%	2.7%	≥ 70.7%	≥ 80.0%	≥ 80.0%			Assure

The IIPs Impact to NOF (2)
Data pulled from Power BI Group IRP 20.10.26

Group summary (Effectiveness & Experience) - Alert:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
Inpatient - Bed Occupancy (General & Acute)	Sep-26	95.4%	4.4%	92.0%	93.3%				Alert
Inpatient - Days between DRD and Discharge Date	Sep-26	5.0	0.0	≤ 4.0	≤ 4.1				Alert
A&E - Urgent Community Response Attendances assessed < 2 ho...	Sep-26	97.6%	-0.2%						
CQC Inpatient Survey Satisfaction Mean Score	Sep-26	8.2	0.0						
Inpatient - Annual Growth Under 18s Elective Activity	Sep-26	-1.9%	0.1%						
Inpatient - Average Length Of Stay (Elective)	Sep-26	0.4	0.0						
Inpatient - Bed Days Lost to NCTR Patients	Sep-26	5,384	-4,205						
Inpatient - Bed occupancy classed as clinically ready for discharge	Sep-26	23.5%	0.3%						
Inpatient - Emergency Readmissions within 30 days	Aug-26	10.4%	0.1%						
Mortality - Crude Mortality (non-elective)	Sep-26	2.0%	-0.2%						

Group summary (Effectiveness & Experience) - Advise:

Mortality - SHMI	May-26	1.0	0.0			≤ 1.0			Advise

Group summary (Effectiveness & Experience) - Assure:

Inpatient - Average Length Of Stay (Non-Elective)	Sep-26	3.1	0.0	≤ 7.1	≤ 7.2				Assure
Inpatient - Corridor Care on Wards	Sep-26	25.0	5.0						Assure
Inpatient - Day Case Rate	Sep-26	90.7%	1.2%			≥ 85.0%			Assure
Inpatient - Elective Spells	Sep-26	12,102	579	12,791	12,210				Assure

The IIPs Impact to NOF (3)
Data pulled from Power BI Group IRP 20.10.26

Group summary (Finance & Productivity) - Alert:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
Finance - Agency YTD actual spend against previous year (000's)	Sep-26	65.5%	-1.7% ↑			≤ 70.0%			Assure
Finance - Bank YTD actual spend against previous year (000's)	Sep-26	76.9%	-0.5% ↑			≤ 70.0%			Alert
Finance - CIP YTD against Plan	Sep-26	60.0%	-4.6% ↓						Alert
Finance - ECP YTD actual spend against previous year (000's)	Sep-26	159.5%	-1.0% ↑			≤ 70.0%			Alert
Finance - Overtime YTD actual spend against previous year (000's)	Sep-26	88.2%	-3.0% ↑			≤ 70.0%			Alert
Finance - Planned Surplus/Deficit	Sep-26	-63,065	0 —						
Finance - Variance YTD to Financial Plan	Sep-26	-20,839	-4,456 ↓						

Group summary (Finance & Productivity) - Advise:

Theatres - Capped Theatre Utilisation	Sep-26	81.6%	-1.7% ↓			≥ 85.0%			Advise

Group summary (Finance & Productivity) - Assure:

Finance - Agency YTD actual spend against previous year (000's)	Sep-26	65.5%	-1.7% ↑			≤ 70.0%			Assure

The IIPs Impact to NOF (4)
Data pulled from Power BI Group IRP 20.10.26

Group summary (Patient Safety) - Alert:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
Infections - C.Difficile	Aug-26	17	7 ↓						Alert
Infections - E.Coli	Aug-26	28	5 ↓						Alert
Pressure Ulcers - Hospital acquired	Sep-26	363	-16 ↑						Alert
Staff Survey - Raising Concerns sub-score	Sep-26	6.1	0.0 –						Alert
VTE Risk Assessment	Sep-26	93.7%	-0.3% ↓			≥ 95.0%			Alert
VTE Risk Assessment 14 Hour Standard	Aug-26	92.2%	-0.5% ↓			≥ 95.0%			Alert
CQC Safe Inspection Score	Sep-26	1.5	0.0 –						
Falls - Moderate and above (per 1,000 bed days)	Sep-26	0.1	0.0 ↑						
Infections - C.Difficile (per 1,000 bed days)	Aug-26	0.3	0.1 ↓						
Infections - E.Coli (per 1,000 bed days)	Aug-26	0.5	0.1 ↓						
Infections - MRSA	Aug-26	0	0 –						
Infections - MRSA (per 1,000 bed days)	Aug-26	0.0	0.0 –						
Patient Safety Incidents - % Harmful	Sep-26	2.5%	-0.5% ↑						

Group summary (Patient Safety) - Advise:

Group summary (Patient Safety) - Assure:

Infections - MRSA (Cumulative)	Aug-26	1	0 –						Assure

The IIPs Impact to NOF (5)
Data pulled from Power BI Group IRP 20.10.26

Group summary (People & Workforce) - Alert:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
Healthcare Worker Flu Vaccination Rate	Apr-26	51.1%	-0.3%			≥ 60.0%			Alert
Staff Appraisal Rate (AfC)	Aug-26	81.8%	0.2%			≥ 85.0%			Alert
Staff e-Job Planning	Sep-26	76.1%	-9.1%			≥ 95.0%			Alert
Staff Headcount reduction against target (350)	Sep-26	-9.0%	-31.9%			≥ 100.0%			Alert
Staff Mandatory Training - Role Specific	Aug-26	82.5%	1.2%			≥ 85.0%			Alert
Staff Sickness Absence Rate	Aug-26	4.9%	0.1%			≤ 4.0%			Alert
Staff Survey - Engagement Theme Score	Sep-26	6.4	0.0			≥ 6.6			Alert
Staff Time to Employment Checks	Sep-26	28.9	3.6			≤ 20.0			Alert
Staff Time to Offer	Sep-26	11.7	2.1			≤ 2.0			Alert
Staff Time to Shortlist	Sep-26	10.3	-1.3			≤ 5.0			Alert
Staff Headcount reduction against baseline	Sep-26	31	112						
Staff Headcount reduction on previous month	Sep-26	112	115						

Group summary (People & Workforce) - Advise:

Group summary (People & Workforce) - Assure:

Staff Mandatory Training - Core	Aug-26	87.1%	1.8%			≥ 85.0%			Assure
Staff Turnover Annual FTE Rate	Aug-26	6.9%	-0.4%			≤ 8.0%			Assure

IIP Delivery Progress

1. By Workstream Overview
2. Key IIP Risks in month
3. Individual Workstream progress including key KPIs
4. Comms and Engagement

Listening to Clinicians, Learning from Patients

IIP Overview October Summary by Workstream

NHS Humber Health Partnership

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

	August	September	October
Leadership			
1.1 Governance Reset & Stabilisation			
1.2 Board & Exc Development			
Clinical Governance			
2.1 Clinical Governance Improvement			
2.2 PSIRF			
2.3 Ward Accreditation			
Safety and Quality			
3.1a Quality Priorities Sepsis			
3.1b Quality Priorities Insulin			
3.1c Quality Priorities Infection Reduction			
3.1d Quality Priorities Safer Surgery			
3.1e Quality Priorities Preventing Deconditioning			
3.2 Patient Experience, Complaints & PALs			
3.3 CQC Actions			
3.4 Maternity	To be progressed	To be progressed	PoaP to be ratified November
Medical/Clinical Model			
4.1 Clinical Policy Group			
4.2 Learning Academy			
4.4 EPR			
Operational Performance			
5.1 Unplanned Care (UEC)			
5.2a Outpatients			
5.2b Theatres (Surgical Improvement)			
5.2c Cancer			
5.2d Diagnostics			
5.2e RTT			
5.3 Care group Recovery	To be progressed	To be progressed	To be progressed
5.4 Humber Acute Services			
5.5 Tertiary	To be progressed	To be progressed	To be progressed
People			
6.3 Staff Culture, leadership & Experience			

October Number of Workstreams in IIP	Active	On hold pending discussion	Minimal Assurance	Limited Assurance	Reasonable Assurance
26	24	2	7 (-3)	13 (+2)	+3

Key Updates in Month:

- **Governance Reset** and **Board & Executive Development** is progressively improving month on month establishing the governance and leadership foundations required to strengthen organisational oversight and accountability.
- Workstream delivery continues to progress, although executive assurance ratings remain static across a range of plans until measurable improvement against agreed KPIs can be demonstrated.
- A **Maternity** Plan on a Page has been developed and is due for ratification in November, bringing the 10 point plan into the IIP to ensure a coordinated framework to strengthen oversight of delivery, progress and impact.
- The **Care Group Recovery** workstream is progressing, with a proposed transition to 'Performance, Accountability and Organisational Intelligence Improvement'. This will strengthen the focus on measurable improvement and provide a clear mechanism for tracking delivery and evidencing progress against 7 key Value Circle recommendations.
- **Planned and Unplanned Care** workstreams are being reviewed to strengthen focus on priority recovery areas and streamline governance, accountability and reporting.
- **Clinical Policy Group** and **Learning Academy** deliverables will be reassessed to ensure alignment with the revised organisational direction.
- Minimal Assurance is maintained for PALS, Complaints and Patient Experience, allowing further evidence of sustained improvement following process resets.
- In October, the IIP has monitored a total of **209** deliverables.
- 29 deliverables (13%) are rated Off Track/Escalate, reflecting target dates missed by more than one month. Of these, six are pending closure subject to final evidence, while the remaining deliverables require focused recovery action to return delivery to plan, where achievable.
- **23** (+14 from Sept) deliverables are complete with full evidenced and closed.
- Measurable benefits from completed deliverables are not yet fully evident, with continued KPI monitoring required to evidence sustained impact and benefits realisation.

Highest Risks to Delivery

The IIP Oversight Group has identified and reviewed the following key programme risks during the month, which are highlighted to the Board for visibility, assurance and continued oversight. The immediate priority is to safeguard delivery of the IIP through a period of complex organisational transition, while strengthening the evidence required to demonstrate delivery against regulatory undertakings and CQC Section 29A requirements, completing outstanding external review recommendations and evidencing measurable and sustained improvement.

BOARD-LEVEL RISK **CURRENT EXPOSURE | IMPACT | REQUIRED MITIGATION**

1 Transition and central PMO capacity

Exposure HUTH and NLaG are moving towards separate sovereign arrangements while the central PMO is predominantly NLaG staffed and already committed.

Impact Fragmented ownership, duplicated reporting and weakened assurance against existing commitments.

Mitigation Agree future programme ownership, minimum assurance requirements and a resourced transition plan; protect critical central PMO capacity.

2 EPR readiness and implementation

Exposure EPR remains at Minimal Assurance due to product functionality for go-live, delayed implementation planning and uncertainty around data migration.

Impact Risk to safe go-live, operational continuity and delivery confidence.

Mitigation Maintain executive oversight; confirm accountable mitigations, implementation milestones, supplier actions and data-migration assurance.

3 Operational recovery and capacity

Exposure UEC, cancer, diagnostics and RTT recovery plans require clearer baselines, trajectories, capacity assumptions, milestones and evidence of impact.

Impact Performance recovery may not be delivered or sustained, with continued regulatory and patient-flow pressures.

Mitigation Strengthen recovery plans through existing governance; align planned and unplanned care reporting and escalate variance against agreed trajectories.

4 Data, KPI and benefits maturity

Exposure Incomplete baselines, variable KPI quality, limited BI capacity and inconsistent benefits evidence restrict the ability to demonstrate improvement.

Impact Reduced confidence in assurance ratings, decision-making and attribution of organisational impact.

Mitigation Prioritise BI support; validate baselines and trajectories; automate aligned reporting; require evidence of benefits before deliverable closure.

5 Workforce and clinical ownership

Exposure Delivery capacity and capability remain variable, with several workstreams dependent on sustained clinical leadership and specialist workforce capacity.

Impact Slower implementation, inconsistent delivery and reduced ability to sustain improvement.

Mitigation Confirm accountable clinical and operational leads; target scarce capacity to priority workstreams; extend IQIG engagement to NLaG clinicians.

6 Governance, risk and assurance maturity

Exposure Risk identification and control maturity remain inconsistent, and some workstreams are still mobilising or reviewing their future scope and deliverables.

Impact Material risks may be identified late and assurance may overstate delivery confidence.

Mitigation Continue SRO confirm-and-challenge; validate controls and mitigations; align risks to the BAF; complete CPG and Regulatory Undertakings reviews.

October Update – Leadership Domain

1.1 Governance Reset & Stabilisation

Reasonable Assurance: Reflecting establishing the governance foundations required to strengthen organisational oversight and accountability.

- BAF refresh completed and presented to the Audit, Risk & Governance Committee (ARG) on 15 October. Final ratification is scheduled for Board on 12 November, alongside a Board development session and establishment of a systematic review cycle to ensure BAF becomes a dynamic assurance tool.
- Agreed approach established via NEDs to ensure the BAF informs committee agendas, scrutiny and assurance, with associated expectations now being developed into the Board Leadership Compact.
- Draft Governance Manuals for NLAG and HUTH were presented to ARG on 15 October, with feedback now being incorporated ahead of implementation for the new Boards.
- The Performance Accountability Framework was presented to ARG and is scheduled for Board ratification in November.
- AAA reporting successfully piloted and rolled out across all Committees and Executive forums, with ARG scheduled to adopt the approach at next session in January 2027. Wider adoption is evident across other Partnership governance forums.
- Work to refresh the Board and Committee forward programme is progressing in parallel with BAF refresh.

1.2 Board & Executive Development

Reasonable Assurance: Reflecting strengthening Board and Executive effectiveness whilst recognising dependencies on wider organisational change.

- One NED and two Associate NEDs recruited and commenced in post 01 October.
- NLAG Chair commenced 01 October, CEO commenced post 05 October. Expression of interest exercise commenced at a regional level in October to establish an Interim NLAG Executive Team. All appointments will be made in November, with successful candidates starting in post as soon as possible. For HUTH substantive posts have been advertised for CMO, CNO, Director of Performance, Planning and Business Intelligence, and Corporate Board Secretary roles.
- All Executive portfolios have been reviewed and approved. All Executive appraisals complete (for current post holders). All NED appraisals complete (with exception of new post holders), HUTH chair appraisal planned 09 November.
- Communications and engagement arrangements are established now as business-as-usual, including staff roadshows, leadership visibility activity, targeted communications, the IIP intranet presence.
- Diagnostic engagement for the Board and Executive Development Programmes is underway supported by Value Circle. First dedicated development session being scheduled. Executive development has commenced with first session completed 01 October.
- Provider Capability assessment undertaken against Insightful Provider Board guidance and submitted to region.
- Board Leadership Compact being developed including roadmap for ratification, development opportunity and embedding.

Listening to Clinicians, Learning from Patients

October Update – Clinical Governance Domain (1)

NHS Humber Health Partnership

2.1 Clinical Governance

Limited Assurance: Delivery remains broadly on track, with revised forecast dates reflecting recognised workstream dependencies rather than delivery failure.

- Partnership-wide risk register cleansing is nearing completion as planned, with improved risk oversight and governance arrangements established. Risk Management Strategy progressing through governance approval.
- Preparatory work to align the Corporate Risk Register with the refreshed BAF has commenced.
- Audit governance arrangements remain in place, supported by established monitoring and reporting processes, with opportunities identified to strengthen consistency of oversight and clinical engagement across the Partnership.
- The revised EQIA Policy has been approved, with implementation planning now progressing. No retrospective EQIAs are currently reported.
- Monthly NICE compliance monitoring is established across all Care Groups, supported by specialty-level reporting and governance oversight.

Proportion of risks overdue for review has reduced from 7.2% in July to 4.95% in September

% documents & policies in date

88%

% of NICE compliance (target 100%)

NLAG = 89%
HUTH = 84%

% of retrospective EQIAs completed

Non overdue

2.2 PSIRF

Limited Assurance: Workforce capacity risks persist and several performance measures remain below target; however, significant progress has been made across key areas with strengthened governance and oversight in place.

- Casework tracking and oversight arrangements are now embedded, providing routine monitoring of PSII investigations, proportional learning responses, Duty of Candour compliance and safety actions.
- Recovery of PSII cases exceeding six months across both organisations remains on track for completion by the end of Q3, with enhanced executive oversight and additional resource supporting delivery.
- PSIRF Policy is pending approval in October 2026. Incident management, harm review, escalation and learning arrangements have been reviewed and strengthened, with supporting Standard Operating Procedures nearing completion. These will provide greater clarity regarding ownership, accountability, escalation processes and organisational learning at Care Group level.
- Reporting frameworks have been strengthened across Q&S and Board reporting to support improved triangulation of themes, providing clearer assurance on emerging areas for improvement and learning. Further testing and refinement will continue over the coming months with planning for learning framework commenced.
- Performance against patient safety harm measures remains a key area of focus.

Number of cases that exceed 6 months for PSII (Excluding MSNI data):
HUTH = 17
NLAG = 8

Duty of Candour written compliance within 10 working days (rolling 12months)
HUTH = 77.13%
NLAG = 85.72%

Proportionate Learning Response timeliness cases over 6 months (excluding MSNI data)
HUTH = 20
NLAG = 4

Learning from Incidents, complaints and claims reporting to Quality and Safety Committee – Quarterly
Q1 – complete
Q2 - complete

October Update – Clinical Governance Domain (2)

2.3 Ward Accreditation

Reasonable assurance: Reflecting clear evidence of delivery and continued progression against programme objectives. Delivery risks remain controlled and are being mitigated through the procurement of a digital solution and increased capacity to support implementation and ongoing programme delivery.

- Review and learning of the self-assessment tool is complete, with the revised Cohort 2 standards now approved.
- Quality priorities have been incorporated into the self-assessment, including NEWS compliance, deconditioning and sepsis, the SHOP model and flow, infection prevention and control and insulin management.
- Programme is progressing from delivery of actions towards demonstrating measurable impact, supported by the introduction of KPIs covering NEWS compliance, incidents resulting in harm, leadership training and staff engagement, for agreement at the next Corporate & Clinical Governance Steering Group.
- Implementation of Audit R remains a key dependency for the pace and sustainability of the wider programme rollout. Funding has been approved and additional 0.15WTE staffing resource now aligned. Implementation is anticipated in December 2026 with Cohort 2 implementation date revised to reflect this dependency.
- The programme is working closely with Care Groups to establish a Ward-Level Governance Learning and Assurance Framework to ensure learning, actions and key messages from Care Group Governance meetings are consistently disseminated, displayed and embedded within ward/ service teams, supporting quality improvement and improved patient outcomes.

Wards and services enrolled in the accreditation programme.

Cohort 1 28% (27) - 5th May 2026 achieved

Wards and services with structured improvement plans, implementing actions.

56% (14/25) for Cohort 1 by August 2026 achieved

Wards and services with trained lead for new accreditation process

Cohort 1 28% (27) - 5th May 2026 achieved

October Update – Quality & Safety Domain (1)

3.1a Quality Priority – Sepsis

Limited Assurance: Digital workflows are not yet available on the South Bank; however, manual audits will continue using metrics aligned to the new HUTH dashboard to maintain consistent oversight.

- Agreed sepsis metrics and targets are being incorporated into North and South Bank dashboards. Automated data will support HUTH, with manual audits providing interim South Bank data. From next month, reporting will enable assessment of themes and progress against key metrics within a dashboard.
- Baseline reviews, audits and case note reviews have been completed or are underway to better understand current performance and identify priority improvement areas. Perfect week for sepsis (ED HUTH / AMU NLAG) due to take place in November.
- Paediatric Gap Analysis against NICE Guidance has been completed, this inform subsequent pathway revisions and prioritisation of improvement actions and the findings are currently being collated for agreement of next steps.
- A six-week Sepsis education programme has been launched, multidisciplinary education initiatives are progressing, and cross-site collaboration has strengthened learning and benchmarking opportunities.
- Multiple PDSA opportunities have been identified across Admission routes and Inpatient settings to improve recognition, escalation and timely treatment of sepsis.
- Martha's Rule implementation has progressed significantly, with the SOP ratified, escalation pathways agreed, training and communications delivered, and launch preparations completed.
- To support improvement activity , a sepsis perfect week is being schduled, with plans for this to take place within ED at HUTH and AMU at NLAG. A meeting has been arranged with the relevant clinical and operational leads to discuss the approach and ensure engagement.

KPIs and targets aligned to the Sepsis 6 bundle are now agreed, supported by a dashboard that will enable routine performance monitoring from November.

3.1b Quality Priority Safe Care for Patients Prescribed Insulin

Limited Assurance: Key interventions delivered but further evidence of impact and assurance required, including review of post Hypo Awareness Week audit findings.

- Hypo Awareness week was completed on 18 September. Various resources to support management of hypos were shared and new Hypo boxes were distributed to the South Bank ward teams as planned.
- An audit is under development to review the success of the of the week with results to be shared within the October Task & Finish Group for review. Once these results are shared, the Group aim to submit this information to the Hypo Awareness week panel for an Excellence Award.
- Cambridge Diabetes Education Programme (CDEP) Diabetes training package has been added to 2020 of the South Bank staff's mandatory training matrix to mirror the training available to North Bank staff. Uptake will be monitored at the Insulin Safety Task & Finish Group and Mandatory Learning Oversight Group.

Number of insulin related incidents reported – Group Monthly Average

Nov 24 – Jan 26 = 15.2
Mar 26 – Aug 26 = 11.3

Reduction in number of insulin related incidents causing harm – Group Monthly Average

Nov 24 – Jan 26 = 4.07
Mar 26 – Aug 26 = 3.67

Number of insulin related Never Events across the Group

Mar 26 – Aug 26 = 0

October Update – Quality & Safety Domain (2)

3.1c Quality Priority - Infection Reduction

Limited Assurance: Despite improvement during the year, performance remains above the threshold for reportable organisms.

- The revised catheter policy has progressed to final approval and ratification.
- Development of the TWOC referral pathway is nearing completion, with implementation dependent on completion of staff training.
- The Device-Related Infection Task and Finish Group is due to commence in October, with priorities, measures and governance arrangements being developed. The IPC Education and Engagement Workstream has commenced its training-gap analysis, competency review and engagement with clinical and educational leads.
- Pilot wards have been identified across HUTH and NLaG for antimicrobial stewardship testing, with engagement underway.
- The final NHSE and H&Y ICB IPC assurance report has been received, and its recommendations are being mapped to the workstream to ensure clear oversight and delivery. A gap analysis against CQC Section 21 requirements is progressing, with no significant areas of concern identified to date.
- HUTH Access-category antibiotic use and hand-hygiene compliance are currently reported above their respective targets. NLaG total antibiotic use is also reported as meeting the stated reduction target.
- Existing infection measures are being reviewed to identify more meaningful ward, specialty and care-group indicators.

Rate of C.diff infections – 12 months rolling

(baseline 1.75) HUTH = 1.81
(baseline 1.83) NLAG = 2.5

Rate of E.coli bloodstream infections – 12 months rolling

(baseline 1.05) HUTH = 1.13
(baseline 1.56) NLAG =1

Number of MRSA Bacteraemia - 12month rolling
(baseline 6) HUTH = 2
(baseline 5) NLAG = 4

3.1d Quality Priority – Safer Surgery and Interventions

Limited Assurance: Despite demonstrable progress within theatres, the continued occurrence of Never Events across the organisation limits the level of assurance that improvements are fully embedded and consistently effective.

- Implementation and embedding of LocSSIPs within areas performing procedures outside of theatres due to the recent Never Event reported at HUTH are now underway.
- Learning from experience – changes implemented to the orthopaedic safety checklist to ensure all prothesis are the same brand, audit of compliance underway.
- Safer Surgery learning summit planned for November, MDT and focus on invasive procedures.
- Continuing to embed consistent use of NatSSIPs2 checklists across all sites and continued delivery of simulation-based and competency training for Theatre Teams have been successfully embedded into practice and will continue to be monitored through the AMaT Ward Assurance NatSSIPs audit and fed-back to the Care Groups on a monthly basis.

Reduce number of NE

2025 Jan – Dec
HUTH 7/ NLAG 6
2026 Jan – to date
HUTH 3 / NLAG 2

FTSU themes / concerns raised relevant to Safer Surgery

2025 HUTH 2 / NLAG 6
2026 HUTH 0 / NLAG 0

% NatSSIPs compliance Safer Surgery list brief audit

(Baseline 96.2%) 96.6%

% NatSIPPs compliance Invasive Procedure Safety checklist

(Baseline 87.5%) 90.9%

October Update – Quality & Safety Domain (3)

3.1ePreventing Deconditioning

Limited Assurance: Progressed from planning into active ward based discovery across the agreed pilot areas, with key enabling deliverables completed. A robust evidence base is being developed to inform implementation, with further assurance dependent on demonstrating consistent delivery and measurable impact.

- Structured observation, documentation review and staff, patient and carer feedback are underway across pilot wards, providing triangulated evidence on current practice, barriers to mobility and opportunities to promote patient independence.
- Early findings have been validated with ward teams, identifying opportunities to reduce duplication within existing assessment and documentation processes and supporting locally owned improvement.
- Development of the Preventing Deconditioning care bundle is progressing, informed by frontline observations, patient experience, staff feedback and review of existing assessment processes.
- A dedicated working group is being established to review assessment tools, address duplication and support development of a more streamlined approach to deconditioning prevention.
- Outcome measures and indicators are being developed to demonstrate functional improvement and impact while minimising additional data collection burden, alongside continued patient and public involvement to support co-production.
- The Equality and Quality Impact Assessment has been completed, reviewed by the Task and Finish Group and submitted through the formal governance process.

Pilot Wards Number of inpatient falls causing moderate or above harm per 1000 bed days
(baseline 6.7) HUTH = 7.2
(baseline 8.45) NLAG = 15.5

Pilot Wards Number of hospital acquired pressure ulcers per 1000 bed days
(baseline 1.31) HUTH = 1.1
(baseline 7.5) NLAG = 8.1

Pilot Wards average length of stay for non-elective patients
(baseline 8.2) HUTH = 7.5
(baseline NLAG 10.6) = 11.5

October Update – Quality & Safety Domain (4)

3.2 Patient Experience, Complaints & PALS Improvement

Minimal Assurance: Good progress has been made in addressing the PALS backlog, but further assurance is required that improvements to processes are becoming embedded and learning is translating into sustained improvement.

- The 470 backlog PALS cases at HUTH dating pre-27 July has now been cleared by September as planned. Significant progress has been made in reducing the overdue complaints backlog, with a substantial number of historic cases closed during this reporting period. This has temporarily impacted reported KPI performance; however, capacity and focus are now increasingly directed towards new complaints and PALS, supporting improved timeliness and future KPI performance.
- Value Circle supporting process mapping for complaints (PALS complete). Redesign of PALS processes underway with staffing capacity being aligned to areas of greatest need to improve efficiency and responsiveness.
- The CQC Section 29A gap analysis has been completed and the workstream has been strengthened to ensure focus moves towards systematically learning to reduce the risk of recurrence and patient harm.
- Care Groups are now able to access a dashboard that identifies trends, opportunities and areas for improvement across Patient Experience, PALS and Complaints.
- Reporting frameworks have been strengthened across Q&S and Board reporting to support improved triangulation of themes, providing clearer assurance on emerging areas for improvement and learning. Further testing and refinement will continue over the coming months.
- To align processes, the PALS SOP and Complaints Policy amendments are now ratified. Terms of Reference for Care Group PALS and Complaints Meetings now approved. The Group Patient Experience Strategy needs developing.
- A revised location for the HUTH PALS service has been agreed, strengthening public visibility and access to PALS support.

Complaints response rate within 60 days (at 29 Oct)

HUTH = 36.05%
NLAG = 66%

PALS response rate within 10 days (at 29 Oct)

HUTH = 19.1%
NLAG = 48.2%

PALS Response Rate to MPs within 10 Working Days (at 29 Oct)

HUTH = 33.3%
NLAG = 0%

3.3 CQC Actions

Limited Assurance: Improved governance and process arrangements are now in place however, further evidence is required to demonstrate that these are consistently embedded, operating effectively and delivering the intended outcomes.

- Planned process assurance measures have been implemented, strengthening oversight and assurance of delivery.
- Well-Led Report is currently in draft format with the CQC - expected to be finalised within Q3 26/27.
- Action Plans remain in place for Medicine and ED at HUTH, Outpatients at Goole and UEC at NLAG. Action Plan development underway with End of Life and ED at DPOW. UEC at NLaG and Outpatients at Goole have actions within their plans that are progressing to closure within the next reporting cycle.
- A new KPI has been introduced to monitor actions remaining open for more than six months without appropriate review, escalation or agreed extension. No current CQC actions breach this threshold, providing assurance that actions are being actively managed and appropriately governed.

Reduction in number of overdue milestones from CQC action plan

0 overdue

Number of actions remaining open for more than 6 months without formal review, escalation

0 overdue

Integrated Improvement Plan Progress October Update – Clinical Model (1)

4.1 Clinical Policy Group Development

Minimal Assurance: Progress is being made against deliverables however, gaps remain in KPI development and named accountability for outstanding actions. The transition to two separate organisations also creates delivery risk, with ownership and future delivery arrangements for several deliverables requiring resolution.

- Clinical Policy Group established and operational, with agreed governance, membership, decision-making responsibilities and reporting arrangements in place.
- Group Clinical Strategy relaunched, providing an agreed strategic framework for HHP's clinical priorities, service model and transformation ambitions.
- Draft Clinical Harmonisation Framework developed as an initial engagement tool. Further implementation now requires review in the context of the transition to two separate organisations, to clarify the appropriate future approach, ownership and scope.
- Engagement with Chiefs of Service is the next key step, to agree clinical pathway priorities and inform the future programme of work.

4.3 Learning Academy

Limited Assurance: Progress against deliverables is recognised however; risks of LISA demand remains high until risk based triage and prioritisation model is in place.

- The workstream title has changed to Learning Academy in month, reflecting stakeholder feedback that the current name is not resonating effectively. Associated documentation and communications will be updated.
- The HHP Improvement Way (CQI methodology) and governance-led, risk-based triage and prioritisation model have been developed and are awaiting formal approval, providing the proposed framework for a more consistent and risk-led approach to improvement.
- Organisational separation remains an emerging delivery risk. The extent and timing of separation are not yet sufficiently clear to determine the full impact on existing improvement arrangements and some deliverables, ownership and governance arrangements may therefore require adaptation in due course.
- The Medical Leadership programme relaunched with a full cohort of participants from both organisations taking part. Mapping to the NLMF has taken place. National reporting for September showed 68 colleagues across all sites have completed the NLMF self-assessment to date. Work is now progressing to raise the profile of the framework and the importance of completing to increase uptake between now and March.
- The workstream is working closely with the Staff Engagement and Culture Workstream to define the safety culture and develop Board-to-Ward Civility, Values, Professionalism and Inclusion Programme. A new Simulation commissioning programme is in place with Head of Learning & Development attending learning response panels and PSIRF oversight meetings to ensure that Sim response is triaged to the correct priorities. New follow up measures in place to measure effectiveness of SIM being piloted.
- New governance arrangements in place for Group Medical Education Service ensures that consistent high standards are in place and any improvement programmes are effectively monitored. Process Mapping event planned for employee lifecycle of Resident Drs to improve Trust and Local Induction, across all departments such as recruitment, medical staffing as well as medical education.

Integrated Improvement Plan Progress October Update – Clinical Model (2)

4.4 EPR

Minimal Assurance: EPR Key risks relate to product functionality for go live, the delayed Delivery Implementation Plan and uncertainty around data migration. Mitigations remain to be confirmed and require continuing executive oversight.

- The team is still assessing the impact of Dedalus confirming that not all Phase 1 OBS requirements will be available in ORBIS at the planned go-live point. Planning continues on the basis of the contracted OBS functionality until the position is resolved.
- Clinical safety and functionality gaps remain significant. The programme clinicians are systematically validating the impact of the Dedalus OBS responses in the context of the proposal of a multi-phase deployment.
- Product design and technical delivery planning continues, requiring active collaboration with Dedalus.
- Programme governance is maturing around emerging design, scope and change decisions.
- Overall, substantial mobilisation and design activity has been achieved. The key challenge is bringing scope, the supplier roadmap, clinical safety, data migration, operational change and implementation readiness together into a credible and sustainable delivery roadmap.

October Update – Operational Performance (1)

5.1 UEC Unplanned Care

Minimal Assurance: Key deliverables remain delayed and measurable impact is not yet consistently evidenced

- Care Coordination Centre workforce funding and the operating model remain unresolved. Consultation, recruitment, training, estates and funding decisions are becoming critical ahead of the planned April 2027 Phase 2 go-live.
- Implementation support is required for Call Before Convey across both South Bank sites, while a Frailty Single Point of Access is not established on North Bank.
- Frailty capacity remains constrained, with no ring-fenced frailty beds at DPoW and HUTH's eight-bed Frailty SDEC currently unfunded.
- Paediatric flow requires continued focus across both banks, including completion of the thematic review of ED breaches and agreement of clinically safe ED-to-PAU pathways.
- North Bank long length-of-stay work requires agreement of the initial 3–4 wards and review approach. Winter delivery also remains dependent on respiratory and IPC readiness and resolution of workforce, funding, partner, EQIA and estates dependencies.

A&E 4-hour Standard (Sep 2026)
(Baseline 69%) HUTH = 65.7%
(Baseline 73%) NLaG = 71.7%

Patients cared for in inappropriate spaces (Sep 2026)
(Baseline 35) HUTH = 37
(Baseline 6) NLaG = 0

30-day readmission rate band (Aug 2026)
(Baseline 10%) HUTH = 9.7%
(Baseline 11%) NLaG = 11.5%

Ambulance Handover within 45mins (Sep 2026)
(Baseline 88%) HUTH = 98.2%
(Baseline 75%) NLaG = 75.6%

5.2a Outpatients

Reasonable Assurance: Delivery is on track, with progress in demand and capacity and elective SPoA, although implementation dependencies remain.

- All seven reported deliverables are currently in progress/on track.
- Significant progress is reported on demand and capacity and Elective SPoA project delivery, with workstream KPIs and risks identified and agreed.
- National SPoA dependencies and delays to the technical specification remain a risk to implementation timescales.
- Clinical leadership capacity, digital capacity and administrative resource continue to present material implementation risks.

Waiting Time to First Appointment (Weeks)
(Baseline 22.2) HUTH = 15.2
(Baseline 15.1) NLaG = 20.9

RTT Non-admitted waiting list >52 weeks
(Baseline 2288) HUTH = 1903
(Baseline 1337) NLaG = 1231

Episodes moved or discharged to PIFU
(Baseline 3.4%) HUTH = 4.5%
(Baseline 4.8%) NLaG = 3.3%

Discharged from First Attendance
(Baseline 26.8%) HUTH = 30.6%
(Baseline 27.1% NLaG = 27.6%

October Update – Operational Performance (2)

5.2b Surgical Improvement (Theatres)

Limited Assurance: Deliverables are progressing, but limited KPI improvement means performance impact is not yet sufficiently demonstrated

- All seven reported deliverables are on track, but the current assurance remains Limited because positive movement in KPI performance is limited.
- Digital and Information Services capacity is constrained by EPR and competing priorities, creating risk to resolution of data-quality and reporting issues and development of theatre and pre-assessment dashboards.
- The underlying Operational Performance material shows the programme is focused on theatre utilisation, productivity, pre-assessment, theatre planning, safer surgery and stronger governance

>85% Capped Utilisation (Sep 2026)

Baseline 79.8% HUTH =81.4%
Baseline 79.5% NLaG = 82.7%

Dropped Session Rate (Aug 2026)

Baseline 20.4% HUTH =23.5%
Baseline 9.9% NLaG = 14.1%

Avg Cases per 4hr list (Aug 2026)

Baseline 2.5% HUTH =2.5%
Baseline 2.7% NLaG = 2.8%

% of cases cancelled 0-3 days before day of surgery

Baseline 10.2% HUTH =tbc
Baseline 10.2% NLaG = tbc

5.2c Cancer

Limited Assurance: Deliverables are progressing, but limited KPI improvement means performance impact is not yet sufficiently demonstrated

- Existing arrangements are reported as ineffective, with the pace of change insufficient to deliver the required level of improvement.
- FDS improvement is insufficient, with unwarranted variation between tumour sites and low data completeness constraining assurance on performance and future 62-day impact.
- Improvement in 31-day performance is insufficient, with treatment waits affecting the ability to recover 62-day performance; the workstream also identifies the need to address treatment backlogs.
- Current initiatives are not delivering the required improvement in 62-day performance, while the backlog is increasing overall and concerns are recorded regarding harm associated with prolonged waits.
- Finance and workforce capacity to provide the additional activity required for backlog clearance remains a high-level risk

% of patients meeting the 28-day faster diagnosis standard (Aug 2026)
Baseline 66.2% HUTH =72.9%
Baseline 66.21% NLaG=71.1%

% of patients treated within 62 days of referral (Aug 2026)
Baseline 56% HUTH =51.8%
Baseline 74% NLaG = 59.9%

31-day Decision to Treat (Aug 2026)

Baseline 78.4% HUTH =78.2%
Baseline 98.1% NLaG = 92.2%

October Update – Operational Performance (3)

5.2d Diagnostics

Minimal Assurance: Recovery delivery is not yet sufficiently evidenced, with significant demand, capacity, workforce, equipment and utilisation constraints remaining

- Recovery delivery is not yet evidenced through the KPI position, with baselines, trajectories and elements of the delivery plan requiring further agreement and validation.
- Significant demand, capacity, workforce, equipment and utilisation constraints remain unresolved and continue to limit confidence in sustainable recovery.
- The recovery approach needs to demonstrate a clearer route to improving diagnostic compliance, reducing the backlog and aligning capacity to current and future demand. The Operational Performance plan identifies these as core deliverables alongside improved waiting-list management and governance.
- Workforce sustainability and sufficient diagnostic capacity remain key dependencies, alongside improved data quality, pathway visibility and reporting

% of patients meeting the 28-day faster diagnosis standard (Aug 2026)	Diagnostics within 6wks (Sep 2026)
Baseline 66.2% HUTH =72.9% Baseline 66.21% NLaG=71.1%	(Baseline 33.8%)HUTH =38.2% (Baseline 29.9%)NLaG=31.2%

5.2e RTT

Minimal Assurance: Recovery planning is strengthening, but trajectories, baselines and specialty level delivery plans require further refinement and validation before improvement can be evidenced.

- Progress has been made in developing and testing demand and capacity models with Care Groups, improving understanding of specialty-level challenges and recovery opportunities.
- Recovery trajectories, baseline positions, performance measures and specialty-level recovery plans continue to be refined and validated.
- Stronger foundations for recovery planning are now established, but modelling assumptions need to translate into agreed and deliverable specialty-level plans.
- RTT recovery remains dependent on diagnostic improvement, workforce capacity, elective capacity and other linked Operational Performance programmes. These dependencies are reflected in the underlying Operational Performance material.

% of patients waiting up to 18 weeks for care (Sep 2026)	% of patients waiting up to 18 weeks for care versus plan (Sep 2026)
(Baseline tbc) HUTH = 59.2% (Baseline 61.4% NLaG= 58.7%	(Baseline tbc) HUTH = -4.5% (Baseline tbc) NLaG = -2.7%
% of patients waiting over 52 weeks for care (Sep 2026)	% of patients waiting less that 18 weeks for community care
(Baseline 3.5%) HUTH = 4.2% (Baseline 2.1%) NLaG = 3.7%	(Baseline 15.7%) NLaG = tbc

October Update – Operational Performance (4)

5.3 Care Group Recovery

Refreshed plan on page is under development.

- The Care Group Recovery workstream is progressing, with a proposed transition to 'Performance, Accountability and Organisational Intelligence Improvement'. This will strengthen the focus on measurable improvement and provide a clear mechanism for tracking delivery and evidencing progress against 7 key Value Circle recommendations relating to the IPR and Performance Accountability Framework.

5.4 Humber Acute Services

Limited Assurance: Service consolidation has progressed, but benefits are not yet fully demonstrated and organisational transition creates a material strategic dependency.

- Ophthalmology, ENT, Cardiology and Gastroenterology pathway consolidation has progressed, with governance and monitoring arrangements established to track benefits and alignment with the agreed service model.
- Planning for future specialty consolidations and critical care developments is progressing.
- Work is ongoing to demonstrate the qualitative benefits from service consolidations already delivered.
- The move away from the HHP Group model creates a significant strategic issue for the programme. The Oversight paper identifies that the original HASR business case and previously consulted model may need reconsideration in the context of NLaG becoming a sovereign organisation

Reduce LoS NLaG Ophthalmology (Oct 2026)

(Baseline 0) = 0

Reduce LoS NLaG ENT (Oct 2026)

(Baseline 0.9) = 0.6

Reduce LoS NLaG Cardiology (Oct 2026)

(Baseline 3.8) = 1.9

Reduce LoS NLaG Gastroenterology (Oct 2026)

(Baseline 0.9) = 0.6

5.5 Tertiary

Workstream remains in development

- Scope and future model for a tertiary service being developed, leads now identified.
- Recommendations to be presented to Clinical Policy Group in December.

October Update – People (1)

6.3 Culture, Leadership & Experience

Limited Assurance: Delivery remains on track, but organisational change and increasing delivery risks limit confidence in achieving and evidencing the intended culture and staff experience outcomes.

- All six deliverables are reported as on track; however, two delivery risks have increased to a score of 20 following the organisational review.
- Delivery is focused on improving staff advocacy, engagement, experience, psychological safety, inclusion, wellbeing and retention, aligned with the relevant National Oversight Framework and external recommendations.
- Development of the Group-wide safety culture model continues, with the current delivery plan linking this to a standardised improvement methodology and the systematic identification, escalation and resolution of safety risks.
- Positive EDI and staff-engagement activity is progressing, including inclusive recruitment, the Step-Up programme and sexual-safety work. No immediate escalation was identified in the 8 October Delivery Group notes.
- Staff Survey response at both HUTH and NLaG is below the national average, while structural change, efficiency measures, psychological safety and limited specialist capacity are identified as material risks to delivery.
- The workstream aims to improve the HHP Staff Survey Engagement Score from 6.4 to 6.6, with national survey results awaited; the stress-related sickness absence baseline and target also remain to be confirmed

Improve the HUTH/NLAG Staff Survey Advocacy Score

HUTH Baseline 5.92
NLAG Baseline 5.92

Increase the HHP NHS Staff Survey Engagement Score

HHP Baseline 6.4

Reduce workplace stress-related absence

HUTH baseline 4.5%
NLAG baseline5.3%

IIP Workstream Lead Briefing – Issue 2

PMO have been supporting Workstream Leads and Delivery Teams to move from reporting activity to demonstrating improvement…

1 **Meaningful assurance**

Improving reporting by ensuring there is evidence to support executive assurance RAGs rather than colour alone.

2 **Triangulating the full picture**

Facilitating teams to connect deliverables, risks, KPIs and outcomes so assurance reflects both delivery progress and measurable impact.

3 **Earlier risk escalation**

Ensuring risks are clearly articulated, linked to delivery and outcomes, and escalated early where mitigation or executive support is required.

4 **One Improvement Story**

Facilitating a single, aligned narrative across the IIP, FRP and Transition Programme, demonstrating organisational impact and improvement.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)281

Name of Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	12 November 2026
Director Lead	Lyn Simpson, Chief Executive
Contact Officer / Author	Richard Dickinson, Associate Director of Quality Governance
Title of Report	National Reports and Guidance

Executive Summary	The attached report provides a summary of guidance and national reports and relevant operational lead identified for the period of September. The items are published from:
	• NHS England (NHSE)
	  ○ Elective Single Point of Access: technical guidance and implementation considerations
	  ○ Interim clinical prioritisation guidance for blood ketone testing during supply disruption.
	  ○ Privacy, dignity and safety in hospital accommodation
	  ○ Guidance on NHS staff facilities
	• Department of Health and Social Care (DHSC)
	  ○ Health Bill: role and functions of the restructured DHSC
	• Health Services Safety Investigations Body (HSSIB)
	  ○ Electronic referrals for ongoing care: risk of losing patient referrals interim report
	
	The Boards-in-Common are asked to note the content of the report.

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

Source	Date	Title & Link	Brief Synopsis	Lead officer
NHS England	12 October 2026	Elective Single Point of Access: technical guidance and implementation considerations [england.nhs.uk]	Establishes a national approach to coordinating elective Advice and Guidance requests and referrals through a single digital entry point in secondary care. It includes actions for ICSs and partners to expand Advice and Guidance, improve digital assessment through e-RS and implement elective Single Point of Access locally. Urgent suspected cancer referrals are excluded Direct implications for secondary-care referral management, specialist triage, outpatient pathways, e-RS configuration and interfaces with primary care and the ICB.	Chief Delivery Officer / Elective Care / Digital.
NHS England,	12 October 2026; updated 30 Octobe r 2026	Interim clinical prioritisation guidance for blood ketone testing during supply disruption. [england.nhs.uk],	Responds to the supply disruption affecting NOVA point-of-care ketone strips and MHRA Device Safety Incident DSI/2026/013. It applies to acute, primary, community and ambulance services. Organisations should review usable stock, expiry dates and confirmed deliveries. Where supply remains constrained, lack of immediate capillary ketone testing must not delay assessment, escalation, treatment or resuscitation Relevant to Emergency Departments, acute medicine, paediatrics, maternity, diabetes services, pathology, point-of-care testing, pharmacy and procurement.	Chief Medical Officer / Pathology / Diabetes / Medicines Safety.
NHS England	15 October 2026; updated 16 October 2026	Privacy, dignity and safety in hospital accommodation [england.nhs.uk]	Revised guidance supporting decisions about hospital accommodation, the NHS Constitution pledge on same-sex accommodation and the needs of all patients. NHS organisations are asked to review local policies, practices and environments, with Board decisions being lawful, proportionate, evidence-based and documented. Applies directly to inpatient accommodation, admission and placement decisions, ward environments, privacy, dignity, equality and operational escalation.	Chief Nurse / Chief Operating Officer / EDI / Estates.
NHS England,	15 October 2026; updated 16 October 2026	Guidance on NHS staff facilities [england.nhs.uk]	Advises NHS trusts, foundation trusts and ICBs on the provision and use of staff changing, washing and showering areas, toilets and staff accommodation. It states that suitable facilities are required to protect staff privacy, dignity and safety and that organisations should act rather than await further employment guidance. Requires consideration across workforce, estates, health and safety, equality, staff networks and employment-policy arrangements.	Chief People Officer / Estates / EDI.
DHSC, updated	22 October 2026	Health Bill: role and functions of the restructured DHSC [gov.uk]	Explains the proposed transfer of NHS England functions to the Secretary of State or the wider system. The intended restructured DHSC would set national direction, steward resources and provide oversight, while providers, ICBs and local partners lead delivery. Relevant to future accountability, oversight and the changing relationship between providers, ICBs, regional structures and the national centre.	Chief Executive / Trust Secretary.

HSSIB,	22 October 2026	Electronic referrals for ongoing care: risk of losing patient referrals interim report [hssib.org.uk]	Identifies incidents where referrals disappeared from provider e-RS worklists without warning, including automatic removal where no action had occurred for 180 days. HSSIB calls on providers to assess the risk formally, establish robust local checks and bring digital, patient-safety, patient-experience and complaints teams together to identify potentially lost referrals, including use of weekly drop-off data. Directly relevant to elective pathways, referral tracking, waiting-list validation, clinical safety, complaints and digital governance. There is an important connection with NHS England's October Elective Single Point of Access guidance.	Chief Delivery Officer / CIO / Clinical Safety Officer / Patient Safety.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)282

Name of Meeting	**Trust Boards Committees-in-Common**
Date of the Meeting	12 November 2026
Director Lead	Hilda Gwilliams – Group Chief Patient Safety Officer Peter Sedman – Deputy Group Chief Medical Officer
Contact Officer / Author	Richard Dickinson – Associate Director of Quality Governance Michela Littlewood – Associate Director of Quality Governance
Title of Report	**Monthly Patient Safety Report**
Executive Summary	The purpose of the report is to demonstrate the oversight of the processes that enable learning from harm, including patient safety and experience. Identification of themes are included, with analysis and an overview in respect of the following areas: **Alert** • Infection control alert organisms monthly update with threshold trajectory data. • There has been a Never Event in September 2026, with an Immediate Response Meeting held. Wrong implant. **Advise** • Patient safety incidents reported from September 2026 • Inquests and Regulation 28 Prevention of future deaths letters update ○ No new Regulation 28 reports. • Patient Experience contacts from September 2026 and improvement plans **Assure** • Current workstreams for PSIRF learning responses and PSII tracking. • Safer Surgery NatSSIPS audit engagement and reliability improvement. • Learning from experience examples demonstrate outcomes from investigations. **Recommendation** The Board is asked to take assurance from the processes outlined the content of the report.

Background Information and/or Supporting Document(s) (if applicable)	This is a monthly summary report that builds on some previously reported information, providing updates to the data and workstreams being applied to manage issues and risks.
Prior Approval Process	None
Financial Implication(s) (if applicable)	None directly
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None directly
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Monthly Patient Safety Report, September 2026

This report contains data from the reporting period of September 2026.

Section 1: Clinical Incidents

Definition

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

Incident Reporting

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

- Reporting rates

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

- Distribution of harm levels

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

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

Pressure ulcers identified on admission remains the highest category across the group. It is acknowledged that the patient has suffered harm, however as the skin damage occurs outside of the acute setting, or the duty of care of our services. These incidents are recorded as no harm from a reporting perspective. Falls in the hospitals and Pressure Ulcers in Hospital and North Lincolnshire Community team continue to be the most frequently reported patient safety incidents. Moderate harm rates are a greater proportion in NLAG due to community pressure ulcer cases with the North Lincolnshire team.

Figure 1 – Patient Safety Incident Overview Dashboards

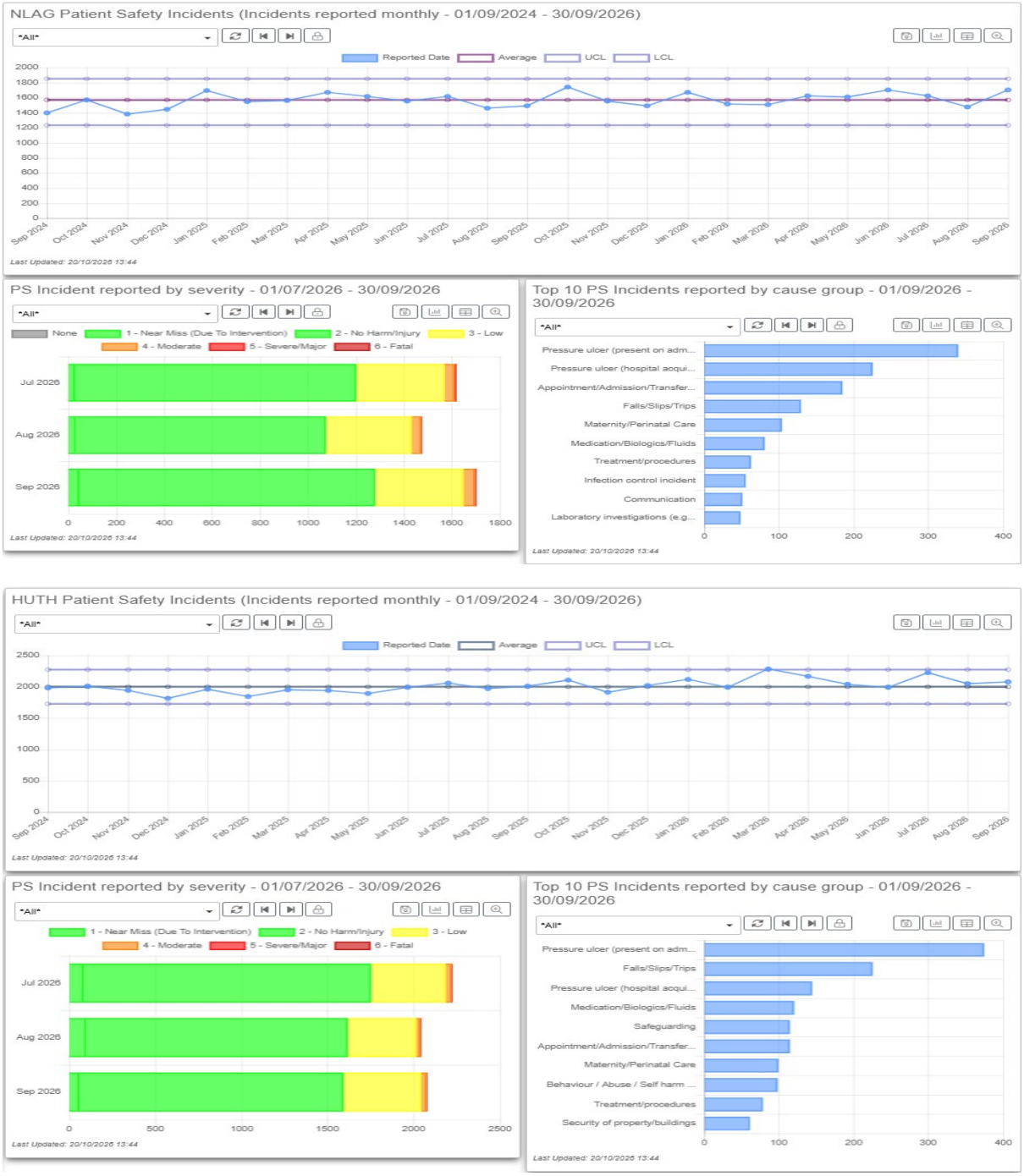


Figure 2: Patient Safety incidents with moderate or greater severity grading by Group and Trust.

Reported in September 2026	NLAG	HUTH	HHP
Fatal	1	2	3
Severe/Major	3	2	5
Moderate	48	32	80
Total	**52**	**36**	**88**

All 88 cases are under review by care group Nurse Directors and through relevant reporting routes of the Falls Group, Pressure Ulcer review groups and the Weekly Learning Response Panel.

Section 2: Infection Prevention Control (IPC)

Context

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

Quality and Safety Performance

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

Figure 3: HUTH current HCAI figures

HUTH	Sep-26	THRESHOLD HUTH FY 2026/27	TOTAL 2026/27	NHS Outcomes Framework Q1
MRSA BSI	1	0	1	2 in 12 months Score 2.24
MSSA BSI	2	No threshold set	31	
ECOLI BSI	16	192	106	Score 2
KLEBSIELLA BSI	8	69	38	
PSEUDOMONAS BSI	3	26	14	
CDI	11	61	61	Score 3

Figure 4: NLAG Current HCAI figures

NLAG	Sep-26	THRESHOLD NLAG FY 2026/27	TOTAL 2026/27	NHS Outcomes Framework Q1
MRSA BSI	0	0	1	5 in 12 months Score 3.13
MSSA BSI	2	No threshold set	12	-
ECOLI BSI	9	57	51	Score 4
KLEBSIELLA BSI	4	34	13	-
PSEUDOMONAS BSI	1	5	8	-
CDI	12	18	35	Score 4

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

Section 3: Patient Safety Incident Response Framework (PSIRF)

Definition

The NHS PSIRF framework mandates a proportionate, learning-focused approach to patient safety incidents, moving away from a “blame culture” and excessive, formulaic

investigations. It focuses resources on actions that improve safety through compassionate engagement, system-based reviews, and tailored responses.

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

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

The cumulative HHP position is there are 111 patient safety learning responses in progress, reduced from 141 three months ago. 42 Patient Safety Incident Investigations (PSII) and 69 proportionate learning responses (After Action Review and MDT Reviews). A breakdown by Trust is captured below. The red marker on the tables is the demarcation line for targeting completion in 6 months for PSII and Proportionate learning response recovery, with PSIRF guidance advising complexity may require longer time to complete for PSII cases.

PSII Position NLAG

For the reporting period up to the end of September, there are 12 open PSII cases, with 3 closed and 1 new MNSI case declared in the last month. There is progress across many of the investigations within our control:

- 2 cases are externally investigated by the Maternity and Newborn Safety Investigations (MNSI) Team hosted by the Care Quality Commission (CQC).
- 1 case is on hold due to a police force investigation, allergic reaction to penicillin from 2023.
- Of the remaining 9 cases:
    - 1 PSII reports are the final report stage with family engagement
    - 4 reports are being quality checked before presenting to the PSIRF Oversight Group to approve.
    - This leaves 4 cases being investigated and compiling reports.
- All cases over 6 months are planned to be completed during Q3.

Figure 5: PSII open casework

NLAG PSII	2023	2024	2025				2026					Grand Total
	Oct	Nov	May	Jul	Aug	Sep	Oct	Dec	Mar	Apr	Sep	
Total	1*	1	1	1	1	1	2	1	1	1**	1**	12

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

Proportional Learning Response Position NLAG

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

The below table summarises the position at the end of September 2026, in relation to the total number of open Proportional Learning Responses is 9, with 7 cases completed last month. There are 4 cases in the quality checking process for completion. 8 reports are being written and 7 cases in progress. There are a reducing number of long standing proportionate response remaining open with 4 over 6 months.

Figure 6: Proportional Learning Responses

NLAG Proportional Learning Response stages in process	2025	2026								Grand Total
	Dec	Jan	Mar	Apr	May	Jun	Jul	Aug	Sep	
Assurance			1	1	1	1				4
Report	1		1	1		1	4			8
Review		1						2	4	7
Grand Total	1	1	2	2	1	2	4	2	4	19

PSII Position HUTH

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

- For the reporting period up to the end of September, there are 30 open PSII cases with 3 of these being externally investigated by MNSI.
- 5 cases are going through draft report engagement with patients and their families.
- 11 PSII reports are at various stages of sign off through the Report QA process.
- 2 PSIIs have been completed over the past month, with 1 case declared in September.
- 11 cases are under active investigation.
- All cases over 6 months are planned to be completed during Q3.

Figure 7: HUTH PSII open casework

HUTH PSII	2024	2025							2026						Grand Total
Total	1	2	3	3	1	2	1	1	3	4*	5*	1	2*	1	30

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

Proportional Learning Response Position

The below table summarises the current position as of September 2026, in relation to the total number of open Proportional Learning Responses is 50, with 7 cases completed in the previous month and 7 cases declared, 13 cases in the quality checking and sign off process. There are several overdue cases, which are being tracked and monitored to improve timeliness of completion with the respective care groups.

Figure 8 - HUTH Proportional Learning Responses

HUTH Proportional Learning Responses stages in process	2024	2025	2026													Grand Total
In progress		1	2	3		1	1	2	2	1		4	5	8	7	37
Sign off process	1		1		1		1	1		2	2	1	2	1		13
Grand Total	1	1	3	3	1	1	2	3	2	3	2	5	7	9	7	50

Section 4: Never Events

Definition

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

Never Event Improvement Plan

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

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

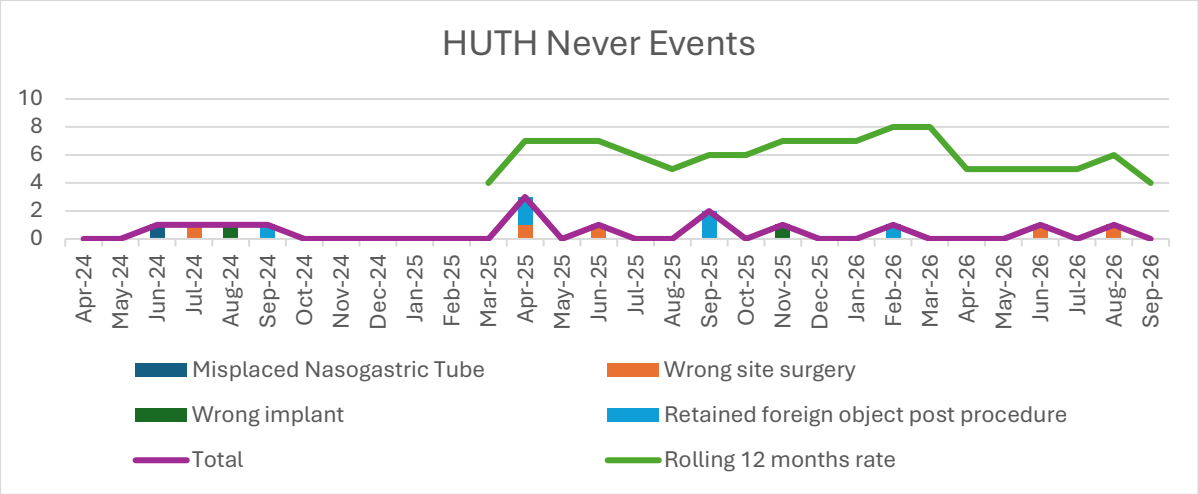
Never Event Position

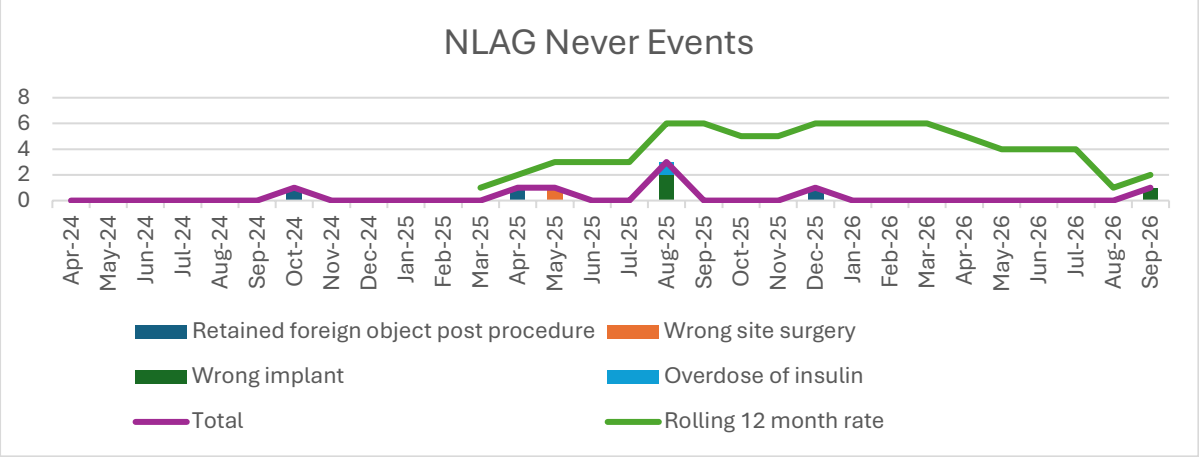
The wrong site surgery never event incident (lumbar puncture on wrong patient) on 31 August 2026 at HRI, has progressed through the investigation meeting and after action review have been undertaken and is the report is being compiled.

In September 2026 there was a wrong implant never event at Goole. The patient had a mis-selected femoral stem of a different manufacturer for their total knee replacement. They required revision surgery, which was undertaken successfully. An after action review has been undertaken following the immediate response meeting. Storage of implants from more than one manufacturer in the same storage cupboard was identified as an issue, as well as the focus of size and laterality of components, rather than manufacturer/brand used.

The charts below provide an overview of the rate of Never Events. NLAG has had 2 never events in the rolling 12 months. HUTH has had 4 never events in the rolling 12 months. This shows some improvement from the highest points of 8 at HUTH and 6 at NLAG, but also concern due to checking processes not being effective in these recent cases.

Figure 9 – Never Event charts





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

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

Audit overview

Audit	Frequency	Compliance over last 6 periods					
(HHP) Invasive Procedure Safety Checklist DOCUMENTATION Audit (NatSSIPs2)	M	92.4%	88.9%	89.7%	92.8%	90.9%	94.0%
(HHP) Invasive Procedure Safety Checklist OBSERVATION Audit (NatSSIPs2)	M	99.8%	99.7%	99.4%	99.5%	99.7%	99.7%
(HHP) Safer Surgery List Brief Audit (NatSSIPs2)	M	95.1%	95.6%	95.3%	94.6%	96.6%	96.0%
(HHP) Safer Surgery List Debrief Audit (NatSSIPs2)	M	97.3%	96.9%	98.4%	95.9%	98.4%	97.1%
(HHP) STOP before you block audit (NatSSIPs2)	M	99.3%	98.9%	100.0%	99.5%	100.0%	99.4%

Further detailed reports, with site breakdown have been shared with TACC care group for remedy. Surgical wards also contribute to the Documentation Audit predominantly feature in the ward to theatre checking processes.

Improvement actions include:

- A series of safety summits commenced on 8 May 2026 supporting improvements in patient safety and culture for TACC care group, covering Digestive Diseases and Families care groups so far.
- A Surgical Safety series of engagement sessions are planned throughout 2026, including professional standards setting.
- Implementation of the NatSSIPS2 theatre checklists for south bank is being supported with training and group wide audit of processes, checking documentation and direct observation.
- A further briefing with chiefs of service is planned with the Chief Medical Officer.

Section 5: Coroner's Inquests

Definition

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

Coroner Case Position

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

The key themes from inquests include:

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

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

- Regulation 28 Letters

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

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

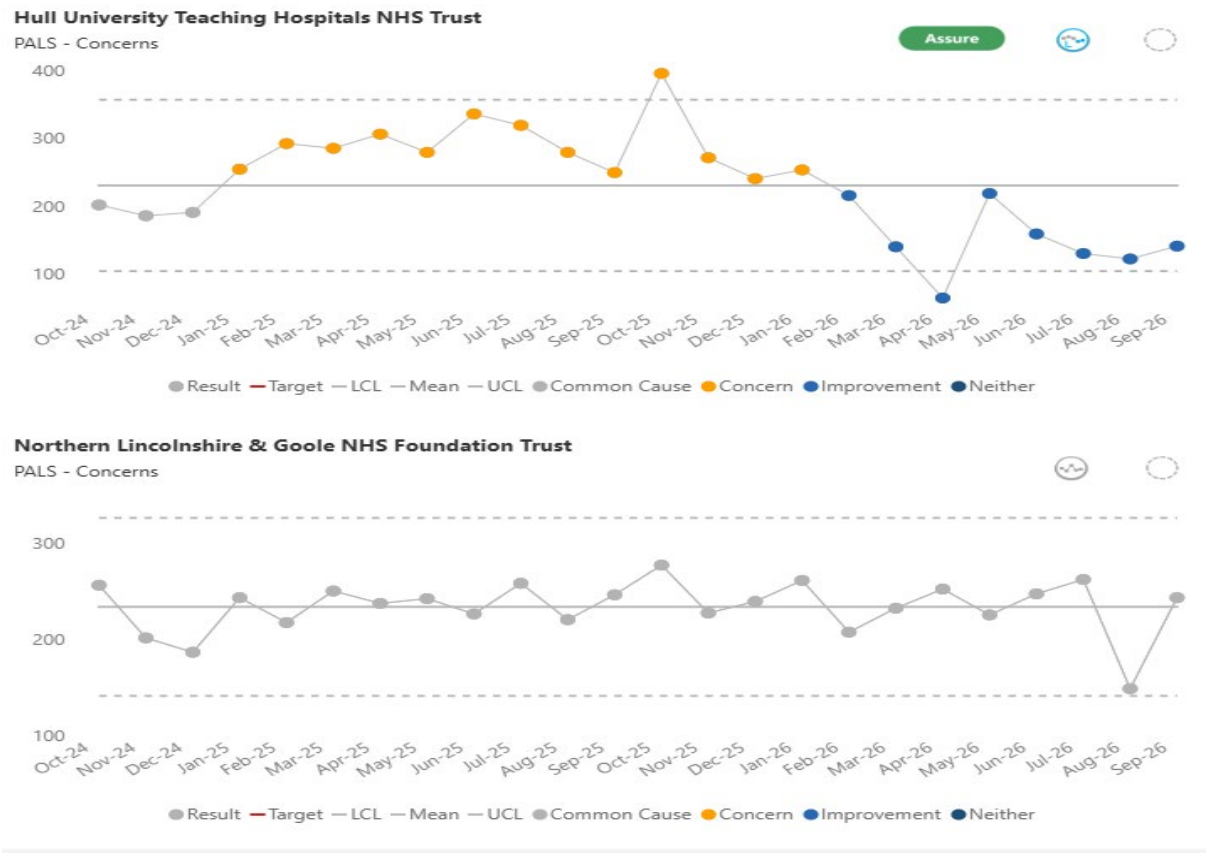
Section 6 - Patient Experience, Patient Advice Liaison Service (PALs) and Complaints

The learning from harm Patient Experience, PALs and Complaint Section provides an update across the Group. Work is being undertaken to note the changes over

time with themes and trends and any harms that are found and reviewed via the PALs and complaints route. In addition, the Patient Experience team collect feedback via compliments, Friends and Family Tests and other annual report, this information is provided in Quarterly Patient Experience reports.

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

Figure 11 PALs cases logged

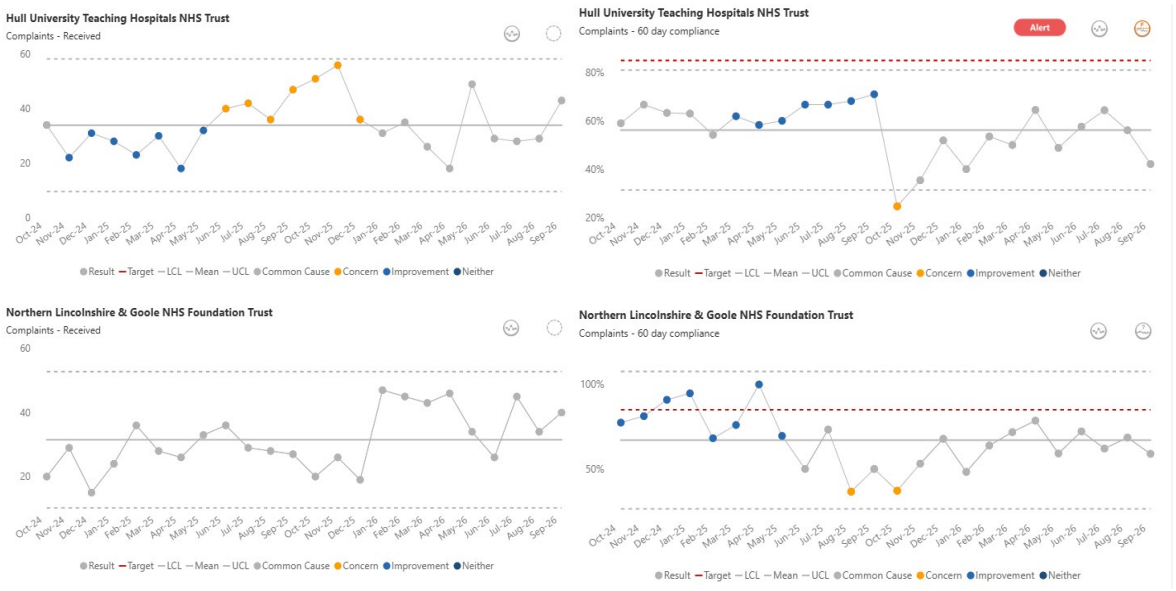


HHP PALS Themes and Learning

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

Complaints

Figure 12: Complaints received and Response performance



Complaint response with 60 days remains under the target for completion time at 42-59%. There has been progress with reducing the backlog of open cases.

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

HHP Complaints Themes and Learning

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

Section 7: Learning from experience safety actions

Summarised examples of finalised PSII cases are provided below:

1. MNSI MI-048987: Severe neonatal brain injury (HUTH)
Case summary:
Following an unexplained seizure in late pregnancy, maternity risk was not fully reassessed. During labour, fetal bradycardia developed and difficulties confirming the fetal heart rate contributed to delayed expedited birth. The baby required resuscitation and therapeutic cooling and was subsequently diagnosed with severe brain injury.
Key safety actions:

- Obstetric review of pregnant women presenting to ED with seizures.
- Strengthen dynamic maternity risk assessment and appropriate place-of-birth planning.
- Direct transfer to theatre where fetal wellbeing cannot be confirmed.

- Allocate a team member to maintain the "helicopter view" during emergencies.
- Strengthen adherence to national therapeutic cooling guidance.

2. PSII 2025 2517: Intrauterine death and uterine rupture (NLAG)
Case summary:
A woman with type 2 diabetes and additional pregnancy risks had a planned delivery later than recommended by relevant guidance. Following intrauterine death, labour was induced and she subsequently deteriorated. Sepsis was initially suspected, but emergency surgery identified a rare complete uterine rupture.
Key safety actions:
- Strengthen delivery planning for women with diabetes and additional risk factors.
- Review how booking HbA1c influences risk assessment and delivery planning.
- Improve Joint Antenatal Clinic documentation and booking processes.
- Increase awareness and training on uterine rupture following intrauterine death.
- Ensure appropriate induction options are discussed and offered.
- Update local stillbirth guidance in line with national guidance.

3. PSII 2025 3701: Neonatal sepsis and death (NLAG)
Case summary:
A newborn developed potential early signs of infection, including pyrexia and raised lactate, but key sepsis risks and the abnormal result were not fully recognised. The baby was discharged before the recommended observation period and later became critically unwell with E. coli sepsis, subsequently dying from multi-organ failure.
Key safety actions:
- Improve recognition and escalation of neonatal sepsis.
- Ensure abnormal results are reviewed, documented, escalated and handed over.
- Reinforce use of appropriate blood gas analysis.
- Implement NEWTT2 and strengthen discharge checks and safety-netting.
- Develop a safer triage pathway for parents reporting an unwell baby.
- Review availability of neonatal equipment within ED.

4. PSII 2026/218: Deterioration following facial trauma and bleeding (HUTH)
Case summary:
A man with facial trauma and ongoing bleeding was subsequently identified as having liver cirrhosis and coagulopathy. During a prolonged and significantly crowded ED stay, opportunities for earlier recognition of bleeding risk, deterioration, neurological monitoring and escalation were identified. He required major

haemorrhage treatment and ICU admission and subsequently died following multiorgan failure.

Key safety actions:

- Strengthen early recognition of complex, high-risk ED presentations.
- Improve escalation and active monitoring of deteriorating patients.
- Ensure one clinical team retains overall responsibility where multiple specialties are involved.
- Improve documentation, reassessment and escalation of persistent bleeding.
- Strengthen clinical education on haemorrhage and coagulopathy.

Section 8: Summary

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

There are several workstreams that are reviewing processes and taking forward improvement plans, aligned to the Integrate Improvement Plans, that impact on topics relevant to this report including:

- Governance reset including BAF
- Clinical Governance
- PSIRF
- Patient Experience
- Quality Priorities
    - Sepsis
    - Medication safety: Insulin
    - Safer Surgery and Interventions
    - Prevention of Deconditioning
    - Infection prevention

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

ADVISE, ALERT and ASSURE REPORT	
Meeting	Quality and Safety Committees-in-Common
Meeting date	28 October 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**	**Action**	**Timescale**
Quality			
Health Inequalities	The CiC identified a gap in Health Inequalities oversight.	HG to check whether this sits in the Group Chief Delivery Officer's portfolio	Update November meeting.
Doctors Industrial Action	Industrial action being undertaken by doctors in November was raised as a risk	A briefing note to be prepared for the Non-Executive Directors explaining the process for maintaining or standing down clinical lists during the planned action.	Update November meeting.
Operational pressures and Winter resilience	Urgent and Emergency Care remains highly pressured across both banks with repeated Opel 4 level escalations. The North bank was exceeding emergency department red	IPC Board Development discussion to be arranged	To be confirmed.

	lines and there had been a ward closure linked to flu and Covid.		
Maternity and Neonatal Assurance	Neonatal occupancy of approximately 92% was reported as well as increased admissions and transfers out of region. The main bottleneck was in transitional care.	ODN supported piece of work to assess and increase transitional care capacity.	To be presented to the CiC in December 2026
Fuller Phase 2	Significant improvements have been made, however work was continuing regarding security clearance checks and maternity bereavement areas across the three sites.	The CiC requested a refreshed RAG rated audit trail to demonstrate progress since the last report in July 2026.	Update to the Cic in January 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**	**Action**	**Timescale**
Quality			
Clinical Harm Policy	Work was ongoing to replace the current Clinical Harm SOP with a formal policy supported by a SOP. The current harm review trigger was 78 weeks, but it was proposed that this would move to the 52 week standard as recommended by	The proposed policy and SOP to be overseen by the Elective Care Steering Group, with detailed safety assurance returning to the CiC once in place.	Update January 2026

	NHS E.		
Refreshed BAF	The CiC received the updated draft BAF for information. A Board Development session on 12 November would allow Board members to review the risk scores and make any final changes to the BAF.	The BAF and the high-level risks to be aligned and reported quarterly to the CiC	Patient Safety BAF to be received in November 2026.
Mental Health Governance and Safety report	The CiC received the report which highlighted the current mental health arrangements across HPP. Concerns were raised regarding maintaining strategic expertise after dissolution of the Group.	Carnell Farrar reviewing the roles and responsibilities of the Mental Health teams and how future working would be carried out.	TBC
Research compliance and development	The report highlighted a clinical practice breach, confirmed that wider checks found no systemic pattern and described the correct actions in place. Funding risks, innovation activity and the likely effects of dissolution of the Group were also highlighted.	Existing networks, relationships and mentorships would continue, but growth at NLAG needs to be managed due to constraints when securing protected time and incentivising consultants to act as principal investigators.	TBC

ASSURE (Areas of assurance that the Committee has received)			
Issue	**Update**	**Action**	**Timescale**
Quality			
PALs and Complaints	A PALs office had opened at the front entrance of HRI and a new complaints process had been introduced to reduce the response backlog.	Complaints over 60 days had reduced from 84 to 23. HUTH had 17 remaining and NLaG had 6. Local resolution meetings have been arranged, and future reporting will show whether the improvements had been sustained.	Ongoing
Safeguarding Annual Report	The combined HUTH and NLAG report covered activity through to March 2026 and provided assurance against statutory, contractual and commissioning duties.	There were a number of workforce risks including named nurse, learning disability nurse and MCA/DoLs leads. Actions included completion of a business case for a North Bank learning disability nurse, temporary arrangements, remodeling and ongoing ICB discussions.	Ongoing
End of Life Care	The CiC received and update which included; progress in early recognition, care planning, education, comfort assessment, bereavement support and staff wellbeing.	NLAG had received final CQC reports for three palliative and end of life inspections, and all three services had improved from 'requires improvement' to 'good'. Action plans are being developed to sustain progress and work towards 'outstanding'. Learning has been shared with HUTH through a mock inspection.	Ongoing
Duty of Candour	Compliance had improved to approximately 95-98% compliance during September with no overdue cases.	Recovery actions were in place to sustain compliance levels.	Ongoing

NHS
Hull University Teaching Hospitals
NHS Trust

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)283

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12 November 2026
Director Lead	Jo Ledger, Interim Group Chief Nurse Hilda Gwilliams, Group Chief Patient Safety Officer
Contact Officer / Author	Kelly Northcott-Orr, Quality Improvement Manager
Title of Report	**Martha's Rule: Implementation Update**
Executive Summary	This report on Martha's Rule brings together two years of implementation work across Humber Health Partnership (HHP). It provides a baseline account of progress across both trusts, remaining priorities and the arrangements supporting ongoing patient-safety assurance. The three core components are implemented across adult, maternity and paediatric inpatient services, building on established deterioration and escalation arrangements. The approved Standard Operating Procedure (SOP), routine Patient Wellness Question (PWQ) recording, established 24/7 Critical Care Outreach Team (CCOT) provision, staff education and communications provide the foundations for delivery. This includes the multilingual WhatsApp escalation channel, launched on 2 November 2026. The remaining work towards the March 2027 contractual requirement focuses on completing neonatal implementation by 31 March 2027 and embedding consistent and equitable delivery across services. Emergency Department (ED) implementation is expected by 31 March 2028, supported by NHS England funding. Priorities include staff awareness and stronger assurance against the six Core Standards. Implementation progress is established; effectiveness and sustainability require continued monitoring and evaluation. The principal unresolved dependencies are sustainable CCOT capacity at Diana, Princess of Wales Hospital and Medicus continuity at NLaG. The business case for additional CCOT capacity has been submitted, but its outcome remains outstanding. Medicus supports clinical recording and national reporting and is separate from the WhatsApp escalation contract. Outstanding digitisation and unconfirmed BadgerNet integration also require continued oversight. The Boards are asked to receive assurance on implementation progress, note the outstanding capacity and digital dependencies, and seek assurance on progress towards resolution through the existing business-case and approval processes. Continued monitoring is required to establish effectiveness and sustainability.

Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Implementation funding has been received. Financial dependencies remain around additional CCOT resources, with a business-case decision outstanding, and continuity of the clinical recording system at NLaG. Longer-term funding for the WhatsApp escalation channel will be considered following evaluation. These matters will follow existing approval processes.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Implementation aims to support equitable access to escalation and ensure patient and family concerns are heard. Multilingual messaging and a telephone alternative to digital access help address language barriers and digital exclusion. Further monitoring is needed to assess access for people with communication or support needs, limited health literacy, or no family or carer support, and identify any additional adjustments required.
Recommended action(s) required	☐ Approval ☐ Information ü Assurance ☐ Other – please detail below:

Martha’s Rule: Implementation Update

Martha’s Rule: Implementation Update 1
Purpose of the paper 2
Executive summary 2
Background 2
Who is Martha? 2
What is Martha’s Rule? 3
The three components 3
The six NHS England Core Standards 3
Current progress 4
The three components 4
The six Core Standards 5
Self-assessment against the six Core Standards 9
Next phase of Martha’s Rule implementation 10
Maternity 10
Neonatal services 11
Emergency Departments 11
Summary of current position 12
Risks 14
Next steps 15
Conclusion 16
Recommendations 17
References 17
National references 17
Local supporting references 18

Purpose of the paper

This paper summarises implementation of Martha's Rule across Humber Health Partnership (HHP), covering both Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). It sets out the national requirements, progress made and the next phase of implementation within maternity, neonatal and emergency department (ED) services.

The paper provides assurance on the progress made across HHP and summarises established arrangements and areas requiring continued monitoring. HHP is used throughout for the shared implementation programme; HUTH and NLaG are named where arrangements differ between the two trusts.

Executive summary

This report on Martha's Rule brings together two years of implementation work across Humber Health Partnership (HHP). It provides a baseline account of progress across both trusts, remaining priorities and the arrangements supporting ongoing patient-safety assurance.

The three core components are implemented within adult and paediatric inpatient services, and maternity is included within established deterioration and escalation arrangements. The approved Standard Operating Procedure (SOP), routine Patient Wellness Question (PWQ) recording, established 24/7 Critical Care Outreach Team (CCOT) provision, staff education and communications including the multilingual WhatsApp escalation channel which launched on 2 November 2026 all providing a strong foundation.

HHP is progressing towards the March 2027 contractual requirement. Neonatal implementation is being developed for completion by 31 March 2027, while ED implementation is expected by 31 March 2028, supported by NHS England funding. The focus is now on consistent and equitable delivery, staff awareness and stronger assurance against the six Core Standards. Implementation progress is established; effectiveness and sustainability require continued monitoring and evaluation.

The principal unresolved dependencies are sustainable CCOT capacity at Diana, Princess of Wales Hospital and Medicus continuity at NLaG. The additional-resource business case has been submitted, but its outcome remains outstanding. Medicus supports clinical recording and national reporting and is separate from the WhatsApp escalation contract. Outstanding digitisation and unconfirmed BadgerNet integration also require continued oversight.

The Board is asked to receive assurance on implementation progress, note the remaining dependencies and support resolution of the outstanding resource decision through the existing business-case process. Digital continuity and future WhatsApp provision will follow the relevant approval routes.

Background

Who is Martha?

Martha Mills died of sepsis in 2021 after being admitted to hospital with a pancreatic injury following a cycling accident. Her family's concerns about her deterioration were not responded to. The coroner's Prevention of Future Deaths report, issued in February 2022, concluded that she

would probably have survived had she been referred promptly to paediatric intensive care and treated appropriately.

Following this and similar cases, the former Secretary of State for Health and Social Care and NHS England committed to introducing ‘Martha’s Rule’ across the NHS.

What is Martha’s Rule?

Martha’s Rule is a national patient safety initiative designed to support the earlier recognition of deterioration. It strengthens the voice of patients and those close to them and provides an additional route for patients, families, carers and staff to request a rapid clinical review when concerns about deterioration have not been adequately addressed.

Martha’s Rule complements existing clinical assessment, early warning scores and escalation arrangements. It does not replace routine clinical judgement, discussions with the treating team or established deterioration pathways.

The NHS Standard Contract 2026/27 requires NHS Trusts and Foundation Trusts to implement the three core components of Martha’s Rule by 31 March 2027. Implementation should be assessed against the six NHS England Core Standards, which cover reliable and equitable access, independent clinical review, patient involvement, accessibility, staff education and governance.

The three components

1. **Patient Wellness Question (PWQ):** Patients should be asked, at least daily and in a structured and consistent way, how they feel and whether they believe their condition is getting better or worse. Their response should be recorded and acted upon appropriately.
2. **Staff escalation:** Staff must be able to request a rapid review by a different team when they are concerned that a patient is deteriorating and feel that appropriate action has not been taken.
3. **Patient, family and carer escalation:** Patients and those close to them must have a clear and accessible route to request a rapid review when they are concerned that deterioration is occurring and feel that their concerns have not been adequately addressed.

The six NHS England Core Standards

In March 2026, NHS England published six Core Standards setting out what organisations should have in place to demonstrate that Martha’s Rule is being implemented safely, effectively and reliably. The standards provide a framework for self-assessment, audit, commissioner assurance and inspection. NHS England also expects organisations to use local data to identify gaps and improvement opportunities, considering equity, patient involvement and staff confidence throughout. The standards support delivery of Service Condition 33.13 within the Patient Safety section of the NHS Standard Contract 2026/27:

> **Standard 1: Reliable implementation and equitable access:** All three components of Martha’s Rule should be operational and consistently accessible within adult and children's inpatient services. This includes consistent use and recording of the PWQ, reliable access to escalation and appropriately delivered rapid clinical review.
> **Standard 2: Rapid review conducted by independent, appropriately skilled clinicians:** When Martha’s Rule is activated, review should be undertaken or facilitated promptly by an appropriately skilled clinician who is independent of the team responsible for the patient’s

ongoing care. The concerns raised should be considered as part of the review and the outcome clearly communicated.

Standard 3: Meaningful involvement of patients, families, carers and staff in the PWQ and rapid review: Patients and those close to them should be meaningfully involved in both the PWQ and rapid review process. This includes supporting people who may not be able to communicate their concerns directly and ensuring the perspectives of patients, families, carers and staff form part of clinical decision-making.

Standard 4: Equitable access, awareness and understanding: Martha's Rule should be accessible to everyone. Patients, families, carers and staff should know about the Rule, understand its purpose and know how to access it. Reasonable support and communication aids should be available so that language, disability, health literacy, confidence or lack of access to digital technology do not create barriers.

Standard 5: Staff education, knowledge and understanding: Staff, including agency, locum and other transient staff, should understand the purpose of Martha's Rule and their responsibilities within its three components. Staff should have the knowledge and confidence to recognise deterioration, involve patients and families and access the escalation and rapid review process.

Standard 6: Embedding Martha's Rule in governance and quality management systems: Martha's Rule should form part of the organisation's established patient safety, deterioration and quality management arrangements rather than operate as a standalone process. There should be clear oversight, appropriate data collection and reporting, and evidence that learning from activations is being used to support improvement.

Current progress

The three components

The three components work together to support earlier recognition of deterioration: routinely asking patients how they feel, enabling staff to escalate concerns, and providing patients, families and carers with an additional route to request rapid clinical review. The following sets out implementation progress across HHP.

Component 1: Patient Wellness Question (PWQ)

The PWQ, the first component of Martha's Rule, has been implemented within the current adult, paediatric and maternity scope across HHP, with recording adapted to the digital systems available within each clinical setting. The PWQ is embedded within routine care:

Adult inpatient services: the PWQ is fully electronic, with forms integrated within WebV and NerveCentre.

HUTH paediatrics: the PWQ is recorded electronically alongside the Paediatric Early Warning Score (PEWS).

NLaG paediatrics: work is under way to digitise the PWQ, removing reliance on the current paper-based process.

Maternity: the PWQ is paper based. Integration within BadgerNet is being explored but remains dependent on external system development. The existing paper process continues while the position is clarified.

A Business Intelligence (BI) dashboard has been established to monitor PWQ completion and variation. This supports oversight of implementation and enables targeted improvement and support where needed.

The current local Key Performance Indicator (KPI) measures PWQ completion between 08:00 and 20:00, providing a consistent reporting window for monitoring implementation. This does not restrict when patients, families, carers or staff can raise concerns or access the escalation pathway.

The next phase will focus on consistency, digital maturity and assurance. Priorities are to complete PWQ digitisation within NLaG paediatrics, clarify whether integration within BadgerNet will be available for maternity, and use the BI dashboard to identify variation and target support.

Component 2: Staff escalation pathways

The HHP interim Standard Operating Procedure (SOP) has been approved and was published on Bridget in July 2026. It builds on established deterioration policies and sets out adult and paediatric escalation pathways and response arrangements. Supporting governance processes, patient information, communications materials and staff education resources are also in place. The SOP will be adapted as implementation extends into additional settings.

Component 3: Patient, family and carer escalation

The 24-hour Martha's Rule WhatsApp service launched on **2 November 2026**. It provides a structured and accessible route through which patients, families, carers and staff can raise concerns. The service supports triage so that concerns relating to deterioration can be directed to the appropriate clinical team, while other enquiries are signposted appropriately.

The WhatsApp escalation service has a separate one-year contract for the patient, family, carer and staff access channel. An initial evaluation after three months will review usage, accessibility, safety, clinical impact and operational implications. Subject to the findings, a business case for longer-term WhatsApp provision will be progressed through the finance and procurement approval process, with Board consideration where required. This implementation report does not seek approval of a new WhatsApp contract.

The six Core Standards

Overall, implementation is progressing well, with the principal infrastructure for Martha's Rule established across HHP. The focus is now moving from initial implementation to demonstrating consistent, reliable and equitable delivery against the six NHS England Core Standards. Key priorities are completion of outstanding digital developments, neonatal implementation, evaluation of the WhatsApp escalation route, assurance of sustainable rapid review capacity and development of the ED model. The following sets out implementation progress across HHP.

Core Standard 1: Reliable implementation and equitable access

Significant progress has been made in embedding the three components of Martha's Rule across HHP.

The PWQ is fully electronic within adult inpatient services, with forms integrated into WebV and NerveCentre. Within HUTH paediatrics, the PWQ is also electronic and incorporated alongside PEWS. Work is progressing to digitise the process within NLaG paediatrics, where the existing paper process remains in place.

Within maternity, the PWQ is recorded using paper documentation. Integration within BadgerNet is being explored but is not yet confirmed. The paper process remains in place while this external dependency is clarified.

A BI dashboard has been developed to monitor PWQ completion and identify variation, enabling targeted improvement and support to be directed to areas where this is required. The current local KPI monitors PWQ completion between 08:00 and 20:00.

The patient, family and carer escalation component has been strengthened by the launch of the dedicated WhatsApp escalation channel on 2 November 2026. The service will be reviewed after three months to understand its use, impact and sustainability.

Next steps:

Complete outstanding digitisation,
Continue monitoring PWQ compliance and variation,
Assess reliability across all three components rather than PWQ completion alone.

Core Standard 2: Independent and appropriately skilled rapid review

Critical Care Outreach Team (CCOT) provision is established 24 hours a day, seven days a week. Rapid clinical review arrangements form part of HHP's Martha's Rule pathway, providing an escalation route when patients, families, carers or staff remain concerned about deterioration.

The next phase of assurance should focus on demonstrating that rapid review arrangements remain available, responsive, independent and appropriately skilled, including as Martha's Rule is extended into neonatal and ED settings. This is important because NHS England specifically requires reviewers to be independent of the team responsible for the patient's ongoing care and appropriately skilled to undertake or facilitate the required review.

Next steps:

Continue monitoring demand and the sustainability of established rapid review arrangements as implementation extends into additional settings.

Core Standard 3: Meaningful involvement of patients, families, carers and staff

The PWQ provides a routine opportunity for the patient's own perception of their condition to contribute to assessment of deterioration. The patient, family and carer escalation pathway provides an additional route where concerns remain unresolved.

Maternity is already included within HHP's implementation approach, with work continuing to embed established arrangements. Discussions with neonatal teams focus on building Martha's Rule around existing systems and processes rather than duplicating effective arrangements.

This is particularly relevant to Core Standard 3 because NHS England expects families and carers to support babies, young children and patients who cannot directly answer the PWQ and expects their perspectives to inform rapid review.

Next steps:

Complete neonatal arrangements,
Complete ED arrangements,

Continue to review whether patient and family concerns are being consistently captured, acted upon and reflected within clinical decision-making.

Core Standard 4: Equitable access, awareness and understanding

A comprehensive communications and engagement approach has been developed to support equitable awareness and access to Martha's Rule across HHP. This includes consistent branding and messaging across patient and staff communications, helping patients, families, carers and staff to recognise Martha's Rule and understand how concerns can be escalated.

The WhatsApp escalation channel, launched on 2 November 2026, has been developed with multilingual access, reflecting the five most commonly accessed languages across the localities. This supports the aim of reducing language barriers and making the escalation route accessible to a broader range of patients, families and carers.

Access is not dependent on use of the QR code or digital confidence. The CCOT telephone number is clearly displayed alongside the QR code, providing an alternative route for people who cannot use the QR code, do not have an appropriate digital device or prefer telephone access.

This approach aligns closely with NHS England Core Standard 4, which requires organisations to ensure that patients, families, carers and staff are aware of Martha's Rule and can access it fairly and consistently. The standard specifically states that people should not be disadvantaged because of language, disability, health literacy, confidence or access to digital devices.

Next steps:

Continue to monitor awareness and use of the different access routes,
Review whether communications are reaching all patient groups equitably,
Use feedback and utilisation data to identify where further targeted communication or accessibility support is required.

Core Standard 5: Staff education, knowledge and understanding

A programme of staff education and engagement is in place to support understanding of Martha's Rule and the role staff have in recognising deterioration, listening to patient and family concerns and activating the appropriate escalation route. This supports the NHS England expectation that staff understand all three components of Martha's Rule and feel confident in their role.

Progress includes:

Ward and clinical area engagement: CCOT and the Paediatric Clinical Nurse Educator have been visiting wards and clinical areas across HHP to raise awareness of Martha's Rule and provide staff training.

Integration into existing education: Martha's Rule has been incorporated into Assessment, Treatment, Human factors, Escalation, NEWS monitoring in Simulation (ATHENS) and resuscitation training, helping to embed it within established deterioration and patient safety education rather than treating it as a standalone initiative.

NHS England e-learning: an application has been submitted to the Mandatory Learning Oversight Group for the NHS England Martha's Rule e-learning package to become mandatory training for all staff across HHP. A final decision is expected on 5 November 2026. The training is available within the HHP Learning Management System, and **428** staff had completed training as at 1 November 2026.

This approach aligns with Core Standard 5, which requires staff, including locum, agency and transient staff, to understand the purpose and intent of all three components, know how to facilitate escalation and rapid review, and feel supported and empowered to act when concerns are raised.

Next steps:

Confirm the outcome of the mandatory training application,
Continue targeted ward-based education,
Develop assurance arrangements to monitor completion, staff awareness and confidence. Particular attention will be required for new starters and temporary, locum and agency staff to ensure consistent understanding across HHP.

Core Standard 6: Embedding Martha's Rule in governance and quality management systems

Martha's Rule is being embedded within HHP's established patient safety, deterioration and quality governance arrangements, rather than operating as a standalone initiative. This reflects NHS England's expectation that Martha's Rule aligns with existing approaches to recognising and responding to deterioration and that data and learning are used to support continuous improvement.

The approved HHP interim SOP, published on Bridget in July 2026, builds on existing deterioration policies and escalation arrangements. It provides an established framework for implementation and will be updated as further learning is gathered and pathways are adapted for additional settings.

National data collection and reporting are ongoing. Locally, a specific Martha's Rule reporting code has been added to Ulysses, supporting identification and review of Martha's Rule-related incidents and providing an additional source of information for organisational learning.

The PWQ BI dashboard is established and provides oversight of PWQ completion and variation. The next stage is to consider how this can be enhanced to incorporate wider Martha's Rule measures, moving beyond PWQ completion to provide a more rounded view of implementation, use, outcomes and impact.

Monitoring and evaluation will continue as implementation matures, including local information on referral volumes, response, themes and impact on CCOT capacity. Current oversight is provided

through established patient safety arrangements and Quality Priority reporting. The next phase is to embed routine business-as-usual reporting and maintain clear escalation of existing and emerging workforce, resource or patient-safety concerns.

Next steps:

Establish an ongoing assurance and reporting framework for Martha's Rule, including:

- Continued monitoring of activity, impact, outcomes and learning,
- Enhancing the PWQ dashboard with wider Martha's Rule metrics, including referral activity, response and themes,
- Monitoring the operational impact of Martha's Rule on CCOT capacity and workload, using quantitative and qualitative information,
- Maintaining clear escalation routes for existing and emerging CCOT capacity or patient-safety concerns as routine governance arrangements mature,
- Progressing the proposal to record CCOT capacity and resource concerns through the organisational risk-management process, informed by local evidence,
- Ensuring Martha's Rule continues to receive senior-level oversight beyond its current Quality Priority reporting arrangements.

Self-assessment against the six Core Standards

A structured feedback and self-assessment process has been established to assess implementation against the six NHS England Core Standards. The first exercise was undertaken in **August 2026** and will be repeated every six months, allowing HHP to monitor progress, identify variation and assess whether improvement actions are having the intended effect.

The first self-assessment identified examples of established practice, including use of the PWQ, established escalation arrangements and access to Critical Care Outreach support. However, it also found that awareness, confidence and implementation remained variable across services.

The principal themes were:

Variable awareness and implementation: some areas described established practice, while others reported limited awareness or uncertainty about what to do when Martha's Rule is requested.

Further assurance needed on rapid clinical review: Critical Care Outreach was frequently recognised as a valued source of independent support, but respondents raised questions about the definition and availability of an independent reviewer, expected response arrangements, out-of-hours cover and workforce capacity.

Need for wider workforce education: respondents supported e-learning but also identified the need for mandatory training, practical guidance, face-to-face discussion and wider engagement across medical, nursing, allied health professional, support, bank and agency staff groups.

Barriers to equitable access: concerns included access for people with learning disabilities or dementia, people whose first language is not English, children and young people, and patients without family or carer support. Suggested improvements included translated, Easy Read, visual and non-digital information, alongside interpretation and advocacy.

Variation in meaningful patient and family involvement: positive examples were identified, but feedback suggested that the PWQ can sometimes become a task rather than

a meaningful conversation. Communication and feedback following escalation were also identified as areas for improvement.

Governance and learning arrangements need to mature: respondents sought greater clarity about routine reporting, oversight, ownership and how learning from activations will be shared once implementation moves into business as usual.

The August self-assessment provides a baseline for improvement rather than a stand-alone assessment of the current position. Since then, communications, education and access arrangements have been strengthened. The findings demonstrate established practice alongside areas needing further support and have informed the implementation priorities. Repeat assessment and ongoing monitoring will help evaluate whether these actions are improving consistency across services.

The implementation framework already in place and subsequent actions addressing the self-assessment findings include:

The launch of a comprehensive communications strategy,
Multilingual access through the WhatsApp route,
Clear promotion of the CCOT telephone number as a non-QR alternative,
Ward-based education delivered by CCOT and the Paediatric Clinical Nurse Educator,
Integration of Martha's Rule into ATHENS and resuscitation training,
An application to make the NHS England e-learning package mandatory for all staff,
The approved HHP interim SOP, published on Bridget in July 2026, as the framework underpinning implementation,
The addition of a Martha's Rule code to Ulysses to support incident reporting and thematic analysis,
Ongoing work to strengthen dashboard reporting and governance oversight.

Next phase of Martha's Rule implementation

NHS England is extending Martha's Rule beyond the initial adult and paediatric inpatient implementation, with further development across maternity, neonatal and ED services. HHP is working towards neonatal implementation by **31 March 2027**, alongside the contractual requirement to implement the three core components in relevant inpatient settings. Phased ED implementation is expected to be completed by **31 March 2028**, recognising the additional complexity of this environment. HHP has received funding from NHS England to support Martha's Rule implementation in these additional areas.

Maternity

Maternity services are already included within the initial implementation of Martha's Rule across HHP. Existing maternity deterioration and escalation arrangements have been aligned with the wider Martha's Rule approach, with the focus now on continuing to embed the three components, strengthen assurance and address remaining digital requirements.

The PWQ is paper based within maternity. Opportunities for integration within BadgerNet are being explored but are not yet confirmed. Existing recording arrangements continue, with monitoring and assurance supported through the paper process while the digital position is clarified.

Next steps:

- Continue to monitor implementation,
- Clarify whether digital integration of the PWQ within BadgerNet will be available,
- Ensure maternity arrangements remain aligned with the six NHS England Core Standards.

Neonatal services

Neonatal services represent the next phase of implementation, with the three components to be implemented by **31 March 2027**. Work is under way to develop an appropriate model that builds on established neonatal deterioration, escalation and family-engagement arrangements rather than creating separate or duplicative processes.

Current work is focused on:

- Adapting the PWQ appropriately for neonatal settings,
- Establishing the model for independent, appropriately skilled clinical review,
- Ensuring parental and family concerns can be received, recorded and escalated effectively,
- Adapting the existing SOP, patient information and escalation route for parents and families,
- Establishing leadership, governance, monitoring and reporting arrangements.

The intention is to retain what already works well within neonatal services while ensuring that the three components and six Core Standards of Martha's Rule are addressed.

Next steps:

- Finalise the neonatal model,
- Agree clinical escalation and review arrangements,
- Adapt supporting documentation and communications,
- Establish reporting and assurance arrangements ahead of implementation.

Emergency Departments

NHS England has extended Martha's Rule to Emergency Departments, with implementation expected to be completed by the end of March 2028. The scope includes adult and paediatric majors, resuscitation areas, reception and waiting rooms, and temporary escalation spaces, including corridors. NHS England recognises that the ED environment requires local testing and adaptation and expects organisations to build on existing escalation processes, governance arrangements and established Martha's Rule pathways.

Initial planning has commenced across HHP. The approach will build on the existing inpatient Martha's Rule pathway and established clinical escalation arrangements, while recognising the additional complexities associated with patient flow, waiting areas, temporary escalation spaces and changing clinical responsibility within ED.

Next steps:

- Develop and test the local ED model, including the PWQ, patient, family and carer escalation route, and independent clinical review arrangements,
- Assess workforce and digital requirements,
- Establish appropriate monitoring, governance and assurance arrangements ahead of the national deadline.

Summary of current position

HHP is on trajectory to meet the NHS Standard Contract requirement for implementation of the three core components of Martha's Rule by 31 March 2027. The three core components are implemented within the current adult and paediatric inpatient scope, with continued work to embed consistent delivery and strengthen assurance against the six NHS England Core Standards.

This positive implementation position sits alongside an existing CCOT capacity pressure at Diana, Princess of Wales Hospital (DPoW), within NLaG. A business case for additional resources has been submitted to the Board, but the outcome has been delayed and remains outstanding. The risk relates to sustainable capacity as additional requirements are embedded, not the establishment of 24/7 CCOT provision.

The following table summarises the current position:

Area	RAG	Position / evidence / actions
Adult inpatient implementation	**Green** On track	The three core components are implemented within adult inpatient services. The PWQ is fully electronic through WebV and NerveCentre, supported by established staff, patient, family and carer escalation and rapid clinical review arrangements. The focus to March 2027 is on continued embedding, monitoring and demonstrating consistent delivery.
Paediatric inpatient implementation	**Green** On track	The three core components are implemented within paediatric inpatient services. In HUTH paediatrics, the PWQ is electronic and incorporated alongside PEWS. The PWQ remains operational in NLaG paediatrics while further work progresses to digitise recording. The remaining digital development does not prevent delivery of the core component.
Adult ED implementation	**Green** On track	This forms part of the next national phase, with expected completion by the end of March 2028. Local planning is at an early stage and will build on existing deterioration, escalation and governance arrangements. The model will cover majors, resuscitation, reception and waiting areas, and temporary escalation spaces.
Paediatric ED implementation	**Green** On track	This is a planned extension with expected completion by the end of March 2028. Development will build on existing paediatric deterioration and escalation arrangements.
Maternity implementation	**Green** On track	Maternity is included within implementation across HHP, with the three core components incorporated into existing deterioration and escalation arrangements. The PWQ is in place but currently paper based. Electronic integration depends on changes to BadgerNet functionality outside HHP's direct control. Paper documentation continues but limits automated oversight and makes audit and assurance more resource intensive. Continued focus is required on embedding the

Area	RAG	Position / evidence / actions
		pathway, monitoring implementation and exploring digital integration.
Neonatal implementation	**Amber** Risk of being off track	Neonatal implementation is at an early stage, with the three components to be implemented by 31 March 2027. Work builds on established neonatal deterioration, escalation and family-centred care arrangements. The amber rating reflects the risk to timely delivery while the adapted PWQ, independent clinical review model, parental and family escalation, communications and governance arrangements remain to be finalised and embedded. Progress will continue to be monitored against HHP's implementation timeframe.
24/7 independent review arrangements	**Amber** Risk of being off track	CCOT provision is established 24 hours a day, seven days a week, with independent clinical review arrangements in place. The amber rating reflects sustainable workforce capacity, including the existing DPoW pressure within NLaG, rather than absence of out-of-hours provision. The additional-resource business case has been submitted to the Board, but its outcome is delayed. Activity, demand and operational impact will continue to be monitored.
Patient, family and carer communication	**Green** On track	A comprehensive communications strategy and consistent Martha's Rule branding are in place. The WhatsApp escalation route is multilingual, reflecting the five most commonly accessed languages locally, with the CCOT telephone number promoted alongside the QR code to provide an alternative route for people unable to use digital access. Continued monitoring will assess awareness, accessibility and equitable use.
Staff training	**Amber** Risk of being off track	Education and engagement are established through CCOT and Paediatric Clinical Nurse Educator ward visits, alongside inclusion within ATHENS and resuscitation training. An application has been submitted to make the NHS England Martha's Rule e-learning mandatory for all staff, with a decision expected on 5 November 2026. The amber rating reflects variable staff awareness and the need to strengthen training coverage and assurance, while the mandatory-training decision remains outstanding.
Digital recording and documentation	**Amber** Risk of being off track	Electronic PWQ recording is established within adult services and HUTH paediatrics, with digitisation progressing within NLaG paediatrics. Maternity continues to use paper documentation. Electronic maternity integration depends on changes to BadgerNet functionality outside HHP's direct control. Paper recording supports continued delivery but limits

Area	RAG	Position / evidence / actions
		automated oversight and makes audit and assurance more resource intensive.
National data submission	**Amber** Risk of being off track	National data collection and submission arrangements are established. Medicus supports clinical recording, data capture and reporting; it is separate from the WhatsApp escalation channel. HUTH has a 12-month Medicus contract. Continuity remains a dependency at NLaG while contractual and longer-term digital arrangements are resolved. Loss of Medicus before a suitable replacement is available could increase manual collection and affect monitoring, extraction and national reporting. Continuity requires resolution through digital, finance and procurement approval arrangements, with Board consideration where required.
Implementation against the six Core Standards	**Amber** Risk of being off track	A formal self-assessment process is established against the six NHS England Core Standards, with the first assessment completed in August 2026 and six-monthly review planned. The baseline demonstrated established elements but identified variation in awareness and implementation and opportunities to strengthen rapid-review assurance, workforce education, equitable access, meaningful patient and family involvement and governance. The remaining period to March 2027 provides an opportunity to evidence improvement against this baseline.

Risks

CCOT capacity and sustainability: Martha's Rule introduces additional requirements for CCOT across HHP alongside existing service pressures. Established 24/7 provision remains in place. Referral activity, response, time required and impact on wider clinical work will be monitored to understand demand and inform resource requirements. Existing and emerging workforce or patient-safety concerns will continue to be escalated through established governance arrangements.

DPoW CCOT service capacity: NLaG has an existing capacity pressure within the DPoW deteriorating-patient service, with a reported 26-hour staffing shortfall. Previous assessment indicated that the gap could approach two whole-time equivalent (WTE) posts when the additional requirements associated with Martha's Rule, maternity and paediatric provision are considered. A business case for additional resources has been submitted, but the outcome has been delayed and remains outstanding. A request to continue the current staffing arrangement for a further six months has also been progressed. The sustainable longer-term resource position remains unresolved and requires an outcome through the existing Board business-case process.

Recording and digital capability: Variation between clinical systems continues to require different approaches to PWQ recording. Electronic recording is established within adult services and HUTH paediatrics, with work progressing to digitise the process within NLaG

paediatrics. Continued development is required to achieve consistent electronic recording and strengthen monitoring, audit and assurance across HHP.

Maternity digital recording and assurance: Electronic PWQ integration depends on external changes to BadgerNet and is not yet confirmed. Paper recording remains in place, so the PWQ continues to form part of maternity care. This limits automated reporting and makes audit more resource intensive. The digital position will continue to be monitored alongside existing recording and assurance arrangements.

Staff awareness and equitable access: The first Core Standards self-assessment demonstrated variable awareness and confidence across services and highlighted potential barriers for people with learning disabilities or dementia, people whose first language is not English, and other groups requiring communication support. The multilingual WhatsApp channel and alternative access routes provide mitigation, but continued monitoring is required to determine whether Martha's Rule is understood and accessed equitably.

Evaluation of impact and effectiveness: The WhatsApp channel is newly launched and its impact requires evaluation. National reporting, local activity data, patient and family feedback and learning from activations will provide a broader view than referral counts alone. Enhanced reporting will support review of response, outcomes, equitable access and operational impact.

Ongoing governance: Oversight is currently supported through patient safety and Quality Priority reporting arrangements. Routine business-as-usual reporting needs to be embedded so that activity, outcomes, learning, workforce impact and existing and emerging risks remain visible at senior level as implementation matures.

Long-term sustainability of the WhatsApp escalation channel: The patient, family, carer and staff access channel has a separate one-year contract and is not the Medicus clinical recording system. Continued provision beyond that period depends on evaluation and an agreed funding model. Any longer-term business case will follow finance and procurement approval arrangements, with Board consideration where required. No new WhatsApp contract approval is sought through this report.

Medicus continuity and future digital solution: Medicus supports clinical recording, data capture and Martha's Rule national reporting; its contract is separate from the WhatsApp escalation channel. HUTH has a 12-month Medicus contract, while continuity remains a dependency at NLaG. Contractual arrangements need to be resolved through digital, finance and procurement approvals, with Board consideration where required. Loss of Medicus before a suitable replacement is available could increase manual work, affect data extraction and reporting, and add pressure to CCOT. The future Orbis U solution is being developed but should not be treated as an available replacement until its functionality and readiness are confirmed.

Next steps

The next phase will focus on embedding, assuring and extending Martha's Rule across HHP, with priorities to:

Repeat the Core Standards self-assessment every six months, using the August 2026 findings as a baseline to monitor improvement and target further support.

Strengthen PWQ recording by completing digitisation within NLaG paediatrics, exploring electronic recording within maternity, and maintaining existing paper processes while digital developments are progressed.

Enhance the existing PWQ BI dashboard to incorporate wider Martha's Rule measures, including escalation activity, response, outcomes, patient experience, equity and learning.

Evaluate the WhatsApp escalation service, including the planned three-month review of utilisation, accessibility, impact and operational implications, with findings informing the longer-term model and associated business case.

Complete neonatal implementation by 31 March 2027, building on established deterioration and family-engagement arrangements and finalising the PWQ, independent clinical review, escalation, documentation, communications and governance model.

Continue to embed maternity implementation, maintaining paper recording and assurance while opportunities for BadgerNet integration are explored.

Complete Emergency Department implementation by 31 March 2028, building on existing escalation and governance arrangements and covering adults and paediatrics, majors, resuscitation, reception and waiting areas, and temporary escalation spaces. NHS England expects ED implementation to be completed by the end of March 2028.

Maintain established 24/7 clinical review arrangements, monitoring sustainable capacity as Martha's Rule extends into additional clinical settings.

Monitor CCOT capacity and progress outstanding resource decisions, including the delayed outcome of the DPoW additional-resource business case already submitted. Continue escalation of existing and emerging workforce, resource or patient-safety concerns through established governance arrangements.

Strengthen staff education and assurance, continuing ward-based support and established training routes and progressing the application for the NHS England Martha's Rule e-learning to become mandatory training, subject to the outstanding decision across HHP.

Maintain accessible and inclusive communication, ensuring both digital and non-digital routes remain clearly available and reviewing whether patients, families and carers can access Martha's Rule equitably. This reflects Core Standard 4, which specifically addresses barriers relating to language, disability, health literacy, confidence and digital access.

Strengthen governance and organisational learning, using national reporting, the local Ulysses reporting code, dashboard intelligence and learning from Martha's Rule activations to inform ongoing improvement.

Conclusion

HHP is in a good position with implementation of Martha's Rule. The approved SOP, adult and paediatric pathways, PWQ recording arrangements, patient information, staff education and escalation routes provide an established foundation across both trusts. The launch of the WhatsApp channel is a further implementation milestone. The focus is now on embedding these arrangements, monitoring consistent and equitable delivery and extending implementation into additional settings.

The report provides assurance on implementation progress and the arrangements supporting continued improvement. Established 24/7 CCOT provision remains in place. Sustainable capacity at DPoW requires the delayed outcome of the additional-resource business case already submitted to the Board, while Medicus continuity at NLaG remains a separate digital and contractual dependency. Neonatal implementation is progressing towards 31 March 2027, with ED implementation expected by the end of March 2028. Continued monitoring and evaluation will support embedding across HHP.

Recommendations

The Board is asked to:

1. Note the national requirement to implement the three core components of Martha's Rule by 31 March 2027 and the separate national expectation for ED implementation by 31 March 2028.
2. Receive assurance on progress made to date and the arrangements established to monitor implementation against the three components and the six NHS England Core Standards.
3. Note the areas requiring continued oversight, particularly CCOT capacity and sustainability, workforce awareness and training, equitable access, assurance of effectiveness, ongoing governance and organisational ownership, and digital-system dependencies affecting recording, monitoring and national reporting.
4. Note neonatal implementation by 31 March 2027 and expected ED implementation by the end of March 2028, supported by NHS England implementation funding.
5. Note the outstanding decision on the DPoW additional-resource business case, which has already been submitted but whose outcome remains outstanding. Support resolution through the existing business-case process and continued escalation of capacity or patient-safety concerns.
6. Support sustainable business-as-usual arrangements and continued monitoring and evaluation. Note that Medicus continuity at NLaG and future WhatsApp provision are separate matters to be progressed through digital, finance and procurement approval arrangements, with Board consideration where required.

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Courts and Tribunals Judiciary (2022). *Martha Mills: Prevention of future deaths report.* Report dated 28 February 2022; published 3 March 2022. Reference 2022-0063. Primary source for the coroner's findings described in the background section. Available at: https://www.judiciary.uk/prevention-of-future-death-reports/jonathan-stevens-prevention-of-future-deaths-report/. Accessed 3 November 2026.

Local supporting references

The following internal documents support the local implementation account. Intranet and programme records may require staff access. Earlier plans and meeting records describe the position at the time and should not be used alone to establish current delivery.

Humber Health Partnership (2026). *Martha's Rule – Interim Group Standard Operating Procedure.* GS059, version 1. Approved 14 July 2026; issued 17 July 2026 and published on Bridget in July 2026. Source address: Martha's Rule – Interim Group Standard Operating Procedure - GS059 - Bridget

Humber Health Partnership. *Martha's Rule staff information page, Bridget.* Referenced in the internal communications plan. Source address: https://www.bridget.org.uk/page/26818.

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)284

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	Thursday 12 November 2026
Director Lead	David Sulch, Non-Executive Director and Maternity & Neonatal Safety Champion
Contact Officer / Author	David Sulch, Non-Executive Director and Maternity & Neonatal Safety Champion
Title of Report	Maternity & Neonatal Safety Champion's Report
Executive Summary	The Safety Champion notes the MOSS drill undertaken and returned within the specified time period as required at NLAG. The Safety Champion notes that there has been a gap in MNVP function since 31/07/2026. There is an interim solution to offer bank contracts until a longer-term sustainable solution is developed. The Patient Engagement Lead Midwives are now in post to support hearing the Service User Voice. The Safety Champion recognises the pressure maternity and neonatal services are continuing to experience due to staffing and acuity. The Safety Champion acknowledges the QIP currently underway at HUTH regarding senior midwifery triage of ultrasound referrals to improve capacity issues. Risks & concerns to escalate: The Safety Champion is concerned about the Caesarean Section capacity at HUTH and what plans are in place for additional caesarean section capacity beyond November. The Safety Champion is aware that theatre maintenance needs to be urgently undertaken at DPOW - plans now being developed to support this work being undertaken in November. The Safety Champion is aware of ongoing challenges regarding BSOTS compliance at HUTH and is monitoring this at present.
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 ü Assurance ☐ Information ☐ Other – please detail below:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

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

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

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

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

Activities undertaken this month:

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

Hull University Teaching Hospitals (HUTH)
17th September 2026 Maternity & Neonatal Assurance Group
15th October 2026 Maternity & Neonatal Assurance Group

Northern Lincolnshire and Goole (NLaG)
17th September 2026 Maternity & Neonatal Assurance Group
15th October 2026 Maternity & Neonatal Assurance Group

Learning Lessons:		**Staff Experience & Feedback:**
The Safety Champion notes that there has been a discrepancy regarding the induction of labour SitRep data and work is being undertaken to improve data accuracy. The Safety champion also notes that the nitrous oxide Group continues to meet to address the potential issues with Entonox use in maternity services.	The Safety Champion notes that there has been a gap in MNVP function since 31/07/2026. There is an interim solution to offer bank contracts until a longer-term sustainable solution is developed. The Patient Engagement Lead Midwives are now in post to support hearing the Service User Voice.	The Safety Champion recognises the pressure maternity and neonatal have experienced over the summer months due to staffing and acuity. The Safety Champion acknowledges the ongoing steps to address concerns raised by staff, particularly in triage areas at NLAG.

Good practice, improvements & innovation to share:

A QIP is currently underway at HUTH regarding senior midwifery triage of ultrasound referrals. Within the first five weeks, the trust has seen an improvement and week five showed 100% of women at HUTH received the required urgent ultrasound appointment with 72 hours

Six newly qualified midwives commenced their posts at HUTH in October. NLAG's newly qualified midwives are due to commence their posts in December.

NLAG MOSS drill undertaken and returned within the specified time period to MOSS team as required.

Risks & concerns to escalate:
The Safety Champion is concerned about the Caesarean Section capacity at HUTH and what plans are in place for additional caesarean section capacity beyond November. The Safety Champion is aware that theatre maintenance needs to be urgently undertaken at DPOW - plans now being developed to support this work being undertaken in November. The Safety Champion is aware of ongoing challenges regarding BSOTS compliance at HUTH and is monitoring this at present.
Activities planned next month:
Safety Champions maintain active involvement across various sites and services, ensuring that concerns are addressed, innovation and advancements are acknowledged, and significant risks are escalated when required. Ongoing priorities will continue to be user experience - for both staff and service users, workplace culture, and access to digital resources in the months ahead. Next month's planned activities include: 19th November 2026 Maternity & Neonatal Assurance Group

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

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)285

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 12 November 2026**
Director Lead	**Jo Ledger, Interim Group Chief Nurse**
Contact Officer / Author	Yvonne McGrath, Group Director of Midwifery
Title of Report	**Maternity and Neonatal Assurance Report (Includes MIS Year 8 Report & Maternal Care Bundle Implementation Plan)**
Executive Summary	**Alert** 1. MOSS alert for HUTH received 14/10/26, will be worked through and responded to within the specified timeframe. 2. Caesarean Section capacity at HUTH – agreement now in place for additional lists until November to facilitate progression of business case and maintain safety. 3. NLAG received a national audit outlier received from NMPA in relation to not meeting the 70% minimum criteria for blood loss. This relates to 2024 data which has been investigated locally. Issues are attributed to CMIS not translating the data into MSDS, this has been resolved since the transition to Maternity Badgernet. **Advise** 1. Induction of labour, HUTH compliance with accurate submission of the daily SITREP remains a concern and focused work with Labour Ward Co-Ordinators. 2. Proposal made to staff at DPOW to support improvements to triage- this will now need to proceed to consultation. A number of minor changes will be made to support improvements to triage care delivery whilst the consultation process is worked through. 3. DPOW- theatre maintenance needs to be urgently undertaken at DPOW- plans now being developed to support this work being undertaken in November. 4. Nitrous oxide Group in place to address the potential issues with Entonox use in maternity services- options paper written and currently under update before submission to the Executive Team. 5. Gap in MNVP function since 31/07/2026 - interim solution to offer bank contracts until a longer term sustainable solution is developed. **Assure** 1. Senior midwifery triage of ultrasound referrals have enabled 100% of women at HUTH to receive the required urgent ultrasound appointment with 72 hours as required by Saving Babies Lives.

	2. NLAG MOSS drill undertaken and returned within the specified time period to MOSS team.
Background Information and/or Supporting Document(s) (if applicable)	MOSS Drill NLAG
Prior Approval Process	Maternal and Neonatal Assurance Group
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ü Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Maternity & Neonatal Safety Assurance Report

Yvonne McGrath

October 2026

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Executive Summary

Performance, challenges, risks and interventions	
Information	The Thirlwall Report has been received and is a separate Agenda item today. MNSI Thematic Review of Homebirths has been published and will be included in the Homebirth PFD work.
Alert	1. MOSS alert for HUTH received 14/10/26, will be worked through and responded to within the specified timeframe. 2. Caesarean Section capacity at HUTH – agreement now in place for additional lists until November to facilitate progression of business case and maintain safety 3. NLAG received a national audit outlier received from NMPA in relation to not meeting the 70% minimum criteria for blood loss. This relates to 2024 data which has been investigated locally. Issues are attributed to CMIS not translating the data into MSDS, this has been resolved since the transition to Maternity Badgernet.
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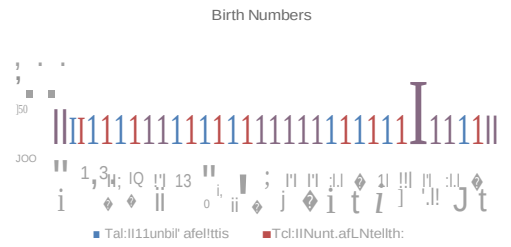
Assure	1. Senior midwifery triage of ultrasound referrals have enabled 100% of women at HUTH to receive the required urgent ultrasound appointment with 72 hours as required by Saving Babies Lives. 2. NLAG MOSS drill undertaken and returned within the specified time period to MOSS team.

1. MATERNITY DASHBOARD OVERVIEW

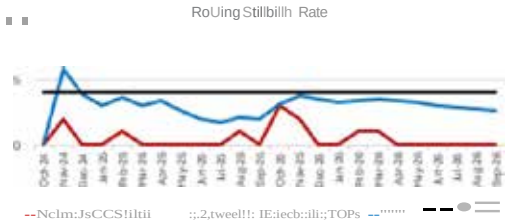
Maternity overview - Diana Princess of Wales (DPOW)

Latest Month: September2026

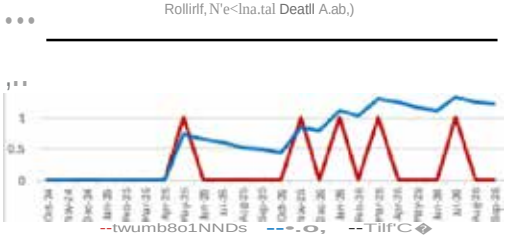
Number of Births I Live Births



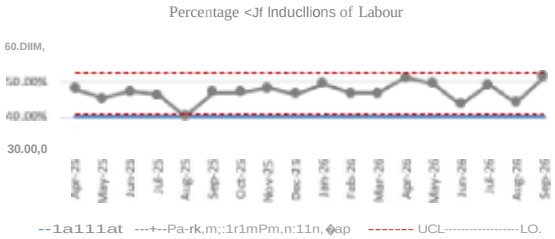
Rolling Stillbirth Rate (per 1000 births)



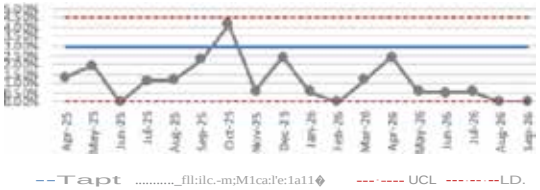
Rolling Neonatal Death Rate (per 1000 births)



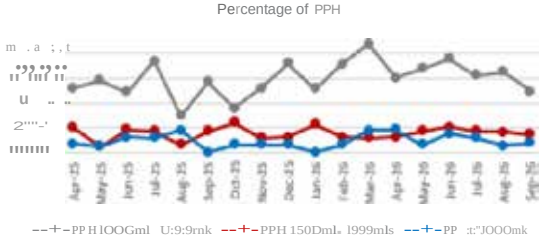
Induction of Labour Rate



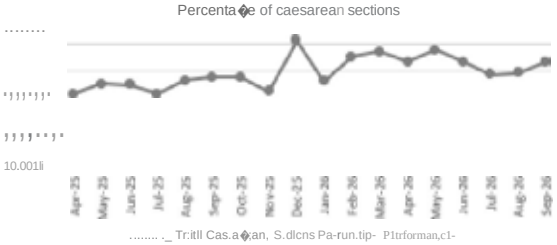
Third and Fourth Degree Tear Rate



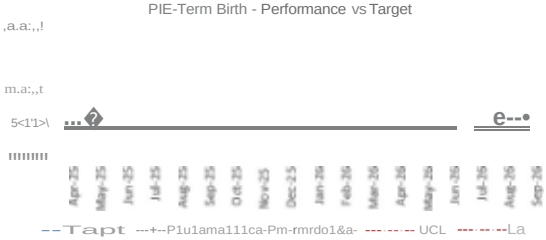
Post-partum Haemorrhage Rate



Caesarean Section Rate



Preterm Birth Rate

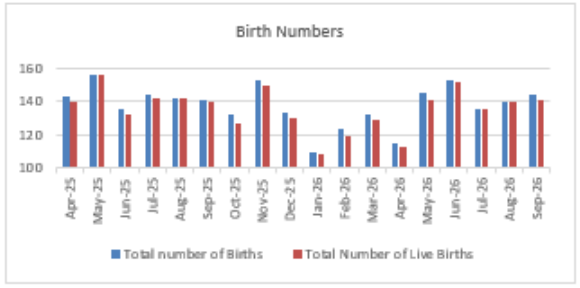


UneHpected Admission to NICU

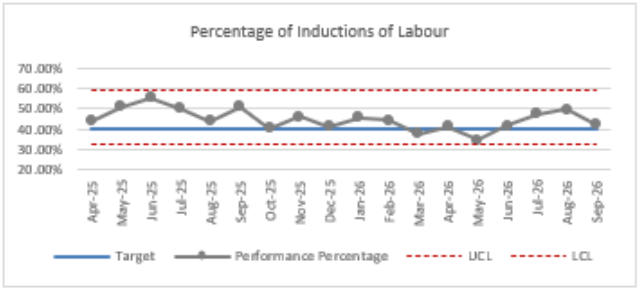
Maternity Overview - Scunthorpe General Hospital (SGH) & Goole District Hospital

Latest Month: September 2026

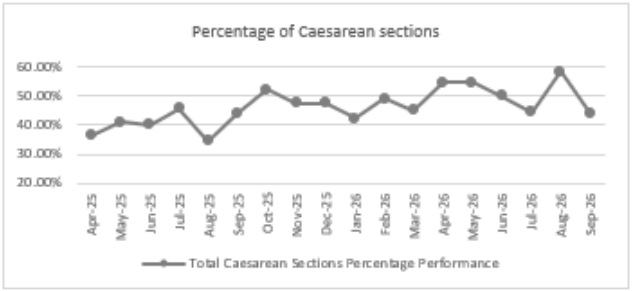
Number of Births / Live Births



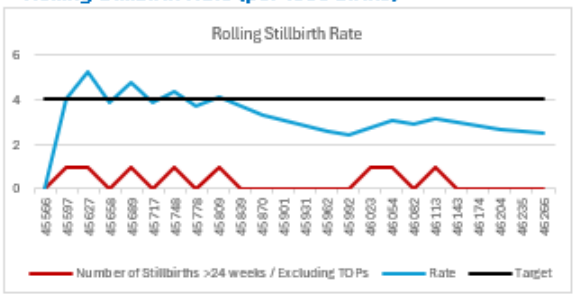
Induction of Labour Rate



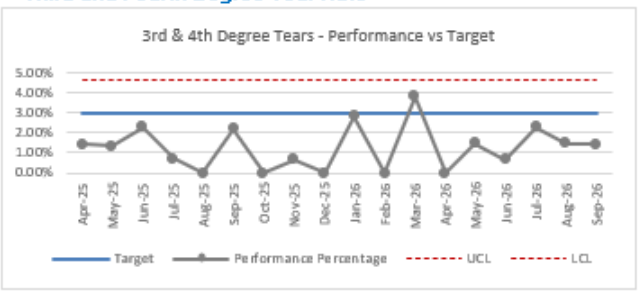
Caesarean Section Rate



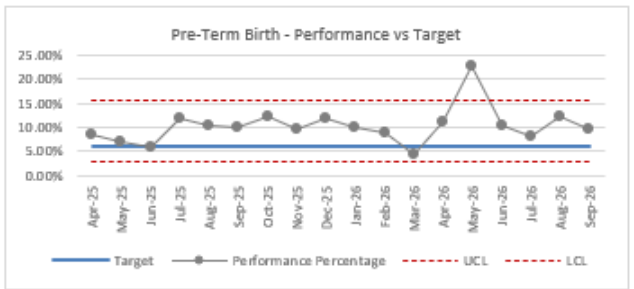
Rolling Stillbirth Rate (per 1000 births)



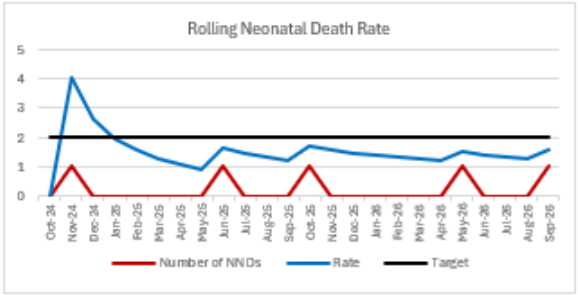
Third and Fourth Degree Tear Rate



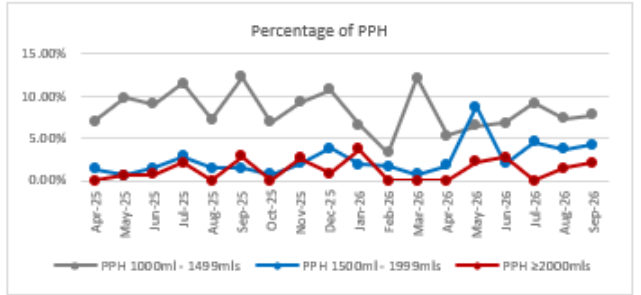
Preterm Birth Rate



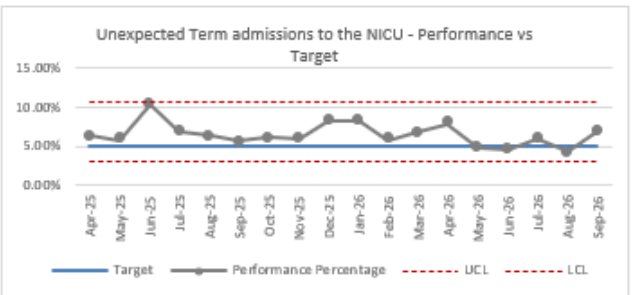
Rolling Neonatal Death Rate (per 1000 births)



Post-partum Haemorrhage Rate



Unexpected Admission to NICU



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

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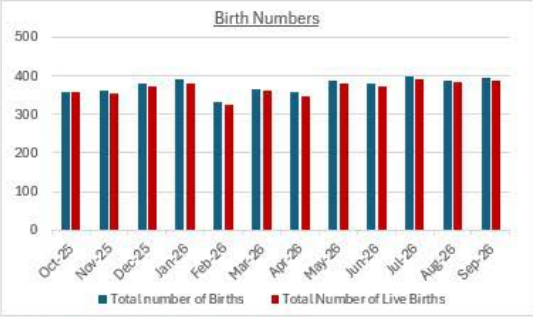
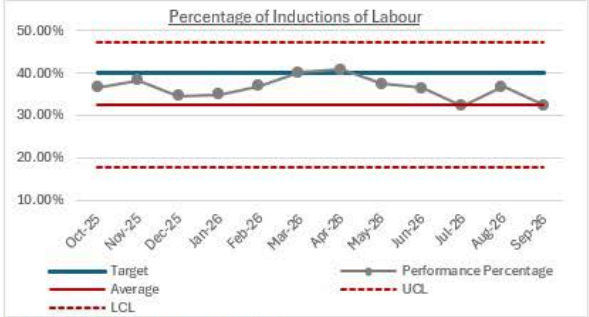
Maternity Overview - Hull University Teaching Hospitals (HUTH)

Latest month: September 2026

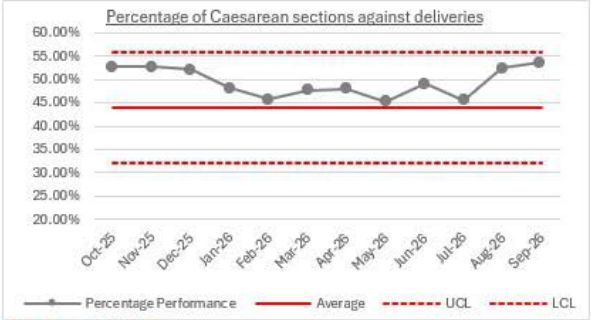
Number of Births / Live Births



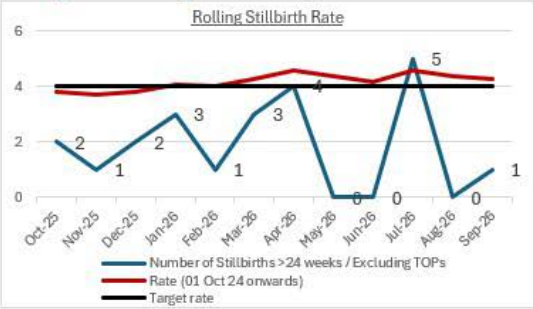
Induction of Labour Rate



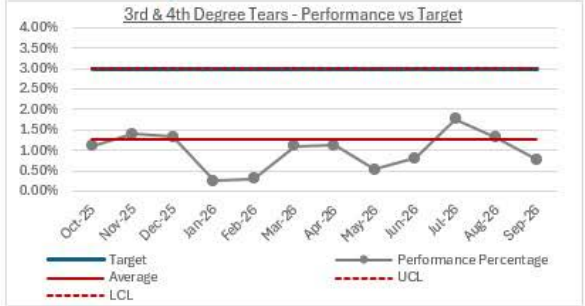
Caesarean Section Rate



Rolling Stillbirth Rate (per 1000 births)

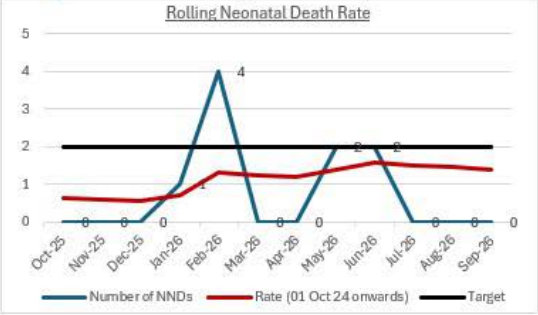


Third and Fourth Degree Tear Rate

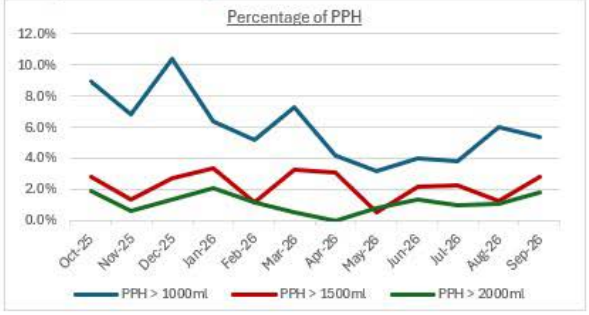


Preterm Birth Rate

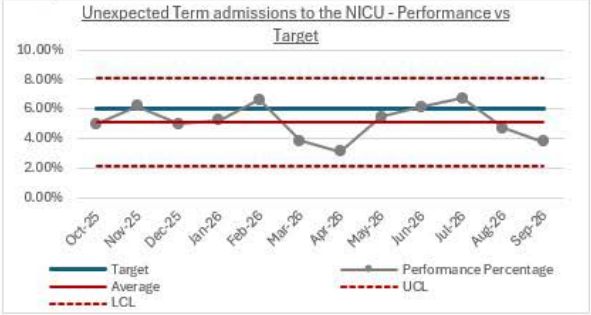
Rolling Neonatal Death Rate (per 1000 births)



Post-partum Haemorrhage Rate



Unexpected Admission to NICU



Dashboard Commentary- September 2026 data

Diana, Princess of Wales Hospital

Pre-term birth rate has remained similar this month.
ATAIN rates have decreased in month

Scunthorpe General Hospital

ATAIN rates have increased in month.
Pre-term birth rates remain stable.

Hull Royal Infirmary

ATAIN rates have continued to trend down this month.

2. PERFORMANCE METRICS

2.1 NHS Resolution Maternity Incentive Scheme Update

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

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

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

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

MIS YEAR 8 Safety action	**HUTH**				**NLAG**			
	Red	Amber	Green	Blue	Red	Amber	Green	Blue
A Workforce and capacity								
B Training								
C Learning from review and investigations								
D Service user voice and equity								
E Care bundles								
F Board oversight, governance, culture and leadership								
Total	**3**	**3**	**0**	**0**	**3**	**3**	**0**	**0**

2.2 CQC Progress Update

Northern Lincolnshire and Goole NHS Foundation Trust

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

Hull University Teaching Hospitals NHS Trusts

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

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

Improvement work continues at both HUTH and NLAG with the overall aim of being fully compliant with the Saving Babies Lives Care Bundle Version 3.2. Current compliance is detailed in the table below for quarter 1 26/27. The key risks across the group relate to smoking in pregnancy, scan capacity (element 3) and pre-term birth / optimisation. The Pre-term Birth Lead Midwife has now been appointed. Delays at NLAG identified for element 6 (separation of diabetes clinics) and requires action to progress.

Data collection for Q2 26/27 is currently underway. Most recent compliance for quarter 1 26/27 is detailed in the table below.

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

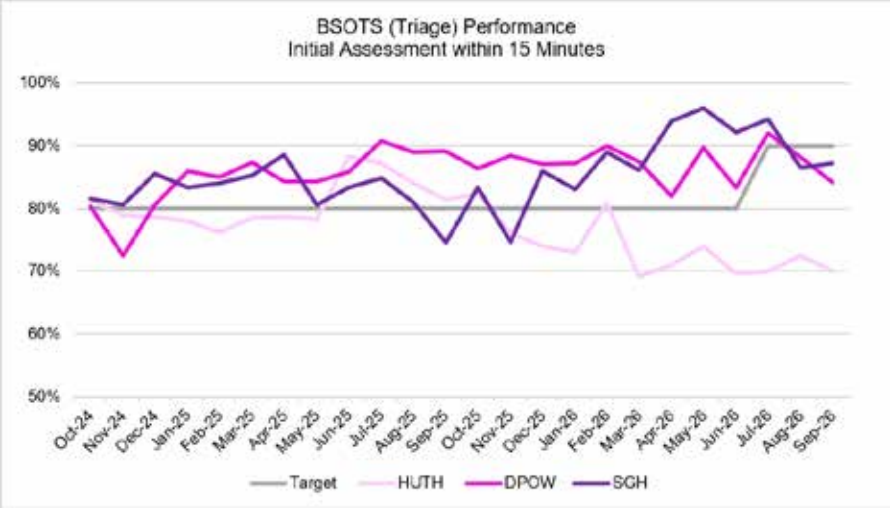
2.4 VTE Risk Assessment Performance

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

	VTE risk assessment completed (6 hours)	VTE risk assessment completed (14 hours)	VTE risk assessment completed (24 hours)	VTE risk assessment completed (postnatal)
HUTH	80%	89%	92%	99.5%
DPOW	82%	87%	92%	95.8%
SGH & GOOLE	66%	80%	89%	97.9%

2.5 Triage

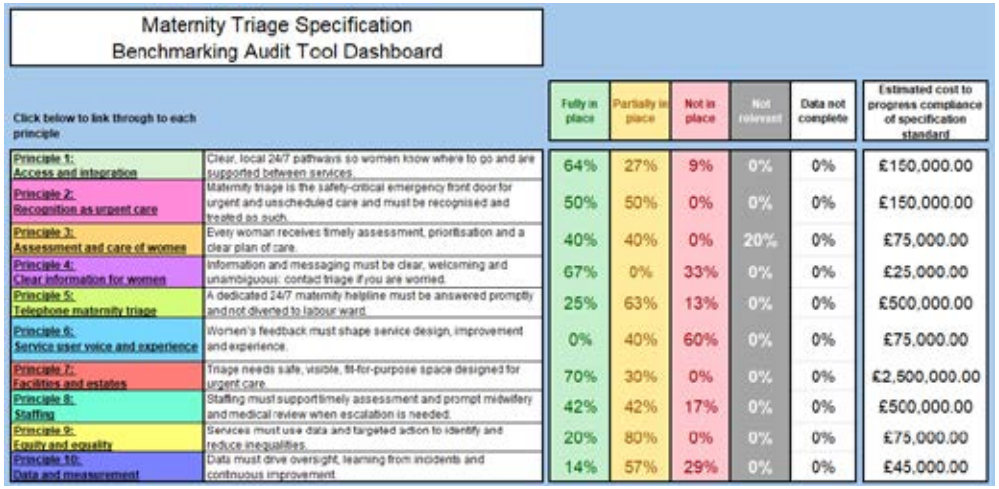
The chart and table below demonstrate ongoing performance with regards to women/birthing people being seen for initial assessment in Triage within 15 minutes of arrival for each hospital site and whether those categorised as red are seen within 15 minutes. Regular communications continued with staff, alongside daily and weekly monitoring of compliance. Concerns have been raised by triage staff and at both HRI and DPOW, Listening Events have been undertaken, a full review is planned in view of these concerns and the requirements of the NHSE 10 Point Plan.



Seen within 15 minutes - Level of urgency: RED				
Month	**Target**	**HUTH**	**DPOW**	**SGH**
Mar 26	100%	88% (7/8)	100% (4/4)	100% (2/2)
Apr 26	100%	100% (10/10)	100% (4/4)	100% (2/2)
May 26	100%	100% (15/15)	100% (5/5)	100% (3/3)
Jun 26	100%	91% (10/11)	100% (5/5)	100% (3/3)
Jul 26	100%	60% (3/5)	100% (4/4)	100% (1/1)
Aug 26	100%	89% (8/9)	100% (5/5)	50% (1/2)
Sep 26	100%	100% (5/5)	100% (4/4)	1 DQ issue

The triage benchmarking exercise has now been undertaken. Please see the benchmarking overview for each site below.

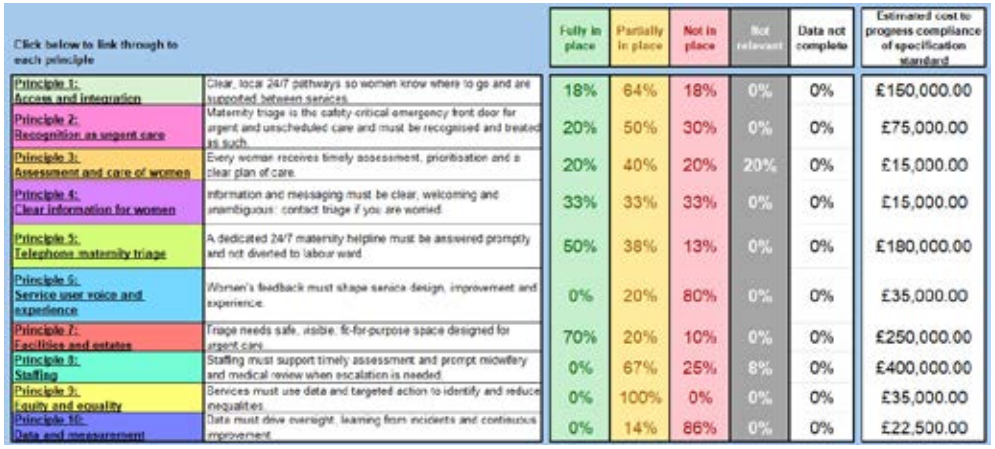
Hull University Teach Hospitals NHS Trust



Maternity Triage Specification
Benchmarking Audit Tool Dashboard

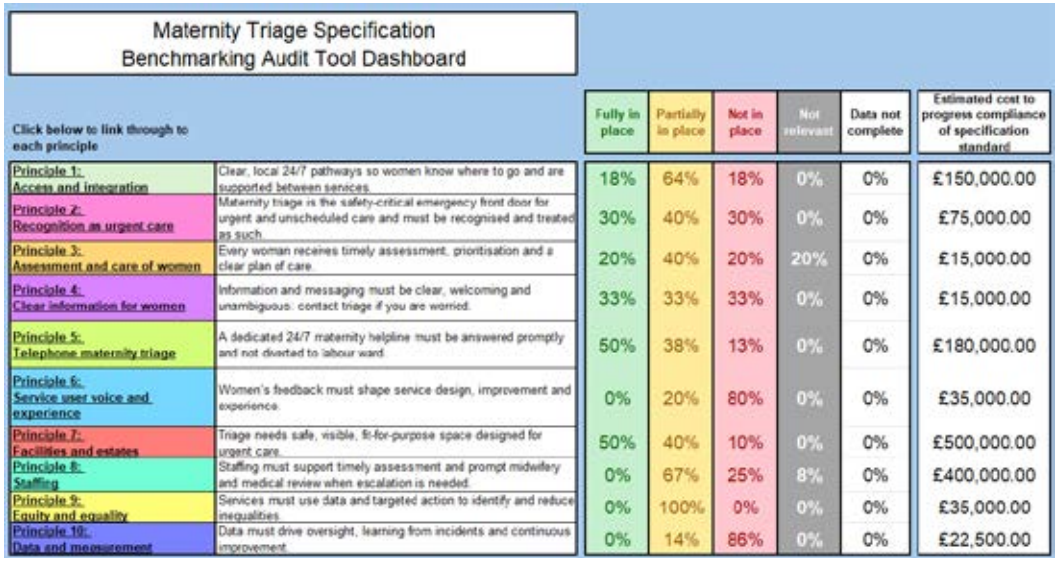
Click below to link through to each principle		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	64%	27%	9%	0%	0%	£150,000.00
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	50%	50%	0%	0%	0%	£150,000.00
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	40%	40%	0%	20%	0%	£75,000.00
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	67%	0%	33%	0%	0%	£25,000.00
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	25%	63%	13%	0%	0%	£500,000.00
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	0%	40%	60%	0%	0%	£75,000.00
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	70%	30%	0%	0%	0%	£2,500,000.00
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	42%	42%	17%	0%	0%	£500,000.00
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	20%	80%	0%	0%	0%	£75,000.00
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	14%	57%	29%	0%	0%	£45,000.00

Diana Princess of Wales Hospital



Click below to link through to each principle		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	18%	64%	18%	0%	0%	£150,000.00
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	20%	50%	30%	0%	0%	£75,000.00
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	20%	40%	20%	20%	0%	£15,000.00
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	33%	33%	33%	0%	0%	£15,000.00
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	50%	38%	13%	0%	0%	£180,000.00
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	0%	20%	80%	0%	0%	£35,000.00
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	70%	20%	10%	0%	0%	£250,000.00
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	0%	67%	25%	8%	0%	£400,000.00
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	0%	100%	0%	0%	0%	£35,000.00
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	0%	14%	86%	0%	0%	£22,500.00

Scunthorpe General Hospital



Maternity Triage Specification
Benchmarking Audit Tool Dashboard

Click below to link through to each principle		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
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Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	30%	40%	30%	0%	0%	£75,000.00
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	20%	40%	20%	20%	0%	£15,000.00
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	33%	33%	33%	0%	0%	£15,000.00
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	50%	38%	13%	0%	0%	£180,000.00
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	0%	20%	80%	0%	0%	£35,000.00
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	50%	40%	10%	0%	0%	£500,000.00
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	0%	67%	25%	8%	0%	£400,000.00
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	0%	100%	0%	0%	0%	£35,000.00
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	0%	14%	86%	0%	0%	£22,500.00

3. PERINATAL MORTALITY

3.1 Perinatal Mortality Summary for the period

Perinatal deaths within month (September 2026)					
	Antepartum Stillbirth	Indeterminate stillbirth	Intrapartum stillbirth	Neonatal death	Infant death/post-neonatal
HUTH	1 (35+4)	-	-	1 (18+4 MTOP)	1 (40+4)
NLAG	-	-	-	2 (32+5, 21+2)	-

3.2 Details of PMRT Review Outcomes (September 2026)

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

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

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

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

Hull University Teaching Hospital NHS Trust

PMRT Reference	Grading of care (mother / baby)	Reviewed at Learning Response Panel	Date Reviewed at Learning Response Panel	Outcome
102879	B / B	N/A		Closed and report written
103099	A / B / A	N/A		Closed and report written
103144	B/ B	N/A		Closed and report written
103272	DBTH grade C. HUTH neonatal care only - A	N/A		Closed and report written
103310	A / A / A	N/A		Closed and report written

Northern Lincolnshire and Goole NHS Foundation Trust

PMRT Reference	Grading of care (mother / baby)	Reviewed at Learning Response Panel	Date Reviewed at Learning Response Panel	Outcome / Learning
103450	B / B	N/A	N/A	Joint case with Doncaster. NLAG care graded A but due to bereavement care provided by Doncaster, overall care graded B.
102771 (External)	B / A	N/A	N/A	Joint case with HUTH. No actions identified.

4. MATERNITY TRAINING COMPLIANCE

Hull University Teaching Hospitals NHS Trust

Month: Sept 26	Midwives	MSWs	Obstetricians (Consultants)	Obstetricians (Other doctors)	Anaesthetist Consultant	Anaesthetist (other)	Neonatal Consultants	Neonatal (Other doctors)	Neonatal Nurses	ANNP
Fetal Monitoring (MIS)	97%	N/A	84% (new starters)	94% (new starters)	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT (MIS)	97%	92%	90% (new starters)	84% (new starters)	100%	13% (new starters)	N/A	N/A	N/A	N/A
Neonatal Resus (1 year MIS)	97%	N/A	N/A	N/A	N/A	N/A	100%	97%	97%	100%
Personalised Care	97%	87%	63% (new starters)	77%	N/A	N/A	N/A		N/A	N/A

Northern Lincolnshire and Goole NHS Foundation Trust

Month: Sept 26	Midwives	MSWs	Obstetricians (Consultants)	Obstetricians (Other doctors)	Anaesthetists (Consultants)	Anaesthetists (other doctors)	Neonatal Consultants	Neonatal (Other doctors)	Neonatal Nurses	ANNP
Fetal Monitoring (MIS)	96%	N/A	100%	58% (new starters)	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT (MIS)	97%	95%	96%	77% (new starters)	92%	95%	N/A	N/A	N/A	N/A
Personalised Care (SBLCB)	95%	95%	80%	50% (new starters)	N/A	N/A	N/A	N/A	N/A	N/A
Care during Labour & PN	97%	N/A	72%	78% (new starters)	N/A	N/A	N/A	N/A	N/A	N/A
Neonatal Resus (1 year) (MIS)	97%	N/A	N/A	N/A	N/A	N/A	93%	100%	98%	N/A
NLS (4 year)	N/A	N/A	N/A	N/A	N/A	N/A	97%	72% (new starters)	N/A	N/A

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

5. SAFER STAFFING

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

Green >90%	The is recognised RAG rating system for fill rates, this is a pragmatic RAG rating devised by the Senior Team. The fill rates are just one tool for assessing safe staffing
Amber >80%	
Red <80%	

Northern Lincolnshire and Goole NHS Foundation Trust

Month: Aug 26	Midwives						Midwifery Support Workers					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
DPOW	Power BI not updated with August data at the time of reporting											
SGH												

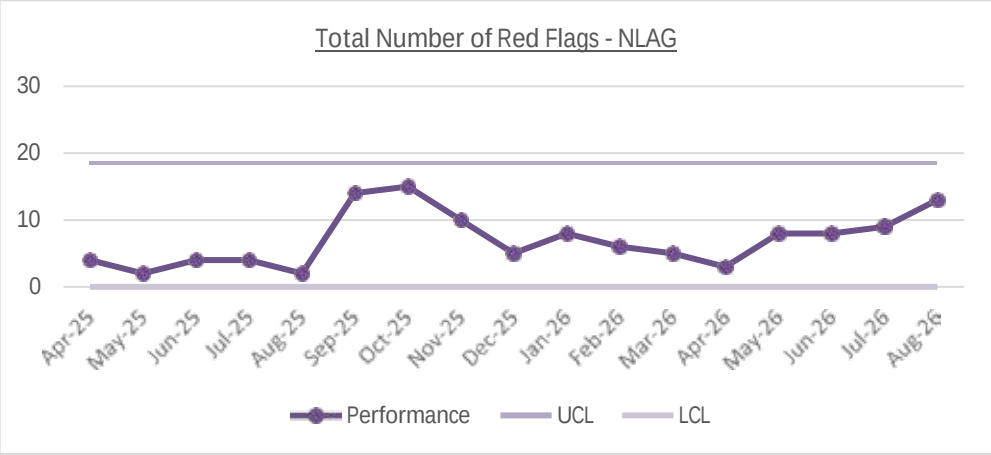
Month: Aug 26	Neonatal Nurses						Care Staff					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
DPOW	Power BI not updated with August data at the time of reporting											
SGH												

Hull University Teaching Hospitals (HUTH)

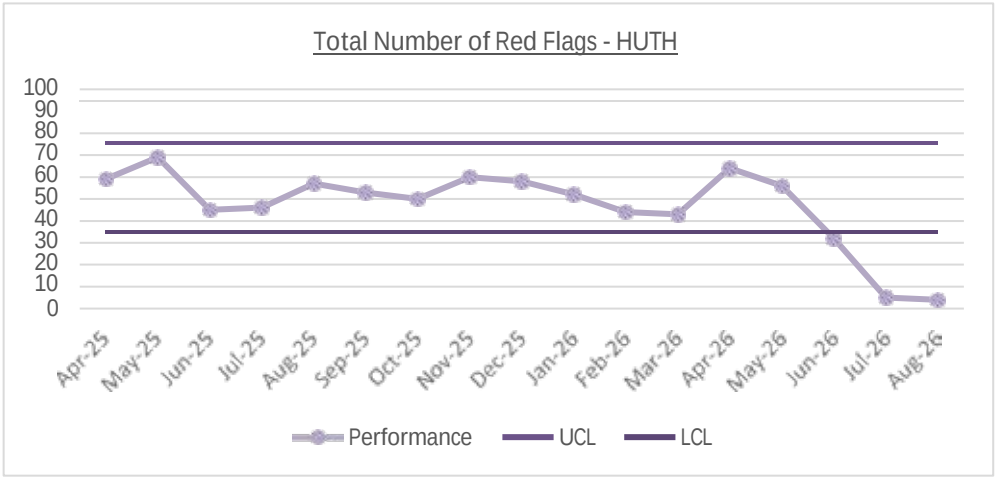
Month: Aug 26	Midwives						Midwifery Support Workers					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
HUTH	8667.33	7905.17	91.21%	5749.00	4889.67	85.05%	3069.70	2631.17	85.71%	2444.00	1920.17	78.57%

Month: Aug 26	Neonatal Nurses						Care Staff					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
HUTH	6714.00	4886.08	72.77%	6138.00	4532.25	73.84%	450.00	369.00	82.00%	341.00	198.00	58.06%

5.2 Red flags



NLAG (Apr 25 – Aug 26)	
Measure	
Delayed or cancelled time critical activity	19
Missed or delayed care	22
Missed medication during an admission to hospital	5
Delay in providing pain relief	1
Delay between presentation and triage	3
Full clinical examination not carried out when presenting in labour	0
Delay between admission for induction and beginning of process	34
Delayed recognition of and action on abnormal vital signs	5
Any occasion when 1 midwife is not able to provide continuous 1:1 care	1
Community staff called to work in the unit	30
Total	120



HUTH (Apr 25 - Aug 26)	
Measure	
Delayed or cancelled time critical activity	259
Missed or delayed care	5
Missed medication during an admission to hospital or MLU	0
Delay in providing pain relief	6
Delay between presentation and triage	1
Full clinical examination not carried out when presenting in labour	0
Delay between admission for induction and beginning of process	520
Delayed recognition of and action on abnormal vital signs	1
Any occasion when 1 midwife is not able to provide continuous 1:1 care	1
Labour Ward Coordinator not supernumerary – Providing 1:1 Care	0
Coordinator unable to maintain supernumerary status- NOT1:1 care	4
Total	797

Data inputting errors at HUTH identified through MOSS and under review in respect of delays in induction of labour and red flags are reducing at HUTH, however, work continues to improve compliance and accuracy of completion to the Sitrep.

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

5.3 Number of times services were suspended

Number of times services were suspended	HUTH			NLAG		
	Jul 26	Aug 26	Sep 26	July 26	Aug 26	Sep 26
Obstetric unit	0	0	0	0	0	2
Midwifery led unit	0	0	0	-	0	1
Homebirth service	1	5	1	9	5	9
Neonatal unit (internal)	10	3	2	3	3	1
Neonatal unit (external)	11	9	2	4	10	4

5.4 Women experiencing delays to induction

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

	HUTH			NLAG		
	July 26	Aug 26	Sep 26	July 26	Aug 26	Sep 26
Delays to induction > 6 hours	57	101	36	7	7	19

5.5 Women experiencing delays to elective Caesarean section > 24 hours

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

	HUTH			NLAG		
	July 26	Aug 26	Sep 26	July 26	Aug 26	Sep 26
Delays to Caesarean section > 24 hours	1	4	3	4	1	2

5.6 Homebirths (September 2026)

Site	No. of homebirths	No. birthing at home against medical advice	No. of births at home where there is an MDT plan in place	No. transferred into acute unit	No. of transfers with a delay
HUTH	4	2	1	0	0
NLAG	2	1	1	1	0

5.7 Staffing Vacancy Rates (July 2026)

Staff group	**Vacancy rate HUTH**	**Vacancy rate adjusted (temporary staff usage) HUTH**	**Vacancy rate NLAG**	**Vacancy rate adjusted (temporary staff usage) NLAG**
Midwifery	3.5%	-2.8%	3.9%	-4.3%
Midwifery Support Workers	0.1%	-7.6%	10.3%	-5.1%
Obstetric Consultants	20.8% (Unable to separate from gynae)	11.0% (Unable to separate from gynae)	-1.3% (Unable to separate from gynae)	-14.1% (Unable to separate from gynae)
Resident Doctors	1.4% (Unable to separate from gynae)	-2.0% (Unable to separate from gynae)	-8.9% (Unable to separate from gynae)	-27.5% (Unable to separate from gynae)
Neonatal Nurses	6.2%	3.7%	28.9%	21.7%
ANNP	Power BI inaccurate	Power BI inaccurate	N/A	N/A
Neonatal Consultants	Power BI inaccurate	Power BI inaccurate	23.6% (Unable to separate from paeds)	16.6% (Unable to separate from paeds)
Resident Doctors	Power BI inaccurate	Power BI inaccurate	16% (Unable to separate from paeds)	0.9% (Unable to separate from paeds)
Obstetric Anaesthetists	0%	0%	12.5%	6.25%
Resident doctors	0%	0%		

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

There remains several specialist midwifery posts where recruitment has been delayed due to job descriptions. Neonatal nursing staffing recruitment continues. Medical staffing recruitment but has been slower than the planned trajectory.

5.8 Missed Breaks (Midwifery) September 2026

The table below provides the percentage of midwifery staff who have worked a shift of 6 hours or more during the reported month and had no break. The data is reported from Safer Care and provided by the e-Rostering and Bank Services team.

	HUTH			NLAG		
	Sept 26	Oct 26	Nov 26	Sept 26	Oct 26	Nov 26
Missed Breaks	9.3%	-	-	12.3%	-	-

6 LEARNING LESSONS

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

Hull University Teaching Hospitals (HUTH)

MNSI number	IMD/Ethnicity	Qualify for EN?	Have the family received notification of role of referral?	Did the family require and received information in a format/language that was accessible for them?	Written Duty of Candour complete	Compliant with Duty of candour?	Details/update
MI-056540	WB – IMDD 1	No	Yes	Yes – but not available via MNSI. Easy read DoC generated.	Yes	Yes	Unbooked pregnancy. IPSB. LMP 42+5. Learning difficulties. Concerns escalated by MNSI to SLT (escalated to LRP and supported by A&E). **Draft report in FA stage.** Safety recommendations have been made, and a plan of birthrights consent training is being made.
MI-059599	WB – IMDD 6	No	Yes	Yes	Yes	Yes	40+2 delivery. IOL due to SUA. Early NND. CoD severe PPHN due to meconium aspiration syndrome. **Draft report in FA stage.** Safety prompts regarding escalation of CTG concerns in the presence of meconium have been completed. The IOL process is continuing to be reviewed.

MI-064813	WB – IMDD 1	No	Yes	Yes	Yes	Yes	38+3 G2 P1 at booking. Pregnancy interval <1 year. Had a CS previously. Attended triage ?SROM and contracting. Amnisure NEG. Uterine activity continues. Transferred to maple for analgesic. Normal CTG. Pain escalated. Transferred to Labour ward. Cont 3:10. IUFD and uterine rupture diagnosed. **Interviews scheduled.** Immediate learning has been circulated regarding the unit escalation policy and how to request additional staff (i.e. specialist midwives/practice leads).

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG)

MNSI number	IMD / Ethnicity	Qualify for EN	Have the family received notification of role of MNSI/EN	Did the family receive information in a format / language that was accessible for them?	Written Duty of Candour complete	Compliant with Duty of candour?	Details/update
MI-049981	9 / White British	No	Yes	Yes	Yes	Yes	Final report received, action plan produced and monitored for completion. **MNSI Safety Prompts:** It is recommended that staff are supported to verbalise timings, interventions done and response to these during a resuscitation to support accurate progression through the newborn life support algorithm in line with national guidance. **MNSI Recommendations:** 1) The Mother did not have symphysis-fundal height measurements taken at the frequency recommended in local guidance.

							What are the barriers to symphysis fundal height measurements? How can staff be supported to fully review a mother's electronic to ensure the appropriate pathway for monitoring of a baby's growth is in place? 2) When the mother telephoned the maternity triage unit and it was assessed she was significantly bleeding and was likely experiencing a placental abruption, she was advised to end the call and phone 999 herself. How can the Trust develop systems to support staff to consider phoning 999 for a mother in the case of a suspected obstetric emergency happening in a community setting? 3) Interpretation was not always offered to the father. What are the barriers to consistently offering an interpreter when one parent does not speak English? How can staff be supported to check a family's understanding of important clinical information?
MI-056976	9 / White British	Yes (CLM1972012)	Yes	Yes	Yes	Yes	Final report received, action plan produced and monitored for completion. **MNSI Safety Prompts:** It is recommended that the Trust works with multi-disciplinary clinical teams to identify and address barriers to the timely recognition, categorisation and management of

							CTGs in line with national and local guidance It is recommended that the Trust supports staff to strengthen their understanding of the national guidance around cooling treatment. This would include recognising that passive cooling treatment is not to be started before a baby's temperature can be continuously monitored or before a formal neurological assessment has taken place. **MNSI Recommendations:** There was not a shared understanding between the family and staff about xxx ability to participate in discussions about the plan of care and procedures in the operating theatre. This was worrying for the parents. How can staff be supported to ensure that mothers have understood the information they have been given? What are the barriers to ensuring a mother's ability to participate in discussions about the plan of care and procedures in emergency and dynamic situations?
MI-058207	8 / White Irish	No	Yes (provided directly by MNSI)	Yes (provided directly by MNSI)	N/A	N/A	Draft report received for factual accuracy, response sent and awaiting final report.
MI-068510	9 / White British	No	Yes	Yes	Yes	Yes	New maternal death – MNSI to make contact with the family.

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

Hull University Teaching Hospitals

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
450009 - 35+4 concealed abruption and antenatal stillbirth.	1/WB	Obstetric	Moderate	Service to Service with YAS. A&E review of care completed. Escalated to LRP (planned W/C 05/10). Well managed obstetric emergency but significant questions from family and maternity teams regarding admission route and significant impact this may have had.
452281 – A review of both the child's and mother's Lorenzo records identified that the mother had an obstetric risk alert recorded on her Lorenzo record which had not been transferred to the baby's Lorenzo record at birth, contrary to local safeguarding procedures. 28/01/2026 the child attended the Paediatric Emergency Department (PED) after an unwitnessed fall resulting in facial injuries. The child underwent triage but was subsequently taken home by the parent/carer before being reviewed by a doctor and was recorded as "did not wait".	1/WB	Obstetric safeguarding	Moderate	Awaiting safeguarding review. Downgraded to near miss. To be discussed at October safeguarding meeting.

Northern Lincolnshire and Goole NHS Foundation Trust

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
448121 – Staff member struck by moving / falling object in staff car park.	N/A	Obstetrics	Moderate	CCTV reviewed and secured, being dealt by relevant departments.
451787 - Trial of Forceps Delivery in Theatre followed by Fourth Degree Tear.	White British / Decile 7	Obstetrics	Moderate	Duty of candour provided. For discussion at clinical review.
451935 - Family services lift broken. Main lift out of action due to replacement work. No access to neonatal unit for maternity services. No access to for immobile patients to any floor. Impact to maternity and neonatal services.	N/A	Obstetrics	Moderate	BCP plan enacted. Informed senior team on group wide safety huddle and again at ops meeting. All elective maternity work stopped. LSCS reappointed. Inductions to commence when lift working. Awaiting external company to attend to give timeframes to allow for additional longer term plans to be made. Neonatal in touch with Embrace.
451924 - the only lift in family service building is currently out of action, leaving us with no access to maternity, a vented patient requires an x-ray however this has been postponed as x ray cannot access the unit. 2 IC babies on the unit both ventilated, x1 HD on CPAP 3sc and 1 TC.	N/A	Neonatal	Major / Severe	Action Taken : Matrons aware, engineers called, room 25 set up on honeysuckle ward for an emergency, planned sections have been cancelled and embrace are aware.

6.3 Maternity Risk Register

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

Hull University Teaching Hospitals NHS Trust

Top three risks on risk register – Maternity / obstetrics & Neonates		
Specialty	**Risk**	**Level**
Maternity	Delay or non-adherence to SBL V3.2 with regards to antenatal scanning capacity	High
Maternity	Maternal Diabetic and Maternal medicine ANC capacity and staffing	Moderate
Maternity	Obstetrics and Gynaecology Consultant staffing (effect on daily patient service and RCOG educational requirements)	Moderate
Neonatal	Hybrid use of BadgerNet and paper records in neonatal units (HHP)	Moderate
Neonatal	High risk of the spread of pseudomonas within the neonatal unit due to it being detected in the sinks	Moderate
Neonatal	Risk of increased drug administration errors due to not having electronic prescribing	Moderate

Northern Lincolnshire and Goole NHS Foundation Trust

Top three risks on risk register – Maternity / obstetrics & Neonates		
Specialty	**Risk**	**Level**
Maternity	Non-compliance with elements of the Fuller enquiry recommendations	High
Maternity & Neonatal	Unreliable lifts within the Family Services Building at DPOW	High
Maternity	Obstetric scan capacity	Moderate
Neonatal	Proximity of clinical hand washing sinks to cot spaces	Moderate
Neonatal	Hybrid use of BadgerNet and paper records in neonatal units (HHP)	Moderate
Neonatal	Sluice on NICU (SGH) non-compliance with infection prevention standards	Moderate

7 SERVICE USER FEEDBACK

7.1 MNVP/Service User Feedback

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

7.2 Complaints Received

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

NLAG		HUTH	
No received:	3	No received:	4
The 3 complaints were related to concerns regarding: clinical care/treatment.		The 4 complaints were related to concerns regarding: 3 clinical cares provided 1 delay in care	

7.3 Friends and Family Test Feedback

Hull University Teaching Hospitals NHS Trust

In August 2026, 38 responses were received. Positive comments are provided alongside feedback regarding areas of improvement.

Score	Responses
1 (Very good)	35 (91%)
2 (Good)	1 (3%)
3 (Okay)	1 (3%)
4 (Poor)	0 (2%)
5 (Very poor)	1 (3%)

Positive feedback included:
“I felt well looked after, care was prompt and tests were explained clearly. The midwife who looked after me was very kind and reassuring.”
“Felt supported throughout.”

Areas for improvement included:
“The level of noise at night, slamming of doors, prevented me from sleeping.”
“The waiting time to be discharged.”

Northern Lincolnshire and Goole NHS Foundation Trust

Friends and Family Test feedback has not been available since June 2026. Regular feedback is obtained from women and their families through a variety of avenues such as Ask a Midwife, PMRT and NICU monthly focus groups with service users. Some of the feedback received during September via Ask a Midwife is included below:

SGH

"I just wanted to say a huge, and long overdue, heartfelt thank you to all of the team on ward 26 and the CDS. On June 10th my partner and I arrived at CDS for the delivery of our first baby and stayed on the maternity ward for two days. We were both incredibly nervous!

Every single person we spoke to was amazing, friendly and beyond helpful.

My son and I literally owe our lives to the amazing people who helped us during my sons delivery.

Also, thank you Millie for taking all of the pictures and videos for us, you're a superstar

Once on the maternity ward I felt like I could relax knowing myself and my baby were being completely taken care of".

DPOW

"Can I please say a huge thank you to the Holly team who have looked after us between 30th August to 1st September.

From being induced through to being discharged, we have received the best care from the whole team and we are so grateful.

An extra thank you to -

Laura, who was so lovely and supportive throughout and made sure I had the most positive birth experience. She was so calming and nothing was too much trouble. We knew that we were in good hands!

Kayla, who looked after us after giving birth and supported with getting feeding established. She really made us feel cared for and again, nothing was too much trouble.

Danielle, who checked in on us regularly and encouraged me to keep going!"

8 LISTENING TO OUR STAFF

8.1 General Staff Feedback

Staffing has been particularly challenging over the summer months, and a couple of concerns have been raised via Freedom to Speak Up Guardian at DPOW.

Options for triage staffing at DPOW has now been shared with staffing.

Several Tea Trollies have taken place at SGH and DPOW with positive feedback.

8.2 Safety Champion Feedback

Walkaround took place on 29th September 2026 at Scunthorpe General Hospital. The walk around covered all areas on the hospital site. The following was raised and discussed with the Safety Champions:

Low morale
Staffing levels at SGH and DPOW and the closing off of the staffing incidents with ‘acceptable’ staffing
Concerns about the new MEWS and the fact that escalation to doctors is required when they are clinically stable (inappropriate parameters)
Lack of CTGs on ward 26

9 NHS England's Maternity & Neonatal 10 Point Plan

Hull University Teaching Hospitals NHS Trust

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

Northern Lincolnshire and Goole NHS Foundation Trust

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

10 Maternity Outcomes Signal System (MOSS)

Hull University Teaching Hospitals NHS Trust

The NHS England MOSS team visited on the 7th of October at HRI and shared the intention for MOSS to be used as a tool to test process rather than as an assurance exercise. The return required will be reviewed in November to support this intended use.

A further MOSS alert was received on the 14th of October. The response will be co-ordinated and returned to the regional teams as per the requirements.

Northern Lincolnshire and Goole NHS Foundation Trust

No formal alerts received. However, as per MIS requirements a MOSS drill was undertaken with the team completing the drill version of the Critical Safety Check within the required timeframe. The alert was approved by the Perinatal Leadership team and by the Trust Board Executive before being shared with the ICB and MOSS team.

The key areas identified where action is required are as follows:

> At times of high acuity as handover for maternity and neonatal are at the same time, representation of the neonatal team is not always achieved at the huddles.
> Full compliance not achieved in performing category 1 and 2 Caesarean sections within the specified timeframes. Data quality issues were also identified on Badgernet. An action plan will be devised to improve compliance and this has been added for continuous monitoring on the Maternity dashboard.
> BSOTS compliance – assessment within 15 minutes of presentation was under the 90% target for August 2026.

Overall it was concluded by the Perinatal Leadership Team that there is at least one known safety issue in the intrapartum service, with a plan of action already in place and progressing as planned.

11 Perinatal Culture Improvement Plan

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

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

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

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

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

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

12 National Audit Outlier Alerts

Northern Lincolnshire and Goole NHS Trust were notified in May 2026 by the National Maternity and Perinatal Audit (NMPA) team as being identified as a potential alarm-level outlier (based on 2024 data) due to poor data completeness (below 70%) for the following indicator:

> *Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation, who have a postpartum haemorrhage of 1500 ml or more*

Unfortunately, the alert notification was not responded to within the specified the time to the NMPA team which is a breach of their Outlier Policy. CQC and HQIP were subsequently informed and the Trust was formally recorded as being an alarm level outlier in the published report. Formal acknowledgement was retrospectively provided to the NMPA team on the 23rd September 2026.

The alert has been investigated with the Information Services team and it was identified that data completeness issues were attributed to CMIS, specifically data not transferring from CMIS to the MSDS. From review of past data, this appears to be a historic issue (dating back to 2020), however, outlier notifications for data completeness have only been issued from 2026 at the request of HQIP.

Since the introduction of Badgernet in September 2024 the MSDS data completeness issue appears to have been resolved for this measure and has significantly improved. Review of 2025 data has also been undertaken, early calculations suggest the benchmark of 70% has been met, however the national audit provider are unable to confirm this as analysis of the 2025 data is underway.

With regards to ongoing monitoring of future submission rates, the MSDS will be approved/signed off by the Director and Head of Midwifery before submission by the Information Services Team.

13 Baby Friendly Initiative

A Frenulotomy clinic has now been established in SGH once a week, this is good news for the North Lincolnshire families and reducing the travel and stress for these families, plus releasing the infant feeding leads at DPOW for other tasks, as they were covering this.

Places at Hull for 3 more staff to be trained in Frenulotomy have now been secured, this includes a NICU nurse which is going to be very beneficial.

Work is continuing to embed the plans made during the initial gold assessment in 2024, and the evidence will be submitted again in December 2026 to go for re-assessment and hopefully sustain the Award with all the hard work and commitment made from the breastfeeding team.

Another BFI staff survey has been completed - so far, of the 75 responses the feedback is very positive with staff feeling they can offer ideas and where possible, action will be taken from this. However, it's difficult to always get feedback without being persistent with the staff to complete.

Audits are completed for the women, with action plans developed if any themes are arising. The main highlights are responsive feeding in relation to bottle feeding mothers, which will be highlighted on the mandatory study day teaching sessions.

14 PERINATAL QUALITY OVERSIGHT MODEL

Hull University Teaching Hospitals NHS Trust

CQC Maternity Ratings	Safe	Effective	Caring	Responsive	Well Led	Overall
	Inadequate	Requires improvement	Good	Requires Improvement	Inadequate	Inadequate
Maternity Support Programme	No					

Data measure	August 2026
Findings of reviews of all perinatal deaths using the real time data monitoring tool	PMRT reviews: 5 (occurred 19th August 2026). External reviewers present. 102879 – 31/40 ANSB (B,B) 103099 – 23/40 NND (A,B,A) 103144 – 42/40 IPSB (B,B) 103272 – 33/40 NND (HUTH care B/A) DBTH care C 103310 – 22-24/40 NND (A/A/A)
Number of cases referred to MNSI/ENS	0
Findings of review of all cases eligible for referral to MNSI	0
Number of incidents graded as moderate or above and what action is being taken	Please refer to body of report – item 5.2
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report – item 4.
Service User Voice feedback - themes	Please refer to body of report – item 7.
Staff feedback from frontline champions and walk-abouts	Walkaround complete 28th August 2026 around all areas at HRI, with discussions regarding staffing, capacity and flow. Equipment concerns and ideas for improvements also discussed.
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No
Coroner Reg 28 made directly to the Trust	0
Progress in achievement of CNST 6 safety actions	MIS Year 8 launched 31/03/2026. See item 2.1.
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	Place to work – 22% Receive treatment - 31%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours (reported annually)	91% - response rate 79% - within IQR

Northern Lincolnshire and Goole NHS Foundation Trust

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

Data measure	August 2026	
Findings of review of all perinatal deaths using the real time data monitoring tool	2 cases were discussed at PMRT meetings during August 2026. CNST requirements met. Full details are provided in section 3.1 of the report. The gradings of care are provided below: 103450 - antepartum stillbirth, graded: B/B (joint care with Doncaster) 102771 – antepartum stillbirth (external case), graded: B/A	
Number of cases referred to MNSI/ENS	0	
Findings of review of all cases eligible for referral to MNSI	The neonatal resuscitation proforma required updating to prompt for the use of interpreters when discussing with parents about events. The SOP for maternity triage was to be updated to ensure staff taking calls when an ambulance is required, they should stay on the line while another person from maternity calls the ambulance.	
Number of patient safety incidents logged and what actions are being taken	166 maternity/obstetrics incidents (0 moderate) / 45 neonatal (1 moderate). Learning identified, shared with clinical teams and actions put in place.	
Training compliance for all staff groups in maternity related to the core competency framework	Please refer to report item 4	
Service User Voice – themes	Communication – not felt listened to, delayed discharge and system access/efficiency.	
Staff feedback from frontline champions and walk-abouts - themes	Walkabout at DPOW 29/07/26 highlighted concerns re access to System 1, theatre lighting and inappropriate referrals to triage. 03/09/2026 Triage Listening Event concerns raised about staffing model and lone working- options paper has now been shared with staff.	
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No	
Coroner Reg 28 made directly to the Trust	0	
Progress in achievement of CNST 6 safety actions	Please refer to report item 2.1.	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)		Place to work – 47% Receive treatment - 58.6%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours (reported annually) 2025		DPOW - 85% - response rate 54% - within IQR SGH – 84% - response rate 100% - within IQR

Annex 9: Critical Safety Check (drill version)

IMPORTANT NOTE: This version of the critical safety check has been adapted to help services carry out a test drill. It is not intended to be used in response to a real signal. Services should use the critical safety check in Annex 1 in response to a real signal.

The **critical safety check** (drill version) is a rapid, structured assessment of key intrapartum care operational safety processes led by the perinatal leadership team, co-produced with staff working in these areas and approved by an accountable executive member of the trust board (see responsibilities below). It is not designed to replace comprehensive audits, investigations or case reviews. Perinatal leadership teams should practice at least one annual drill using the critical safety check, so they are prepared to respond when real signals occur. An annual drill does not need to be carried out if a service has already responded to a real signal within the calendar year using the critical safety check (Annex 1)

Objective: To practice the response to a signal and conclude whether an intrapartum service has a safety issue that needs to be addressed.

Areas of focus: Improvement timelines from known safety themes, leadership and culture, time-limited safety care pathways, risk assessment and escalation processes and safe staffing.

Responsibilities: Completed by the perinatal leadership team and approved by an accountable trust board executive (i.e. chief nurse, chief medical officer or executive trust board safety champion) within 8 working days from a signal. In real level 2 signals, an external peer review of the check should also happen before executive sign-off (see p.6 of the standard operating procedures). We recommend trying to test this as part of the drill. If a signal is received over the weekend or on a bank holiday, the timeline starts from the next working day. The check should be approved face to face or virtually where possible.

After completion and approval: Share the completed critical safety check with ICBs and regions for oversight and support if a safety issue is identified. ICBs or regions can stand down if a check does not conclude there is a safety issue.

Publication reference: PRN02098

Assumed knowledge/processes in place: The perinatal leadership team should have the below information available prior to the critical safety check (drill version):

Knowledge/process	Include summary or refer to relevant documents for the attention of accountable trust board executives
Have an early understanding of the causes of death for term events over the past 3 months	No term events during the 3 month period (June, July and August 26).
Commissioned formal investigations where appropriate	During June, July and August, there have been no referrals to MNSI. There has been one report received with an action plan for recommendations produced and monitored. In view of only one report received, there are no themes identified.
Involved families in the investigation process where appropriate and listened to their insights and feedback	There have been no referrals during this three month period for MNSI / Early Notification. If there were, families would be involved in the investigation process as per the patient engagement flowchart. Where appropriate, each family would be allocated a Family Liaison Officer
Emerging and known safety themes with any timelines of action plans to address	This should include but not necessarily be limited to themes from: conclusions of previous MOSS critical safety checks – N/A Maternity and Newborn Safety Investigation (MNSI) 1 report received during the time period. No themes identified. NHS Resolution annual claims scorecard (published 2025) Annual Patient Safety Incident Report Plan (PSIRP) MBRRACE-UK real time data monitoring tool PMRT Quarter 1 Report (Q2 currently being drafted to include July/August) Q1 Theming Report & Scorecard (Q2 currently being drafted to include July/August)

Advice for completing the check:

do not share patient identifiable information on this form with anyone who does not have a lawful basis to see it – redact first
the completed and approved check needs to be shared with ICBs and regions within 8 working days even if not all questions can be completed
italicised text should be deleted before completing

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Section 1 – MOSS pre-completion check

This section provides accountable trust board executives with additional context that may explain the signal and whether the pre-requisites for implementing MOSS are in place.

MOSS pre-completion check		
Questions	**Answer**	
	Yes/No	**Description**
Have you identified an issue with the data displayed by MOSS (for example, an event was not at term or care/delivery did not take place at the site displayed)?	No	
Is the trust site a NICU plus cardiac surgery centre?	No	
Were any of the events in MOSS that occurred over the last 3 months unavoidable? Please state why.	There were no events	
Are the pre-requisites for implementing MOSS in place (page 5-6 of standard operating procedures)?	Choose an item.	Access to MOSS and operational data: Registration and data access – names submitted. Pathways for rapid review and escalation Escalation pathways and peer review – in place Governance processes in place Monthly review through MNAG (Maternity and Neonatal Assurance Group) attended by Perinatal leadership team and Board level safety champion and non-exec safety champion, and also at speciality governance meetings. National/ Regional Support Through ICB/ LMNS (although cease to exist by end of July 2026), and regional maternity team

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Section 2 – are key safety elements of your intrapartum service in place?

Please complete this section focusing on the activity of your intrapartum service **over the last 3 months**.

Safety culture - conversations with staff and service users		
Questions	**Answer**	
	Yes/No	**Brief description with any action taken** (bulleted only)
1. Are the perinatal leadership team, accountable trust board executives and staff (on labour ward, triage and birth centre) working well together?	Yes, this is working well	There is alignment between the perinatal leadership team and the Board in responding to national requirements such as Saving Babies Lives, Maternity Incentive Scheme and the Ten Point Plan. This is supported by regular updates and triangulation of data. MNAG (Maternity and Neonatal Assurance Group) meets monthly, with the presentation of the Maternity Assurance report, with a highlight report feeding into Quality and Safety Committee. MNAG is chaired by the Chief Nurse and attended by the Trust Maternity Safety Champions and other stakeholders. Monthly Maternity safety champion walk arounds occur for all sites within Northern Lincolnshire and Goole, where staff can raise any issues directly with safety champions. The location of the walkarounds varies, to ensure exposure in all areas. The last walkaround was 29th September 2026 at Scunthorpe General Hospital. Staff reported high activity but staff reported feeling heard. There has been limited capacity for our NED Maternity and Neonatal Safety champion to attend on site, however, there has been online engagement at MNAG and they chair the Quality and safety Committee, where an assurance paper is presented and presented by the DoM monthly.
2. How do you measure your leadership culture and how frequently is this done? What actions have you taken?		The leadership culture is measured through: Listening events – as required based on feedback from staff. Recent listening events have taken place with Ward 26 staff, Triage, CDS Co-ordinators at SGH, Student Midwives. Staff survey Maternity meetings at ward level MDT meetings, such as the perinatal forum, governance and audit meeting (monthly) PMA sessions Monthly Culture and Wellbeing meetings with HR DoM monthly newsletter with QR code to anonymously submit questions/ concerns directly to DoM Safety champion walkabouts – open and approachable (logged on improvement plan)

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		Greatix / shining lights
3. What have MNVP leads or other service users fed back that they feel could be improved?		The last MNVP quarterly report was received in July 2026 before the MNVP service ceased on the 31st July 2026. The MNVP also contributed to the insights section of the Maternity and Neonatal Assurance Report (see below for June feedback). **Northern Lincolnshire and Goole NHS Foundation Trust** **Insights from service users and Maternity & Neonatal Voices Partnership Co-production (June 26 update)** **Going well – Maternity** • Elective LSCS – calm experience & supported in choices. • Community midwives – positive feedback, women feeling listened to, provided with clear non-biased information. • Reports of great care when transferred from another area. **Going well – Neonatal** • Good support received during pregnancies from bereavement midwives and mat staff have been to visit on the unit. • Consistent high praise continues for staff – mainly nurses. • Families feel very supported and encouraged to be involved fully in baby's care (SGH and DPOW). **Not going so well – Maternity** • Triage – feeling concerns are not taken seriously, long waits for calls to be answered / having to call multiple times. • Long waits for birth reflection appointments. • Badgernet – ongoing reporting of slow system/log on issues • Women feeling they don't have a voice when making decisions (particularly with doctors and around place of birth planning). • Disappointed that reclining chairs not yet available for partners. • Discharge delays – particularly at DPOW. • Lack of discussion re decision for IOL. **Not going so well – Neonatal** • Delays to discharge (lack of communication about decisions) • Parking costs – unaware of parking permit available. • Not wanting to stay on Ward 26 due to lack of support for partners • Sibling facilities / resources, particularly for older siblings. No MNVP feedback is available from July onwards, however, the Trust has a 0.4 WTE Patient Engagement Midwife role now in post and Friends and Family Test data is also reported on. However, due to changes in the process the most recent month with detailed data is June 2026 (see below for results). FFT Feedback is shared with the clinical teams for further dissemination. High level feedback was received for July 2026 only (next page). **Northern Lincolnshire and Goole NHS Foundation Trust** In June 2026, 14 responses were received for Maternity and 6 for Neonatal. Positive comments are provided alongside feedback regarding areas of improvement. **Maternity** **Score** / **Responses** 1 (Very good) / 12 (86%) 2 (Good) / 1 (7%) 3 (Neither good nor poor) / 0 (0%) 4 (Poor) / *1 (7%) 5 (Very poor) / 0 (0%) 6 (Don't know) / 0 (0%) **Neonatal** **Score** / **Responses** 1 (Very good) / 6 (100%) 2 (Good) / 0 (0%) 3 (Neither good nor poor) / 0 (0%) 4 (Poor) / 0 (0%) 5 (Very poor) / 0 (0%) 6 (Don't know) / 0 (0%) *The poor comment related to prolonged time from being able to go home to discharge time/communication issues.

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4. From your walkarounds and conversations with staff:		
a) What do staff feel is working well in providing safe care in labour and birth?		The MU Net project: An 18 month project with the Midwifery Led Unit Network, focusing on midwifery led care pathways and physiology. Processes are being reviewed by external experts, and working in conjunction with our team to upskill and increase safety and confidence in delivering midwifery led care and process review. Midwifery staff report increased sense of feeling 'heard'. This is through listening events and increased communication with our teams. We have a compassionate leadership culture and transparent governance procedures. All staff are invited to the case review meetings (rapid reviews)

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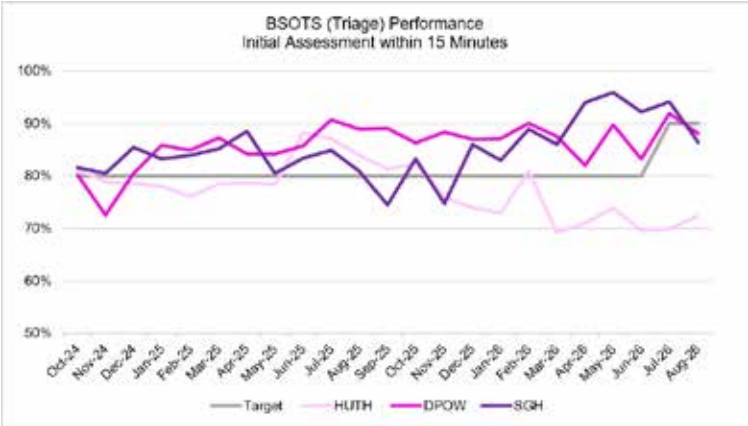
b) What do staff feel could be improved to achieve better outcomes?		Recent listening events have highlighted areas of improvement identified by staff • Skill mix of staff • Equipment • Improvements in culture • Staffing levels

Are you achieving safety timelines for these care pathways?

5. Is the maternity service achieving a triage of new cases within 15 minutes of presentation?	No - we are putting plans in place to improve this and are on track	

Seen within 15 minutes - Level of urgency: RED

Month	Target	HUTH	DPOW	SGH
Feb 26	100%	100% (12/12)	100% (2/2)	100% (3/3)
Mar 26	100%	88% (7/8)	100% (4/4)	100% (2/2)
Apr 26	100%	100% (10/10)	100% (4/4)	100% (2/2)
May 26	100%	100% (15/15)	100% (5/5)	100% (3/3)
Jun 26	100%	91% (10/11)	100% (5/5)	100% (3/3)
Jul 26	100%	60% (3/5)	100% (4/4)	100% (1/1)
Aug 26	100%	89% (8/9)	100% (5/5)	50% (1/2)

Month	Target	Compliance - DPOW	Compliance - SGH
Jun-26	80%	83.3%	92.2%
Jul-26	90%	92.0%	94.2%
Aug-26	90%	88.1%	86.5%

6. Is the maternity service achieving commencement of induction of labour (IOL) within 6 hours from point of admission for	Yes - plans are already in place to maintain	A total of 461 women had an IOL during June, July and August 2026. Of those, 4 were non-registerable births/bereavement cases and were not included in the sample. 457 women/birthing people remained in the sample. Data was cross referenced with Ulysses incident reporting for the same period where a total of 20 delays of at least 6 hours or more were identified.

Month	Women giving birth	IOL (Registerable)	IOL (non-registerable)	Incident form submitted for delayed IOL	IOL Within 6 hours	Compliance
June	345	148	2	8	140	95%

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<table>
<tr>
<td>induction (from home or ward)</td>
<td>/improve this</td>
<td>
<table>
<tr><td>July</td><td>309</td><td>160</td><td>1</td><td>3</td><td>157</td><td>98%</td></tr>
<tr><td>August</td><td>321</td><td>149</td><td>1</td><td>9</td><td>140</td><td>94%</td></tr>
<tr><td>Total</td><td>975</td><td>457</td><td>4</td><td>20</td><td>437</td><td>96%</td></tr>
</table>
Over the 3 month time period, labour was commenced within 6 hours in 96% of cases. Delays were identified in 4%.

<u>National Sitrep data</u>
National Sitrep data is also available for the Trust. Significant amounts of missing data have been identified and actions to address are being taken forward. However, it is acknowledged that internal reporting differs slightly to information submitted via the Sitrep. Therefore, the data below must be interpreted cautiously.
<table>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>June</td><td>12</td><td>7</td><td>7</td></tr>
</table>
</td>
</tr>
<tr>
<td>7. Is the maternity service achieving category 1 caesarean sections as soon as possible and usually within 30 minutes of the decision to deliver?</td>
<td>No - we are putting plans in place to improve this and are on track</td>
<td>
From 01/06/26 - 31/08/26 67 Category 1 LSCS were performed. 58 were performed within 30 minutes, therefore compliance was 87%.
<table>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>June 26</td><td>28</td><td>24</td><td>86%</td></tr>
<tr><td>July 26</td><td>13</td><td>12</td><td>92%</td></tr>
<tr><td>August 26</td><td>26</td><td>22</td><td>85%</td></tr>
</table>
At the time of data collection, data inputting errors were identified, these cases were reviewed and where necessary escalated to the Digital Midwife. The results of the audit will be shared at the Clinical Audit Meeting with an action plan subsequently developed to improve compliance and provide education regarding documentation. Reasons for caesarean sections performed after 30 minutes included:

June
1. Originally grade 2 LSCS, whilst in theatre fetal bradycardia escalated to grade 1. If left as grade 2 would have been compliant as baby delivered within 72 minutes from decision.
2. No obvious reason recorded
3. Head disimpacted (35 minutes from decision to delivery)
4. Unable to tell what time the decision was made.

July
1. Entry into uterus slightly difficult (manual stretching) no other obvious reason for slight delay (delivery 36 minutes after decision).

August
1. Initially planned for Cat 4 LSCS, following spinal felt unwell with low BP FH- bradycardia. Converted to Cat 1 LSCS.
</td>
</tr>
</table>

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<table>
<tr><td></td><td></td><td>2. Delay due to anaesthetist with another patient, decision to delivery 111 minutes. Clinical narrative states grade 2 LSCS but would have breached regardless.
3. No obvious reason for delay, decision to delivery 46 minutes.
4. Cat 2 Called 19:40, upgraded to cat 1 21:16, time of delivery – 21:22. Reg informed - waiting for night team to come on shift, then further delay as paeds team unable to attend immediately. Fetal bradycardia ongoing - reason documented for upgrading to grade 1.</td></tr>
<tr><td>8. Is the maternity service achieving category 2 caesarean sections as soon as possible and usually within 75 minutes of the decision to deliver?</td><td>No - we are putting plans in place to improve this and are on track</td><td>From 01/06/26 - 31/08/26 139 Category 2 LSCS were performed.110 were performed within 30 minutes, therefore compliance was 79%.

<table><tr><td></td><td></td><td></td><td></td></tr><tr><td>June 26</td><td>43</td><td>34</td><td>79%</td></tr><tr><td>July 26</td><td>38</td><td>30</td><td>79%</td></tr><tr><td>August 26</td><td>58</td><td>46</td><td>79%</td></tr></table>
At the time of data collection, data inputting errors were identified, reviewed and where necessary escalated to the Digital Midwife.

It was felt that 4 cases could potentially be excluded as they were recorded as category 2, but from reviewing the documentation and circumstances for each case they should have been categorised as grade 3. If these 4 were excluded compliance would be 81%. All non-compliant cases were reviewed and the results will be discussed at the Clinical Audit Meeting where an action plan will be subsequently developed. Education with staff regarding Badgernet documentation is required. There were a variety of reasons for caesarean sections performed after 75 minutes, some of which are detailed below:

1. ITU Patient due to pneumonia, extensive pre-brief and measured transfer from ITU (decision to delivery 114 minutes)
2. Another emergency in theatre (decision to delivery 176 minutes)
3. Epidural top up not effective, delayed allowing to take effect (decision to delivery 77 minutes)
4. 3 mins late, discussion with neurosurgeon / anaesthetist, Labour ward very busy
5. Difficult vein access (decision to delivery 128 minutes)
6. Awaiting bloods for FBC, U&Es and CRP to come back (decision to delivery 91 minutes).
7. Complicated getting sliding scale/cannulating (decision to delivery 115 minutes)
8. Awaiting bloods and theatre team to arrive (decision to delivery 83 minutes)
9. 10 min delay - no obvious reason
10. Delay by 5 mins due to another case</td></tr>
<tr><td colspan="3">Are you achieving regular multi-disciplinary team (MDT) communication of known or emerging risk factors on the labour ward?</td></tr>
</table>

9. Are you achieving at least one MDT huddle every day on the labour ward based on NHSI guidance?	Yes - this is already in place	MatNeo MDT Huddle undertaken at least daily on the delivery suite at Scunthorpe and on the LDRP unit at Grimsby. Attendance is recorded and stored in accordance with the SOP. Plans made for any immediate concerns and escalated through the senior management team. 08:30, 13:00 hrs and 16:30 hrs - Trust Operational call - Maternity Situation Report sent to Site including OPEL status for Maternity and Neonates. Matron on call attends to present any escalations. If Trust in OPEL 4 - Senior Quad representation required. 10 am Family Services Safety Huddle with Nurse / Midwifery Director, Head of Midwifery and Matrons - review of Pan Group activity, escalation of any concerns, discussion regarding mutual aid if required. If significant pressures, extra huddles enacted throughout the day. Ad-hoc MDT huddles undertaken if required throughout the day depending on clinical and acuity situation.
10. Do your huddles always include a consultant obstetrician, anaesthetist, midwifery co-ordinator and member of the neonatal team?	No/not always - we are putting this in place and are on track	At times of high acuity as handover for maternity and neonatal are at the same time, representation of the neonatal team is not always achieved at the huddles. However, following neonatal handover the maternity co-ordinator will discuss cases for escalation to the nurse in charge on the neonatal units.
11. Is the maternity service achieving a structured handover process in the labour ward, such as SBAR or an equivalent, that can manage known or emerging risks and involves the MDT?	Yes - this is already in place	Process for structured handover is in place. A structured SBAR handover is used during ward handovers and ward rounds with the MDT team. SBAR is embedded in the Badger Net electronic Maternity System and used for all handovers and reviews.
Are your teams carrying out appropriate risk assessment and escalation?		

<table>
<tr>
<td>12. Is the service achieving compliance with element 4 of the current version of the Saving Babies' Lives Care Bundle?</td>
<td>Yes - this is already in place</td>
<td>The last quarterly report was produced in July 26 based on Q1 26/27 data (April - June). Compliance declared at 100% with all 5/5 interventions for element 4 of the Saving Babies' Lives Care Bundle v3.2.

The latest overall training compliance reported 01/10/26 for all staff groups put overall compliance for fetal monitoring training at 93% Trustwide. All guidelines are in place as required. This would mean compliance continues at 100%.</td>
</tr>
<tr>
<td>13. Is the service achieving 90% of attendance in each relevant staff group (as per Maternity Incentive Scheme guidance) at:
fetal monitoring training
multi-professional maternity emergencies training
neonatal resuscitation training</td>
<td>No - we are putting this in place and are on track</td>
<td>Training compliance is assessed at the end of the month. The last 3 months are reported below.
<table>
<tr><th>Month: Jun 26</th><th>Midwives</th><th>MSWs</th><th>Obstetricians (Consultants)</th><th>Obstetricians (Other doctors)</th><th>Anaesthetists (Consultants)</th><th>Anaesthetists (other doctors)</th><th>Neonatal Consultants</th><th>Neonatal (Other doctors)</th><th>Neonatal Nurses</th><th>ANNP</th></tr>
<tr><td>Fetal Monitoring (MIS)</td><td>97%</td><td>N/A</td><td>100%</td><td>97%</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
<tr><td>PROMPT (MIS)</td><td>98%</td><td>95%</td><td>100%</td><td>94%</td><td>96%</td><td>86%</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Personalised Care (SBLCB)</td><td>97%</td><td>96%</td><td>87%</td><td>85%</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Care during Labour & PN</td><td>97%</td><td>N/A</td><td>67%</td><td>84%</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Neonatal Resus (1 year) (MIS)</td><td>97%</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>100%</td><td>91%</td><td>87%</td><td>N/A</td></tr>
<tr><td>NLS (4 year) (MIS)</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>100%</td><td>91%</td><td>N/A</td><td>N/A</td></tr>
</table>
<table>
<tr><th>Month: Jul 26</th><th>Midwives</th><th>MSWs</th><th>Obstetricians (Consultants)</th><th>Obstetricians (Other doctors)</th><th>Anaesthetists (Consultants)</th><th>Anaesthetists (other doctors)</th><th>Neonatal Consultants</th><th>Neonatal (Other doctors)</th><th>Neonatal Nurses</th><th>ANNP</th></tr>
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<tr><td>Care during Labour & PN</td><td>97%</td><td>N/A</td><td>72%</td><td>97%</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
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</table>
<table>
<tr><th>Month: Aug 26</th><th>Midwives</th><th>MSWs</th><th>Obstetricians (Consultants)</th><th>Obstetricians (Other doctors)</th><th>Anaesthetists (Consultants)</th><th>Anaesthetists (other doctors)</th><th>Neonatal Consultants</th><th>Neonatal (Other doctors)</th><th>Neonatal Nurses</th><th>ANNP</th></tr>
<tr><td>Fetal Monitoring (MIS)</td><td>95%</td><td>N/A</td><td>100%</td><td>70% (new starters)</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
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<tr><td>Personalised Care (SBLCB)</td><td>96%</td><td>91%</td><td>84%</td><td>56% (new starters)</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
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<tr><td>NLS (4 year) (MIS)</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>97%</td><td>67% (new starters)</td><td>N/A</td><td>N/A</td></tr>
</table>
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		It is noted that some staff members fall under the required 90%. However, these staff members are booked on at the soonest opportunity. Trajectories anticipate for all staff groups to reach 90% at the second checkpoint declared as per Maternity Incentive Scheme Year 8 which is 30th November 2026. The Perinatal leadership teams maintain an ongoing awareness of training needs.
Is there a stable workforce offering safe and effective care during labour and birth?		
14. Have staff been redeployed or non-clinical midwifery staff (e.g. managers / specialist midwives) utilised to meet minimum **midwifery safe staffing levels** as per your trust's safe staffing policy?	Yes	To ensure patient safety, midwives are at times requested to work in different clinical areas to support with high activity and acuity. This is in agreement with the staff requested, and ensuring they are confident and competent to work in a different clinical area. We have a number of midwives who are 'rotational' so have experience in all clinical areas. Specialist midwives and managers are redeployed when needed as per the escalation policy. Staff redeployment is documented on Safer Care. In the time frame requested there are 35 redeployments recorded.
15. Have there been **obstetric staffing shortfalls** impacting on safe care delivery?	No	No Ulysses submitted or obstetric on-call shifts left uncovered during the 3 month period. DCG143 Handover of Care to another Healthcare Professional in place regarding labour ward cover expectations.
16. Have there been any **anaesthetic staffing shortfalls** as per RCoA guidance impacting on safe care delivery?	No	There is a resident anaesthetist allocated just to labour ward 24/7, consultant obstetric anaesthetist Monday to Friday 08:00 - 18:00 covering labour ward and rest of the time dedicated on call consultant anaesthetists for obstetrics. 100% compliance. From 18:00 – 08:00 there is a dedicated Registrar or middle grade doctor covering obstetrics (DPOW and SGH).

Section 3 – is there any additional information that accountable trust board executives should pay attention to?

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Please use this section if there is anything not captured above that you feel executives should pay attention to, explaining potential safety issues in your intrapartum service over the last 3 months.

Section 4 – conclusion from this critical safety check (drill version)

This section is used to summarise the outcome of the critical safety check (drill version) for accountable trust board executives. If more than one safety issue has been identified and these are being dealt with differently, then overall the perinatal leadership team should select the RAG rating which best describes the safety issue(s) with the highest risk.

Question	**Answer**
How would you summarise the outcome of this critical safety check (drill version)?	GREEN/AMBER - there is at least one known safety issue in our intrapartum service, with a plan of action already in place and progressing as planned

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Section 5 – recommendation from this critical safety check (drill version)

It is recommended that the below actions are taken following the relevant conclusion of this check from section 4.

Conclusion	Action(s)	Please select
GREEN – no safety issues in our intrapartum service have been identified	no action is required other than sharing the completed check with ICB (executive with responsibility for maternity and neonatal services and director of quality) and regional colleagues (regional chief nurse, midwife, obstetrician and medical director) for awareness	☐
GREEN AMBER - there is at least one known safety issue in our intrapartum service, with a plan of action already in place and progressing as planned	the completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note in section 4 of the standard operating procedures) the perinatal leadership team should continue to report to the trust board on plans as required the trust board should continue to provide oversight and active engagement to ensure plans progress and are completed at the required speed	☒
AMBER - there is at least one known safety issue in our intrapartum service, with a plan of action already in place but it is not progressing as planned	the completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note in section 4 of the standard operating procedures). an urgent discussion between the perinatal leadership team and the trust board is required within 4 weeks with an agreement get plans back on track within 12 weeks the trust board should continue to provide oversight and active engagement to ensure plans progress and are completed at the required speed	☐
AMBER RED - there is at least one known safety issue in our intrapartum service, but a plan of action is not in place	the completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note in section 4 of the standard operating procedures) an urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement on a plan within 8 weeks the trust board should continue to provide oversight and active engagement to ensure plans are made and make progress at the required speed	☐
RED – at least one new safety issue in our intrapartum service has been identified which requires a plan of action	the completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note in section 4 of the standard operating procedures) an urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement on a plan within 8 weeks the trust board should continue to provide oversight and active engagement to ensure plans are made and make progress at the required speed	☐

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DATE: 12/10/2026

AGREED BY MEMBERS OF THE PERINATAL LEADERSHIP TEAM AND TRUST BOARD EXECUTIVE(S) AS FOLLOWS:

NAME(S)	ROLE(S)
Jo Ledger	Interim Chief Nurse
Yvonne McGrath	Group Director of Midwifery
Debbie Bray	Group Nurse Director
Jane Allen	Chief of Service

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Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)285

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 12 November 2026**
Director Lead	**Jo Ledger, Interim Group Chief Nurse**
Contact Officer / Author	Yvonne McGrath, Group Director of Midwifery
Title of Report	**Maternity Incentive Scheme Year 8 Progress Report**
Executive Summary	At present, there is ongoing evidence collection for all 6 safety actions at both HUTH and NLAG. Key risks: • A2: Recording of locum usage on an ongoing basis (NLAG). Different systems in place for HUTH/NLAG for monitoring locum staffing. • A5: Evidence outstanding of meeting notes or workforce reports showing that anaesthetic staffing pressures are monitored and discussed alongside maternity and neonatal activity. • A6: Demand/capacity review outstanding for HUTH and NLAG. Evidence outstanding of regular discussion of Caesarean birth capacity at maternity and theatre governance meetings, ensuring the whole pathway is understood and managed jointly. Bi-monthly meetings with TACC/Maternity - agenda to be developed and notes to be taken going forward. • B: Training compliance remains a risk overall. Trajectories are in place to meet the 90% target (across the Group), however, this relies on attendance to planned sessions. • D1: Difficult to evidence adapted appointment formats and longer consultation times for those with language or communication needs retrospectively. Also difficult to audit informed consent retrospectively. • D2: MNVP no longer in place for HHP • E1: Saving Babies' Lives compliance: antenatal scan capacity, smoking in pregnancy (quit rates at delivery) and pre-term birth rates/optimisation. Separation of diabetes clinics at NLAG has not yet been achieved. • F3: MNVP no longer in place. Only 1 NED Safety Champion currently in place with limited resource across the Group. Limited evidence of engagement, no evidence of Board level Safety Champions at safety champion walkabouts or safety champion meetings taking place.
Background Information and/or Supporting Document(s) (if applicable)	NLAG Neonatal Medical Staffing NLAG Neonatal Nursing Staffing HUTH Neonatal Medical Staffing HUTH Neonatal Nursing Staffing HUTH & NLAG Engagement of Short Term Locum Medical Staff (Obstetric Workforce)
Prior Approval Process	Maternal and Neonatal Assurance Group
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A

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

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

NHS Resolution
Maternity (and Perinatal) Incentive Scheme
Year Eight

HUTH & NLAG PROGRESS REPORT

October 2026

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

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

United by Compassion:
Driving for Excellence

Background

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

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

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

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

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

Executive Summary

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

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

MIS YEAR 8 Safety action	HUTH				NLAG			
	Red	Amber	Green	Blue	Red	Amber	Green	Blue
A Workforce and capacity								
B Training								
C Learning from review and investigations								
D Service user voice and equity								
E Care bundles								
F Board oversight, governance, culture and leadership								
Total	**3**	**3**	**0**	**0**	**3**	**3**	**0**	**0**

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

Key risks:

A2: Recording of locum usage on an ongoing basis (NLAG). Different systems in place for HUTH/NLAG for monitoring locum staffing.

A5: Evidence outstanding of meeting notes or workforce reports showing that anaesthetic staffing pressures are monitored and discussed alongside maternity and neonatal activity.

A6: Demand/capacity review outstanding for HUTH and NLAG. Evidence outstanding of regular discussion of Caesarean birth capacity at maternity and theatre governance meetings, ensuring the whole pathway is understood and managed jointly. Bi-monthly meetings with TACC/Maternity - agenda to be developed and notes to be taken going forward.

B: Training compliance remains a risk overall. Trajectories are in place to meet the 90% target (across the Group), however, this relies on attendance to planned sessions.

D1: Difficult to evidence adapted appointment formats and longer consultation times for those with language or communication needs retrospectively. Also difficult to audit informed consent retrospectively.

D2: MNVP no longer in place for HHP

E1: Saving Babies' Lives compliance: antenatal scan capacity, smoking in pregnancy (quit rates at delivery) and pre-term birth rates/optimisation. Separation of diabetes clinics at NLAG has not yet been achieved.

F3: MNVP no longer in place. Only 1 NED Safety Champion currently in place with limited resource across the Group. Limited evidence of engagement, no evidence of Board level Safety Champions at safety champion walkabouts or safety champion meetings taking place.

Steps for Sign Off:

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

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

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

Requirement		HUTH Compliance	NLAG Compliance
A1	**Consultant attendance (obstetric workforce)** Compliance with RCOG "Roles and Responsibilities of the Consultant providing acute care" standard: ≥80% consultant presence in defined acute care situations.		
	Progress update: Audit complete for HHP, please refer to appendix A for summary of results demonstrating compliance. Results shared at MNAG and with Trust Board (August 2026). In terms of evidence for 'what good may look like' both HUTH and NLAG are awaiting a letter from the clinical lead with regards to competency sign off.		

A2	**Short-term locum certification (obstetric workforce)** Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. Eligibility must be verified before first engagement and reviewed annually for all locums on the register.		
	Progress update: HHP spot check audit completed. Full audit report available and will be included in the biannual staffing paper. High level results are provided below. **Risks:** Recording of locum usage on an ongoing basis (NLAG). Different systems in place for HUTH/NLAG for monitoring locum staffing.		

Method

NLAG
All Obstetric rotas were reviewed to identify shifts covered by external locum medical staff for the period of 01 April 2026 to 12 September 2026 by the Rota Co-ordinator. Consultants and foundation year doctors were excluded from reporting as per RCOG / MIS guidance.

HuTH
Information identified and obtained from the Medical Staffing Team Lead for the time period of 01 April 2026 to 30 September 2026.

Summary of Key Findings: Short Term Locums

Standard Description:
NHS Trusts/organisations should ensure that the following criteria are met for employing **short-term** (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a) currently work in their unit on the tier 2 or 3 rota *or* b) have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) *or* c) hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

Against the standards detailed in MIS, a retrospective audit was undertaken from data collected on the monitoring tool, reviewing locum activity/engagement over a five month period (01 April 2026 - 12 September 2026) focusing on tier 2 or 3 (middle grade) rotas.

NLaG Breakdown of compliance

During the audit period a total of 97 tier 2 or 3 rota shifts in Obstetrics were covered by 7 external locum doctors on a short term basis (<2 weeks). The table below details the split between SGH and DPOW.

Short term locum staffing numbers (≤2 weeks)		
Site	**No. of locum doctors booked**	**No. of shifts covered**
SGH	4	71
DPOW	2	26
TOTAL	**6**	**97**

The table below demonstrates the criterion met in relating to standard 1 and the overall compliance for external locum doctors.

Standard Compliance			
EXTERNAL - Short term locum staffing (<2 weeks)			
Site	Currently work in their unit on the tier 2 or 3 rota	Have worked in the unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)	Hold a certificate of eligibility (CEL) to undertake short term locums
NLAG (n=6)	3	1	2
Achievement: 100% compliance			

HuTH Breakdown of compliance

During the audit period 0 shifts were covered by external locums.

Short term locum staffing numbers (≤2 weeks)		
Site	**No. of locum doctors booked**	**No. of shifts covered**
HUTH	0	0

The table below demonstrates the criterion met in relating to standard 1 and the overall compliance for external locum doctors.

Standard Compliance			
EXTERNAL - Short term locum staffing (<2 weeks)			
Site	Currently work in their unit on the tier 2 or 3 rota	Have worked in the unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)	Hold a certificate of eligibility (CEL) to undertake short term locums
HUTH (n=0)	N/A	N/A	N/A
Achievement: Not applicable			

A3	**Neonatal workforce establishment (nursing & medical)** Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU), Special Care Unit (SCU)) and the neonatal nursing workforce calculator output (2020).		
	Progress update: Nursing and Medical benchmarking against BAPM standards undertaken (HHP) with actions agreed to move towards compliance. To be approved at MNAG October 2026 and shared with Trust Board for discussion/sign off in November 2026.		

A4	**Midwifery workforce establishment** Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director and Head of Midwifery should be added where appropriate. Regional Chief Midwives are able to support this process if required.		
	Progress update: Midwifery staffing establishment aligns with Birthrate Plus reports for HUTH and NLAG. Bi-annual staffing report to be shared with Trust Board in December 2026.		
A5	**Anaesthetic workforce** Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards		
	Progress update: Obstetric Anaesthetic rota evidence provided (demonstrating a duty anaesthetist available 24/7 for both HUTH & NLAG). **Risks:** Evidence outstanding of meeting notes or workforce reports showing that anaesthetic staffing pressures are monitored and discussed alongside maternity and neonatal activity. AAA report to be requested from TACC.		

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

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

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

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

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

Requirement		**HUTH compliance**	**NLAG compliance**
B1	**Obstetric emergency training** Trusts must ensure that maternity staff attend annual multidisciplinary obstetric emergency training that incorporates local learning, human factors, communication, teamwork, escalation pathways and situational awareness. Anaesthetists working in maternity are required to attend at least half of the MDT training day as a minimum, during which obstetric emergencies requiring anaesthetic input. Trusts must ensure that an impacted fetal head (IFH) scenario is incorporated into obstetric emergency training by the end of MIS Year 8 as a preparatory step for Avoiding Brain Injury in Childbirth (ABC) implementation, aligning to the proposed ABC methodology. There is not an expectation that all staff will have received training.		
	Progress: Multidisciplinary obstetric emergency training in place at both HUTH and NLAG that incorporates the requirements detailed above. IFH now in place at HUTH and NLAG. **Risks:** Attendance of resident doctors at planned training sessions.		
B2	**Neonatal resuscitation** As a minimum, trusts must ensure that all staff who may act as an unsupervised first attender or primary resuscitator at any birth (including all midwives) complete annual neonatal resuscitation training and are assessed as meeting at least basic capability, as defined in the BAPM Neonatal Airway Safety Standard. Where further enhanced training is in place for additional staff groups, this should continue (e.g. NLS (Newborn Life Support) Course or equivalent).		
	Progress: Neonatal resuscitation training in place for all staff groups. BAPM Neonatal Airway basic capability assessment embedded at HUTH, process introduced for NLAG from September 2026. Awaiting evidence for medical staffing who have already been assessed as competent. **Risks:** Attendance of resident doctors at planned training sessions.		
B3	**Fetal monitoring training** Trusts must ensure that all staff who provide care in antenatal or intrapartum settings, whether substantively or when responding in escalation, complete annual fetal surveillance training.		
	Progress: Multidisciplinary training in place at both HUTH and NLAG, attendance monitored regularly. **Risks:** Attendance of resident doctors at planned training sessions.		

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

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

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

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

C2	**Seek parents' views of care** For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.		
	Progress: Local process and systems in place at HUTH and NLAG. Compliant with requirement for reporting all eligible events. Reported in quarterly PMRT reports.		

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

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

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

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

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

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

D2	**Service-user voice driving safety and quality improvement** Trusts must demonstrate that insights from women, families and carers using maternity and neonatal services are captured and used to inform service improvement plans. Trusts must use demographic data to understand their local population and demonstrate that the voices of women and families from different demographic groups, are actively captured and used to shape priorities within the service. Progress with this work should be monitored through established governance routes quarterly to ensure that actions lead to measurable improvements in safety, quality, or experience.		
	Progress: Use of interpreter audit currently underway. Continue to gather evidence for both neonatal and maternity services for "what good may look like". Incidents triangulated with service user feedback and included with theming reports. **Risks:** MNVP no longer in place for HHP. Service user feedback sought through a variety of channels i.e. Ask a Midwife, Facebook surveys, PMRT.		

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

<table>
<tr><th colspan="2">Requirement</th><th>HUTH compliance</th><th>NLAG compliance</th></tr>
<tr><td rowspan="2">E1</td><td>Saving Babies' Lives Care Bundle (SBLCBv3.2) - Quarterly reporting to the Trust Board
The provider must report quarterly to the Trust Board on progress against full SBLCBv3.2 implementation. Quarterly reports should demonstrate how the Trust has prioritised the requirements of the SBLCB based on local progress, implementation status, and any relevant safety intelligence, including themes and learning from local adverse incidents.

In light of the recent NHSE and RCOG fetal growth chart safety communication, Trusts should include a brief review within their local SBL priorities to confirm safe and appropriate fetal growth surveillance, confirming that fetal growth charts and surveillance pathways meet most recent national safety advice and identifying any local risks or improvement actions relating to fetal growth restriction (FGR) detection as highlighted.</td><td></td><td></td></tr>
<tr><td colspan="3">Progress: Quarterly reports developed and submitted to Trust Board quarterly. Current compliance for quarter 1 26/27 is detailed in the table below. Q2 data collection is underway.
Risks: HHP Antenatal scan capacity, smoking in pregnancy (quit rates at delivery) and pre-term birth rates/optimisation. NLAG risk: Separation of diabetes clinics remains problematic.

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

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

<table>
<tr><td rowspan="2">E2</td><td>Maternal Care Bundle – Implementation Plan
In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the Maternal Care Bundle by March 2027. Progress with implementation is reviewed quarterly through established governance routes.</td><td></td><td></td></tr>
<tr><td colspan="3">Progress: Action plans devised for HUTH and NLAG, to be shared at MNAG in October and Trust Board in November.</td></tr>
</table>

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

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

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

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

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

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

Appendix 1 – Consultant Attendance Audit Results

HUTH:

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

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

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

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

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

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

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

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

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

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

Appendix 2 – Training compliance (Mid-year checkpoint)

HUTH:

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

DPOW:

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

SGH:

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

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CNST MIS Year Eight - Neonatal Medical Workforce Action Plan

Requirements for Safety Action 4:

1. The neonatal unit must meet the British Association of Perinatal Medicine (BAPM) national standards.
2. If these are not met an action plan should be in place and agreed at Board level to meet these recommendations.

BAPM standard requirement	MIS Year 8 status	Action Required	Lead	Timescale	Status	Evidence
Where LNUs have a very busy paediatric/neonatal service and/or have neonatal and paediatric services that are a significant distance apart, the above staffing levels should be enhanced. The threshold should be judged and monitored on clinical governance grounds such as the ability consistently to attend paediatric or neonatal emergencies immediately when summoned. BAPM junior medical staffing guidance for Local Neonatal Units: LNU activity / Tier 1 / Tier 2 >1000 Respiratory Care Days (RCD) or >400 Intensive Care days / >/= 1 resident, dedicated, 24/7 to ensure safety & quality / >/=1 resident, dedicated, 24/7 OR risk analysis if providing <24/7 separate cover Tier 1: Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition. Tier 2: Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff.	**DPOW: 1034 RCD 2025-2026** No action required - dedicated Tier 1 and Tier 2 24/7 cover for paediatrics and neonates. **SGH: RC835D 2025-2026** Dedicated Tier 1 and Tier 2 cover 09:00-17:00. Tier 1 and Tier 2 shared cover for paediatrics and neonates 17:00-09:00.	Increase in establishment or change in rotas required. Workforce review to be shared with Executive Team, action taken to be determined on Board Activity. If plan to maintain both units as LNU	TBC	Workforce Review to be shared with Executive Team	Non-compliant	Approval for recruitment after presentation to board.

BAPM standard requirement	MIS Year 8 status	Action Required	Lead	Timescale	Status	Evidence
BAPM consultant medical staffing guidance for Local Neonatal Units:						
<table><tr><th>LNU activity</th><th>Tier 3</th></tr><tr><td>>1000 Respiratory Care Days or >400 Intensive Care days</td><td>A minimum of 7 WTE neonatal paediatricians / neonatal consultants on the on-call rota**.</td></tr><tr><td colspan="2">**All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics.</td></tr></table> Source: The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK (2022) https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf	8.75 x WTE at DPOW + 2 WTE appointed but yet to start 8 x WTE at SGH+ 1WTE advertised) Dedicated Tier 3 neonatal cover between 09:00-13:00. Tier 3 shared cover for paediatrics and neonates 13:00 – 09:00.	Increase in establishment required as per the business case submitted. Year 2 and 3 increase will need to be funded at the LNU site	TBC	Executive committee need to approve funding for year 2&3	Non-compliant	Further discussion of workforce paper and funding needs to take place
Minimum of 1 consultant with a designated lead interest in neonatology.	SGH: Locum Consultant in post with lead interest. Permanent post advertised and interviews scheduled. DPOW: Vacant post. Permanent post advertised and interviews scheduled.	Recruitment of permanent consultants (DPOW and SGH) with a designated lead interest in neonatology. **DPOW&SGH:** Neonatal interest consultant post interview in October 2026.	TBC	Recruitment in progress	Non-compliant	Job plans / Permanent consultant posts appointed.

BAPM standard requirement	MIS Year 8 status	Action Required	Lead	Timescale	Status	Evidence
BAPM consultant medical staffing guidance for Local Neonatal Units:						
Consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification and substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN.	SGH: Locum consultant (interest in neonatology) currently working towards CESR. Does not have CCT. DPOW: Vacant post (interest in neonatology)	Permanent Recruitment to neonatal lead posts across SGH (to replace locum) & DPOW (vacancy arising from resignation) will have SPIN in Neonates	TBC	6 months	Non-compliant	DPOW/SGH recruitment in process
At least one LNU Tier 3 Consultant should have either a CCT in neonatal medicine or neonatal SPIN module (if this was available during training).	SGH: Does not have a CCT in neonatal medicine or neonatal SPIN module. DPOW: Vacant post. SGH & DPOW permanent posts will fulfil the criteria when employed	To advertise both substantiative posts / appoint consultants into permanent posts who have a CCT or SPIN module in neonates	TBC	6 months	Non-compliant	Qualification following appointment to posts / confirmation from Neonatal Clinical Lead
All consultants covering the service must demonstrate expertise in neonatal care (based on training, experience, CPD and on-going appraisal).	Trustwide: Unable to evidence as standard routine appraisal process does not include assessment of neonatal expertise. SGH: Consultants have rotation / exposure to tertiary neonatal practice (though not in job plan this has been facilitated. Will be in Job plan	Annual assessment package to be developed.	TBC	6 months	Non-compliant	Annual Assessment Package / Plan for consultant assessment.

	2026/27)—completed 2026 DPOW: Consultants have rotation /exposure to tertiary neonatal practice (though not in job plan this has been facilitated). Will be in Job plan 2026/27 - consultant to rotate from October 2026.					

Sources:

The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK (November, 2022) https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf

Staffing Request as per Business Case/Staffing Paper:
The Proposal to implement the BAPM recommendations will ensure dedicated resident doctor cover 24/7 for neonates both Tier1 and Tier2 level. The dedicated consultant cover form neonates will be extended for busy periods until 21.00 hours, and one consultant covering both paediatrics and neonates at night. The change in staffing and rota needs to happen only at one site as the recommendations is for one site to be a Level 2 unit (LNU) and the other site to be Level1 (SCU) as per the recommendations of the Y&H Neonatal Operational delivery network.

This proposal was based on BAPM Framework for Practice 2018:
LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs.https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/64/LNU_doc_Nov_2018.pdf

CNST MIS Year Eight - Neonatal Nursing Workforce Action Plan

Requirements for Safety Action A:

1. A recent neonatal workforce review that clearly shows how the funded posts compare with what BAPM standards, and the neonatal nursing calculator say is needed.
2. Identification of any gaps, along with a realistic (SMART) plan for how the Trust intends to move toward full compliance.

Accompanying documents:

BAPM Phasing Plan
Neonatal Workforce Tools (ODN)
Neonatal Nursing and Medical Workforce Business Case (November 2025)

BAPM standard requirement	MIS Year 8 status – Current position	Action Required	Lead	Timescale	Status	Evidence
A designated lead nurse/midwife is responsible for the clinical and professional leadership and management of the service, working with the lead consultant.	Care Group Nurse Director in place Care Group Midwifery Director in post Neonatal & Paediatric Matrons currently in post at DPOW and SGH who work closely with the lead neonatal unit consultants and Clinical Lead in a MatNeo model of service delivery. Trial of 1 WTE Matron covering neonates (Trustwide) alone to be trialled for a 1 year period from September 2026. Support is also provided to the Band 7 Ward Managers.	No action required.	Deborah Bray, Nurse Director	N/A	Compliant	Rosters Job descriptions
There should be a 1WTE Band 7 Lead nurse for Transitional Care Services who are Supernumerary 100% of the roster period	Arrangements in place to provide a Transitional Care Service. Due to Band 7 Lead Nurse for the LNU's being supernumerary the oversight of the Transitional Care Service is incorporated into their role and responsibilities.	Recruitment of 1 WTE Band 7 Lead Nurse for Transitional Care and Community across NLAG to allow dedicated enhanced leadership of the Transitional Care Service in line with agreed Neonatal Workforce Phasing Plan.	Deborah Bray, Nurse Director Emma Spicer, Operational Matron	October 2026	Partially Compliant	Roster Job Description

BAPM standard requirement	MIS Year 8 status – Current position	Action Required	Lead	Timescale	Status	Evidence
There must be a supernumerary Shift lead 24/7	Neither SGH nor DPOW achieve 24/7 supernumerary status at present. However, 5 WTE Band 7 nurses have been recruited and are due to commence in post September 26 and working as supernumerary shift lead from October 2026. Currently both units have band 6 neonatal nurses acting as shift leads. The establishment does not facilitate supernumerary shift lead	No further action required.	Deborah Bray, Nurse Director Emma Spicer, Operational Matron	October 2026	Partially Compliant	Job descriptions Workforce Phasing Plan Rosters Badgernet staffing report
1 WTE Band 7 Nurse Educator required to work cross site	1 x 0.63 WTE Band 7 Neonatal Nurse Educator in post currently working Trustwide. Funding in place and actively trying to recruit a further 1 WTE Band 7 Lead Nurse Educator (Trustwide) and 2.2 WTE Band 6 Neonatal Nurse Educators to work cross site or site specific. Currently 1 x Band 6 Neonatal Nurse covering on bank (minimum of 6 hours per week.	Re-advertise Band 7 and Band 6 Nurse Educator roles. Recruit as above in line with agreed Neonatal Workforce Phasing Plan.	Emma Spicer, Operational Matron	October 2026	Partially Compliant	Job Description Roster Workforce Phasing Plan
Nursing cot ratio should be met 100% of the time cot ratio should be: 1 IC:1 RN 2 HD:1 RN 4 SC:1 RN 4 TC:1 RN	Staffing levels and cot capacity/acuity data is entered into BadgerNet on a daily basis and risk mitigated accordingly, in line with available escalation plans, and utilisation of wider neonatal workforce. Monitored/reported by MBRRACE/Neonatal ODN via NHS Futures. Red Flag reporting system in place on Ulysses and Safe Care Online Once agreed and ratified through Governance to be added to both Safecare and Ulysses. Phasing plan in place to increase the Direct Cotside Care WTE in line with BAPM requirements, and activity/acuity metrics.	Recruit to required Band 6 QIS WTE roles in line with agreed neonatal workforce phasing plan. Embed red flag reporting into daily incident reporting on Ulysses and Safe Care Live. Further push for embedding to take place once Clinical Sisters (Band 7) are in post.	Deborah Bray, Nurse Director Emma Spicer, Operational Matron	November 2026	Compliant	Roster Workforce phasing plan Badgernet staffing report Safecare live report ODN workforce staffing tool (Quarterly report)

BAPM standard requirement	MIS Year 8 status – Current position	Action Required	Lead	Timescale	Status	Evidence
70% of the workforce should be Registered Nurses.	Current Position (July 2026): **DPOW:** 69.4% **SGH:** 69.2%	Recruit to required Band 6 & Band 7 WTE posts to enable the RN establishment in line with the workforce paper phasing plan. realignment of unregistered workforce to neonatal community-based roles in line with BAPM (2025) & BAPM (2021) guidance. Implementation of a rotational unregistered workforce model between the Neonatal Unit and the NCOT Service required.	Deborah Bray, Nurse Director Emma Spicer, Operational Matron	April 2027 December 2026 April 2027	Partially Compliant	Rosters Badgernet staffing report ODN workforce staffing tool (quarterly report)
30% of the workforce should be non-registered.	Current Position (July 2026): **DPOW:** 26% **SGH:** 37% Over establishment at SGH site is due to the re-alignment of unregistered role within the workforce model and has been approved at Exec Board that this will be managed through natural attrition rather than through redeployment or redundancy at this stage. Engagement sessions for rotational and community model have commenced.				Partially Compliant	
80% of registered nurse workforce should be QIS 70% compliance with QIS standard to be maintained 100% of the time.	NLaG are not currently meeting all the national guidance for QIS standards but have a rolling training programme for both QIS foundation and QIS Speciality, including meeting the 150 hours of supernumerary time. **DPOW**: 63.4% **SGH:** 56.5% Embedded 6 month rolling programme in place with trajectories in place to meet compliance metric in place across the Trust. Forecast improvement to 64% at DPOW and 63% at SGH following recruitment of Band 7 neonatal nurses. **Trajectory to meet 70%:** September 2027.	Continue with training plan in place to support appropriate staff to access the relevant training and education modules to achieve the QIS. New starters without QIS to commence Foundation Programme after supernumerary preceptorship period completed. Recruitment of Band 7 neonatal nurses in line with workforce phasing plan.	Laura Parker, Neonatal Educator Emma Spicer, Operational Matron	Stepped approach in line with phasing plan: April 2027 October 2027	Partially Compliant	Training compliance rates Roster Badgernet staffing report ODN workforce staffing tool (quarterly report)

BAPM standard requirement	MIS Year 8 status – Current position	Action Required	Lead	Timescale	Status	Evidence
Neonatal Care Outreach Team (NCOT) must be available 7 days a week.	Currently running a 7 days service across the Trust. Working towards supplementing the workforce with HCA. Engagement session has occurred as a part of consultation	Recruit to required WTE to enable the RN NCOT establishment to meet the requirement of the approved workforce paper phasing plan Realign the unregistered workforce model in line with the agreed Neonatal Workforce Paper Phasing Plan. Consultation Paper to be written.	Deborah Bray, Nurse Director Emma Spicer, Operational Matron	April 2027	Compliant	Roster Audit results against BAPM guidance for Neonatal Community Outreach
Non-registered workforce should complete a minimum of NVQ level 3 training.	Workforce model for the cot side care (BAPM 2021) and the neonatal outreach service has been mapped against the BAPM NCOT Guidance (2025) and agreed in principle. The revised workforce model for the Unit based cot side care will see a reduction in the unregistered workforce. Approval in principle to develop and enhance the NCOT workforce to meet BPAM (2025) Workforce realignment from the current cot side workforce WTE will be required with support through an appropriate programme of training and competency based education. The current neonatal workforce working cot side have completed the relevant training and competency package required but unregistered workforce within the neonatal unit.	Realign the unregistered workforce model in line with the agreed Neonatal Workforce Paper Phasing Plan Develop an enhanced education package and training programme to support role development across the community setting.	Deborah Bray, Nurse Director Laura Parker, Neonatal Nurse Educator Emma Spicer, Operational Matron	April 2027	Compliant	Roster Job Description Education & Training Programme
Additional Nursing Roles	Active recruitment ongoing to some of the key quality roles (appendix A).	Plan to be developed with regards to recruitment for neonatal quality roles. This will be included in the next Matneo workforce paper.	Deborah Bray, Nurse Director	November 2026	Partially compliant	Matneo workforce paper

Appendix 1: Additional Nursing Quality Roles Q4 25/26 Benchmarking (current)

QUALITY ROLES – SGH						
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**	***Recommended WTE***	***Variance - in post against recommended WTE***
Governance Lead Nurse	7	0.33	0.33	1	**0.26**	**0.07**
Practice Development / Education Lead	7	0.63	0.63	1	**0.14**	**0.49**
Clinical Educator	6	1	0	0	**0.00**	**0.00**
Infant Feeding Lead	0	0	0	0		
Family Integrated Care Lead / equivalent	0	0	0	0	**0.53**	**-0.53**
Family Integrated Care Nurse / equivalent	0	0	0	0		
Family Integrated Care Link Nurse	0	0	0	0		
Other Family Care (please specify)	0	0	0	0		
Bereavement Lead	0	0	0	0	**0.26**	**-0.26**
Palliative Care Lead	0	0	0	0		
Professional Nurse Advocate (PNA)	6	0	0.02	1		
Discharge Co-ordinator	0	0	0	0		
Other (please specify)	0	0	0	0		
Other (please specify)	0	0	0	0		
Other (please specify)	0	0	0	0		
Subtotal - Quality roles		**1.96**	**0.98**	**3**		
TOTAL NON DIRECT PATIENT CARE		**3.96**	**2.98**	**5**		

QUALITY ROLES - DPOW						
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**	***Recommended WTE***	***Variance - in post against recommended WTE***
Governance Lead Nurse	7	0.33	0.33	1		0.29
Practice Development / Education Lead	7	1.1	0	0	out to recruitment	1.00
Clinical Educator	6	1	0	0	out to recruitment	0.00
Infant Feeding Lead	0	0	0	0		
Family Integrated Care Lead / equivalent	0	0	0	0		0.57
Family Integrated Care Nurse / equivalent	0	0	0	0		
Family Integrated Care Link Nurse	0	0	0	0		
Other Family Care (please specify)	0	0	0	0		
Bereavement Lead	0	0	0	0		0.29
Palliative Care Lead	0	0	0	0		
Professional Nurse Advocate (PNA)	0	0	0.4	2	1 x off sick 0.2	
Discharge Co-ordinator	0	0	0	0		
Other (please specify)	0	0	0	0		
Other (please specify)	0	0	0	0		
Other (please specify)	0	0	0	0		
Subtotal - Quality roles		2.43	0.73	3		
TOTAL NON DIRECT PATIENT CARE		4.43	2.73	5		

Sources:

CNST MIS Year Eight - Neonatal Medical Workf

Hull University Teaching Hospitals NHS Tru

Requirements for Safety Action A: Trusts must have a clear plan for a fully funded ne LNU, SCU) and the neonatal nursing workforce ca	
BAPM standard requirement	
All tiers separate rota compliance	Staff at each level should only responsibility for the NICU and with more than one neonatal u should have completely separa at each level of staff at all times
Tier 1 separate rota compliance 24/7	Tier 1 staff (ANNP or junior doc ST1-3) should be available 24/ have no responsibilities outside neonatal care.
Tier 2 separate rota compliance 24/7	Tier 2 staff (ANNP or junior doc and above) should be available and have no responsibilities ou neonatal care (including neona transport).

BAPM standard requirement		MIS Year 8 status	Action Required	Lead	Timescale	Status	Evidence
Tier 3 separate rota compliance 24/7	Tier 3 (consultant) staff available 24/7 with principle duties, including out of hours cover, are to the neonatal unit.	Compliant 8.4 WTE funded consultant rota with 13-hour resident consultant presence & on call overnight.	No action required.	-	-	-	-
Tier 3 presence on the unit	Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers).	Compliant 12-hour resident consultant presence job planned. 3 ward rounds/ day for ITU.	No further action required.	Dr Alia (Clinical Lead)	-	-	-
Tier 1 compliance more than 7000 deliveries per year	Two dedicated Tier 1 (ANNP or junior doctor ST1-3) 24/7 to support emergency care	Not applicable	No further action required.	Dr Alia (Clinical Lead)	-	-	-
Tier 2 compliance if more than 2500 IC (XA01Z) days per year	Two dedicated Tier 2 (or resident consultant presence in addition to tier 3 requirements) available 24/7 with duties only on the neonatal unit.	Compliant regarding dedicated two tier 2 rota in place. Not currently applicable as HRG1 days delivered <2500. Non-compliance advised whilst awaiting approval regarding 12th post.	For future proofing 12 WTE establishment in place but one used for trainee ANNP leaving a functional gap and reliance on locums. Update 26/11/25: The gap (Band 7 post) will be mitigated with increased budgeted establishment following the approval of the medical workforce business case as soon as this is implemented.	Dr Alia (Clinical Lead)	-	-	-

			20/7/26: Vacancy request form submitted to request funding to cover 12th post to fill functional gap as locum reliance is resulting in staffing issues. Still awaiting response. **13/10/26:** 12-person rota is now funded but not filled.				
BAPM standard requirement		**MIS Year 8 status**	**Action Required**	**Lead**	**Timescale**	**Status**	**Evidence**
Tier 3 compliance if more than 2500 IC days per year	Presence of at least two consultant led teams during normal daytime hours.	Compliant HUTH NICU already have consultant led teams 9am-5pm.	No further action required.	-	-	-	-
Tier 3 compliance if more than 4000 IC days per year	Consultant presence 24/7 in addition to Tier 2 staffing requirements	Not applicable	No action required.	-	-	-	-
Tier 3 compliance if more than 4000 IC days per year (daytime hours)	Three consultant led teams during normal daytime hours	Not applicable	No action required.	-	-	-	-
Minimum of 1 consultant with a designated lead interest in neonatology.		Compliant	No action required.	-	-	-	-

Tier 3 consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification / substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN.	Compliant	No action required.	-	-	-	-
All consultants covering the service must demonstrate expertise in neonatal care (based on training, experience, CPD and on-going appraisal).	Job plans have adequate SPA time to allow consultants to demonstrate expertise in neonatal care. Annual consultant neonatal update ran 13th Nov 2024. (first year this has been run)	No action required.	-	-	-	-

Sources:

The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK (2022) https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf

Optimal Arrangements for Neonatal Intensive Care Units in the UK: A BAPM Framework for Practice (2021) https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021

Humber Health Partnership

Hull University Teaching Hospitals NHS Trust

CNST MIS Year Eight - Neonatal Nursing Workforce – Benchmarking

Requirements for Safety Action C:

Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (NICU, LNU, SCU) and the neonatal nursing workforce calculator output (2020). Identification of any gaps should have a realistic (SMART) plan for how the Trust intends to move towards full compliance.

Accompanying documents:

BAPM Phasing Plan
Neonatal Workforce Tools (ODN)
Neonatal Nursing and Medical Workforce Business Case (November 2025)

BAPM standard requirement	MIS Year 8 status	Action Required	Lead	Timescale	Status	Evidence
A designated lead nurse/midwife is responsible for the clinical and professional leadership and management of the service, working with the lead consultant.	Neonatal Matron in post and works closely with the lead consultant in a MatNeo model of service delivery.	No further action required.	Deborah Bray, Nurse Director	N/A	Compliant	N/A
A minimum of 70% (special care) of the workforce should be registered A minimum of 80% (high dependency and intensive care) of the workforce should be registered.	**Current Position:** 95% Registered Nurses. 5% Unregistered Nurses (not included in baseline cot side nursing numbers). **Workforce Paper Opportunities:** Approval in principle to recruit to an establishment that is 100% capacity based and maintains the RN workforce requirements against standards.	Recruit to required WTE and uplift in banding required to enable the RN establishment to meet the requirement of the approved workforce paper phasing plan.	Deborah Bray, Nurse Director	N/A	Compliant – but further action required to meet revised workforce requirements	N/A

BAPM standard requirement	MIS Year 8 status	Action Required	Lead	Timescale	Status	Evidence
A minimum of 70% of the registered nursing and midwifery workforce establishment hold an accredited post-registration qualification in specialised neonatal care (qualified in specialty (QIS).	Current Position: **53%** (as of July 2026). This will be diluted slightly when the NQN's arrive in October 2026 The next cohort of QISS training (5 RN's) will commence the programme in January 2027. HUTH are not currently meeting all the national guidance for QIS standards but have a rolling training programme for both QIS foundation and QIS Speciality, including meeting the 150 hours of supernumerary time. Additional funding received from the ODN to support QIS supernumerary training. As the QISF is now mostly online learning, all new starters commence once in post as this is also part of the NICU induction programme. QISS – we currently send up to 15 staff per year as we access all 3 intakes now throughout the year, sending 5-6 staff per intake. This is now mandatory. We will be 70% compliant by May 2027	Continue to execute current training plan, ensuring allocated staff attend the QIS programme (no more than 8 staff at any one time in the year).	Jenny Hemingway Neonatal Lead Educator	August 2027	Ongoing	Training compliance & Trajectories
Units have a minimum of two registered nurses/midwives on duty at all times, of which at least one is QIS.	Fully Compliant.	No further action required.	Deborah Bray, Nurse Director		Compliant	E-roster
Nursing cot ratio should be met 100% of the time cot ratio should be: 1 IC: 1 RN 2 HD: 1 RN 4 SC: 1 RN 4 TC: 1 RN	**Current Position:** Staffing levels and cot capacity/acuity data is entered into BadgerNet on a daily basis and risk mitigated accordingly, in line with available escalation plans, and utilisation of wider neonatal workforce.	Development of a Red Flag reporting system for monitoring non-compliance against metrics being developed. Once agreed and ratified through Governance to be added to both Safecare and Ulysses.	Deborah Bray, Nurse Director Francesca Matthews, Matron	April 2026 Recruitment Element	Compliant	Workforce Tool

	Workforce Paper Opportunities: Approval in principle to increase the Direct Cotside Care WTE in line with BAPM requirements, and activity/acuity metrics	Recruit to required WTE and progress uplift of Banding in line with agreed neonatal workforce phasing plan.				
There is a nursing co-ordinator on every shift in addition to those providing direct clinical care.	**Current Position:** Band 7 Nurse Co-ordinator established 24/7. Final WTE post being recruited to currently. Mitigation in place to support shift leadership during escalation.	Development of a Red Flag reporting system for monitoring non-compliance against metrics being developed. Once agreed and ratified through Governance to be added to both Safecare and Ulysses.	Deborah Bray, Nurse Director Francesca Matthews, Matron		Compliant	Roster Incident & Red Flag Reports
Neonatal units providing surgical services have a nurse/midwife with neonatal surgical experience who has clinical leadership responsibility for nursing care of babies needing surgery.	**Current Position:** No substantive Nurse/Midwife with surgical clinical leadership responsibility. **Current Mitigation**: Surgical Link Team in place with 1 x Band 7 Clinical Sister who has completed the specialist surgical course. **Workforce Paper Opportunities:** Surgical CNS post approved in principle within the Workforce Paper.	Recruit to post in line with agreed neonatal workforce phasing plans	Deborah Bray , Nurse Director Francesca Matthews, Matron	September 2026	Partially Compliant	Workforce Paper – Phasing Plan
Neonatal units providing surgical services have at least one nurse/midwife with neonatal surgical experience who has responsibility for co-ordinating transfer and discharge of babies pre- and post-surgery, liaising with	**Current Position/Mitigation:** Neonatal Band 7 Shift Co-ordinator is responsible for liaising with the necessary transport team required for transfer. Discharge Lead Nurse also supports the staff with liaising with community services for discharge.	Recruit to CNS post in line with neonatal workforce paper phasing plans	Deborah Bray, Nurse Director Francesca Matthews, Matron	September 2026	Compliant	Workforce Paper – Phasing Plan

primary and community services, and supporting parents and referring teams.	More complex babies are often transferred to Paediatrics Surgical Ward for on-going care once they reach 44 completed weeks. Close collaborative working with the Specialist Lead Nurse in Leeds in place and can reach out for support/advice if needed. **Workforce Paper Opportunities**: Surgical CNS post approved in principle within the Workforce Paper.					
There should be an appropriately resourced clinical education team to support the training and education requirements of the cot side workforce. This team should consist of Nurse Educators at both band 6 and band 7 and have a WTE resource that provides 1 WTE educator per 50 staff members.	**Current Position:** 3 substantive positions filled (2.91 WTE) 100% compliant with current resource Current resource is 2 x FT B6 (1.91 WTE) and 1 x FT B7. **Workforce Paper Opportunities:** Approval of the Nurse Educator uplift to ensure all posts are substantive and Band 7 in line with BAPM.	No action required	Deborah Bray, Nurse Director Francesca Matthews, Matron	April 2026		E-roster
There should be a 1 WTE Band 7 Lead Nurse for Transitional Care Services who are Supernumerary 100% of the roster period.	Fully compliant	No action required.	Francesca Matthews, Matron	-	Compliant	Roster
Neonatal Care Outreach Team (NCOT) must be available 7 days a week.	Fully compliant for a 7day service.	No action required.	Deborah Bray, Nurse Director Francesca Matthews, Matron	-	Compliant	Roster

BAPM standard requirement	MIS Year 8 status	Action Required	Lead	Timescale	Status	Evidence
Non-registered workforce should complete a minimum of NVQ level 3 training.	**Workforce Paper Opportunities:** Workforce model for the cot side care (BAPM 2021) and the neonatal outreach service has been mapped against the BAPM NCOT Guidance (2026) and agreed in principle. The revised workforce model for the Unit based cot side care will see a reduction in the unregistered workforce. Approval in principle to develop and enhance the NCOT workforce to meet BPAM (2026) Workforce realignment from the current cot side workforce WTE will be required with support through an appropriate programme of training and competency based education	Recruit to the unregistered workforce model in line with the agreed Neonatal Workforce Paper Phasing Plan Realign the unregistered workforce model in line with the agreed Neonatal Workforce Paper Phasing Plan Develop an enhanced education package and training programme to support role development across the community setting. No action required for current workforce configuration as all unregistered workforce have completed appropriate programme of study/competency	Deborah Bray Francessca Matthews. Matron	January 2027	Compliant	Roster Job Description Education & Training Programme
Additional Nursing Roles	Active recruitment ongoing to some of the key quality roles (appendix B).	Plan to be developed with regards to recruitment for neonatal quality roles. This will be included in the next Matneo workforce paper.	Deborah Bray, Nurse Director	November 2026	Partially compliant	MatNeo workforce paper

Appendix A
With the condensed FP, it would be possible to send more staff into training which would equate to similar numbers for study time. To spread out these days, the FP will be exclusively virtual, allowing rostered study time to suit the service needs. During the autumn/winter months, this would also allow a 5th member of staff into practice to further the workforce.

Proposed plan from Jan 2027:
Quarter 4 – QIS 5 staff
Quarter 1 – QIS 5 staff
Quarter 2/3 – QIS 5 Staff

This plan would give 15 QIS staff per year
Trajectory to meet 70% QIS compliance May 2027

Appendix B

QUALITY ROLES							
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**	**COMMENTS**	***Recommended WTE***	***Variance - in post against recommended WTE***
Governance Lead Nurse	7	0.96	0.96	1		**0.76**	**0.20**
Practice Development / Education Lead	7	1	1	1		**1.00**	**0.00**
Clinical Educator	6	1.91	1.91	2		**1.70**	**0.21**
Infant Feeding Lead	7	0.8	0.8	1	New in post		
Family Integrated Care Lead / equivalent	0	0	0	0		**1.53**	**-1.53**
Family Integrated Care Nurse / equivalent	0	0	0	0			
Family Integrated Care Link Nurse	0	0	0	0			
Other Family Care (please specify)	0	0	0	0			
Bereavement Lead	7	0.91	0.91	1		**0.76**	**0.15**
Palliative Care Lead	0	0	0	0			
Professional Nurse Advocate (PNA)	0	0	0	0			
Discharge Co-ordinator	6	0.91	0.91	1	Also Safeguarding Lead		
Subtotal - Quality roles		**6.49**	**6.49**	**7**			
TOTAL NON-DIRECT PATIENT CARE		**9.4**	**9.4**	**10**			

NHS
Humber Health
Partnership

FAMILY SERVICES CARE GROUP

NHS Resolution

Maternity (and Perinatal) Incentive Scheme

Year Eight

Safety Action A:
Workforce and Capacity

Engagement of Short Term Locum Medical Staff (Obstetric Workforce)

October 2026

Yvonne McGrath – Group Director of Midwifery

Hayli Garrod – Maternity Audit and Compliance Manager (NLAG)

Eloise Sims – Maternity Audit and Compliance Manager (HUTH)

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

United by Compassion:
Driving for Excellence

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Summary of Key Findings – Standard 1 - Short Term Locum staff	5
Process for employment	6

Introduction
NHS resolution is operating year eight of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The scheme applies to all Acute NHS Trusts that deliver maternity care and incentivises six maternity safety actions. Trusts that can demonstrate they have achieved all six of the safety actions will recover the element of their contribution to the CNST MIS fund. The standards reflect the essential components of safe and effective maternity and neonatal services - the foundations that every Trust should already have in place. MIS is intended to be a practical tool that supports leaders to drive improvement, secure investment and strengthen governance supporting local accountability,

To comply with safety action A2 of the MIS, the Trust must provide assurance that guidance on the engagement of short and long term locums, developed by the Royal College of Obstetricians and Gynaecologists (RCOG) has been implemented. The guidance states that recent high-profile cases in maternity care have highlighted the need for adequate support and supervision of locums who enter the workplace. These individuals face the challenge of providing excellent clinical care but without the knowledge of the organisation or familiarity with the staff with whom they will work. Therefore, the RCOG strongly recommends that healthcare organisations engaging locum doctors refer to the RCOG guidance to support these individuals and ensure they comply with recommended processes such as pre-employment checks and appropriate induction.

The minimum requirement for MIS compliance is:

Short-term locum certification (obstetric workforce)
Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. Eligibility must be verified before first engagement and reviewed annually for all locums on the register.

A ‘locum’ refers to a doctor who is either placed by a locum agency or a locum bank in a healthcare provider organisation or directly engages with healthcare organisations for short-term work (placements of two weeks or less). An NHS certificate of eligibility for locums in O&G was introduced as a pre-requisite for employment of short-term locums for middle grade rotas from February 2023. Locum doctors who have obtained CCT/CESR/CESRCP and are on the GMC specialist register can be employed in a middle grade locum post without a certificate of eligibility if they have current NHS experience (within the past six months) and they have not been out of clinical practice for more than two months such that a more supported return to work package would be necessary (verified via CV). They must provide, as a minimum, references from previous jobs and structured feedback from their last two employers. O&G trainees will require a certificate when they undertake short term locum placements in the following locations: Outside of their deanery/HEE Local Office or in a trust (within their deanery/HEE Local Office) where they have not previously worked as a ST3-7.

This audit has been undertaken to provide evidence of a periodic check within the MIS period and assess compliance against the minimum requirement detailed above. A breakdown of compliance is detailed from page 5 onwards.

Project Team/Discipline Leads (with responsibility for change if required)	
Yvonne McGrath	Group Director of Midwifery – Family Services Care Group
Mr Shendy	Divisional Clinical Lead, NLAG
Mary Johnson	Medical Rostering Service Lead, NLAG
Katrina Panton	Assistant Service Manager, NLAG
Hayli Garrod	Maternity Audit and Compliance Manager, NLAG

References / Basis for Standards

1. NHS Resolution, Maternity (and perinatal) Incentive Scheme – Year Eight, Version 1.0, March 2026
2. Royal College of Obstetricians & Gynaecologists, Guidance on the engagement of short-term locums in maternity care, August 2022

Objectives

1. To assess compliance against national guidance
2. Assess policies and procedures are in place
3. Identify areas for improvement.

Method

NLAG
All Obstetric rotas were reviewed to identify shifts covered by external locum medical staff for the period of 01 April 2026 to 12 September 2026 by the Rota Co-ordinator. Consultants and foundation year doctors were excluded from reporting as per RCOG / MIS guidance.

HuTH
Information identified and obtained from the Medical Staffing Team Lead for the time period of 01 April 2026 to 30 September 2026.

Summary of Key Findings: Short Term Locums

Standard Description:
NHS Trusts/organisations should ensure that the following criteria are met for employing **short-term** (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota *or* b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) *or* c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

Against the standards detailed in MIS, a retrospective audit was undertaken from data collected on the monitoring tool, reviewing locum activity/engagement over a five month period (01 April 2026 - 12 September 2026) focusing on tier 2 or 3 (middle grade) rotas.

NLaG Breakdown of compliance

During the audit period a total of 97 tier 2 or 3 rota shifts in Obstetrics were covered by 7 external locum doctors on a short-term basis (<2 weeks). The table below details the split between SGH and DPOW.

Short term locum staffing numbers (≤2 weeks)		
Site	**No. of locum doctors booked**	**No. of shifts covered**
SGH	4	71
DPOW	2	26
TOTAL	**6**	**97**

The table below demonstrates the criterion met in relating to standard 1 and the overall compliance for external locum doctors.

Standard Compliance			
EXTERNAL - Short term locum staffing (<2 weeks)			
Site	Currently work in their unit on the tier 2 or 3 rota	Have worked in the unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)	Hold a certificate of eligibility (CEL) to undertake short term locums
NLAG (n=6)	3	1	2
Achievement: 100% compliance			

HuTH Breakdown of compliance

During the audit period 0 shifts were covered by external locums.

Short term locum staffing numbers (≤2 weeks)		
Site	**No. of locum doctors booked**	**No. of shifts covered**
HUTH	0	0

The table below demonstrates the criterion met in relating to standard 1 and the overall compliance for external locum doctors.

Standard Compliance			
EXTERNAL - Short term locum staffing (<2 weeks)			
Site	Currently work in their unit on the tier 2 or 3 rota	Have worked in the unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)	Hold a certificate of eligibility (CEL) to undertake short term locums
HUTH (n=0)	N/A	N/A	N/A
Achievement: Not applicable			

NLAG Current Process – Employment of Locums

Locum staff who are put forward to fill vacant shifts have their CVs forwarded by the supplying agency/regional bank. This is then sent onto the Clinical Leads by the Rota Co-Ordinator. Locum Medical staff can only be employed if their compliance is up to date. Due to changes in the framework legislation made in February 2023 no locum doctor can be booked unless fully compliant. Medical locum shifts at NLaG are booked through the master Vendor Holt who has a team responsible for checking and updating compliance. The LMS (Locum Management System) sends notifications for compliance close to expiring.

Locum doctors working at NLaG are given an Induction. This is arranged with the Rota Co-ordinators and Clinical Leads within the division. The locum doctor is then required to sign the document to evidence that this has taken place. When receiving the booking the Rota Co-Ordinator is sent a photograph so that ID badges, door access and system access can be arranged. Any bookings made outside of normal working hours are processed by the Site Matron and an induction will be given relating to the area that they will be working in.

The RCOG compliance and effectiveness tool was introduced for use during MIS year 5 which has allowed a retrospective audit trail and greater oversight for the clinical leads. A Standard Operating Procedure was also developed during MIS year 5 and the Trust continues to work in accordance with this.

HuTH Current Process – Employment of Locums

The Trust currently uses a third-party provider, Retinue, to carry out employment checks. The provider does not permit applications from Obstetrics and Gynaecology registrar or consultants who do not hold an RCOG Certificate of Eligibility or who are not on the Specialist Register. This provides assurance that applicants who do not meet the required eligibility criteria are filtered out during the application process.

In order to ensure compliance, the following should also be followed:

Also see CP616 Management of Induction of New Employees Policy Essential measures:

1. Pre-Appointment Check list – Appendix A This will be undertaken by Medical Staffing and the Health Group Business Team.
2. Induction Programme – Appendix B This is tailored to suit the requirements of the position. It will be sent electronically to the new employee approximately two weeks before their start date.
3. Completion of Position – Appendix D Essential information for Business Team to aid with on boarding: Prior to start date, send an email to the new consultant / locum containing the following: 1. Welcome to the Trust 2. Obstetrics and Gynaecology Induction Booklet 3. Link to the HUTH Internet, inviting them to explore the website at their leisure.
4. Provide information in regard to accommodation on site if applicable.

Essential measures on completion of post:

Feedback on performance to both the locum doctor and to the employing agency.
Completing the required end of placement/exit report and peer/colleague feedback for the doctor.
Notifying the doctor and locum agency (where relevant) if any significant information of note arises in relation to the doctor's practice during their placement (and/or the doctor's responsible officer if the agency is not the doctor's designated body)
Agreeing with the locum agency or NHS England local team (where relevant) whether any necessary investigation is carried out in the organisation, or whether referral to the GMC is appropriate, including quality elements within the service level agreement (if applicable) with the locum agency to facilitate the above.

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)285

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 12 November 2026**
Director Lead	**Jo Ledger, Interim Group Chief Nurse**
Contact Officer / Author	Yvonne McGrath, Group Director of Midwifery
Title of Report	**Maternal Care Bundle (MCB) Implementation Plan 2026/27**
Executive Summary	**NLAG** The Maternal Care Bundle consists of five clinical improvement elements aimed at reducing maternal morbidity and mortality through strengthened pathways for: 1. Venous Thromboembolism (VTE) 2. Pre-Hospital and Acute Care 3. Epilepsy in Pregnancy 4. Maternal Mental Health 5. Obstetric Haemorrhage A Trust-wide implementation programme has been established with executive oversight through existing maternity governance arrangements. Current programme status is assessed as **AMBER**. Significant progress has been achieved through: Recruitment activity for a Maternal Medicine Midwife. Implementation of National MEWS within maternity services. Completion of epilepsy benchmarking and receipt of service review recommendations. Use of blood collection drapes and Baby Lifeline haemorrhage bags. Review and update of postpartum haemorrhage guidance. The principal risks relate to: Early pregnancy thromboprophylaxis pathways. Epilepsy multidisciplinary pathways. Dependency on national digital developments to support maternal mental health screening requirements.

	HUTH The Maternal Care Bundle consists of five clinical improvement elements aimed at reducing maternal morbidity and mortality through strengthened pathways for: 6. Venous Thromboembolism (VTE) 7. Pre-Hospital and Acute Care 8. Epilepsy in Pregnancy 9. Maternal Mental Health 10. Obstetric Haemorrhage A Trust-wide implementation programme has been established with executive oversight through existing maternity governance arrangements. Current programme status is assessed as **AMBER.** Significant progress has been achieved through: Appointment of a Maternal Medicine Midwife. Appointment of an Obstetric Consultant with a specialist interest in Maternal Medicine. Implementation of National MEWS within maternity services. Establishment of significant haemorrhage review processes. Completion of epilepsy benchmarking and receipt of service review recommendations. The principal risks relate to: Early pregnancy thromboprophylaxis pathways. Epilepsy multidisciplinary pathways. Dependency on national digital developments to support maternal mental health screening requirements.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Maternal and Neonatal Assurance Group
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ü Assurance ☐ Other – please detail below:

Maternal Care Bundle (MCB) Implementation Plan 2026/27- Hull University Teaching Hospitals

1. Purpose of Report

The purpose of this report is to present the Trust's Maternal Care Bundle (MCB) Implementation Plan for approval and provide assurance regarding governance arrangements, delivery milestones, identified risks and oversight arrangements.

The report has been developed in response to NHS Resolution Maternity Incentive Scheme (MIS) Year 8 requirement E2, which requires providers to demonstrate a Board-approved implementation plan with clear milestones, collaborative working across services, governance oversight, routine progress reporting and management of implementation risks.

2. Executive Summary

The Maternal Care Bundle consists of five clinical improvement elements aimed at reducing maternal morbidity and mortality through strengthened pathways for:

1. Venous Thromboembolism (VTE)
2. Pre-Hospital and Acute Care
3. Epilepsy in Pregnancy
4. Maternal Mental Health
5. Obstetric Haemorrhage

A Trust-wide implementation programme has been established with executive oversight through existing maternity governance arrangements.

Current programme status is assessed as **AMBER**.

Significant progress has been achieved through:

Appointment of a Maternal Medicine Midwife.

Appointment of an Obstetric Consultant with a specialist interest in Maternal Medicine.

Implementation of National MEWS within maternity services.

Establishment of significant haemorrhage review processes.

Completion of epilepsy benchmarking and receipt of service review recommendations.

The principal risks relate to:

Early pregnancy thromboprophylaxis pathways.

Epilepsy multidisciplinary pathways.

Dependency on national digital developments to support maternal mental health screening requirements.

3. Recommendation

The Board is asked to:

1. Approve the Maternal Care Bundle Implementation Plan and agree a goal implementation date of October 2027. *Note: NHS England had requested full implementation by March 2027, however this timeframe is not achievable.*
2. Note the current programme RAG rating of AMBER.
3. Note the principal risks and mitigating actions.
4. Support continued engagement with system partners to achieve full compliance with Maternal Care Bundle requirements.
5. Devolve responsibility to Quality and Safety Committee to undertake quarterly deep dives of progress and evidence and to advise the board if they agree with the self-assessment ratings by the service.

4. Strategic Context

The Maternal Care Bundle supports delivery of national maternity safety standards through a series of evidence-based interventions designed to reduce avoidable maternal morbidity and mortality.

Implementation requires collaboration across maternity services, acute care, primary care, maternal medicine, neurology, mental health services, the Integrated Care Board (ICB) and regional Maternal Medicine Networks (MMN).

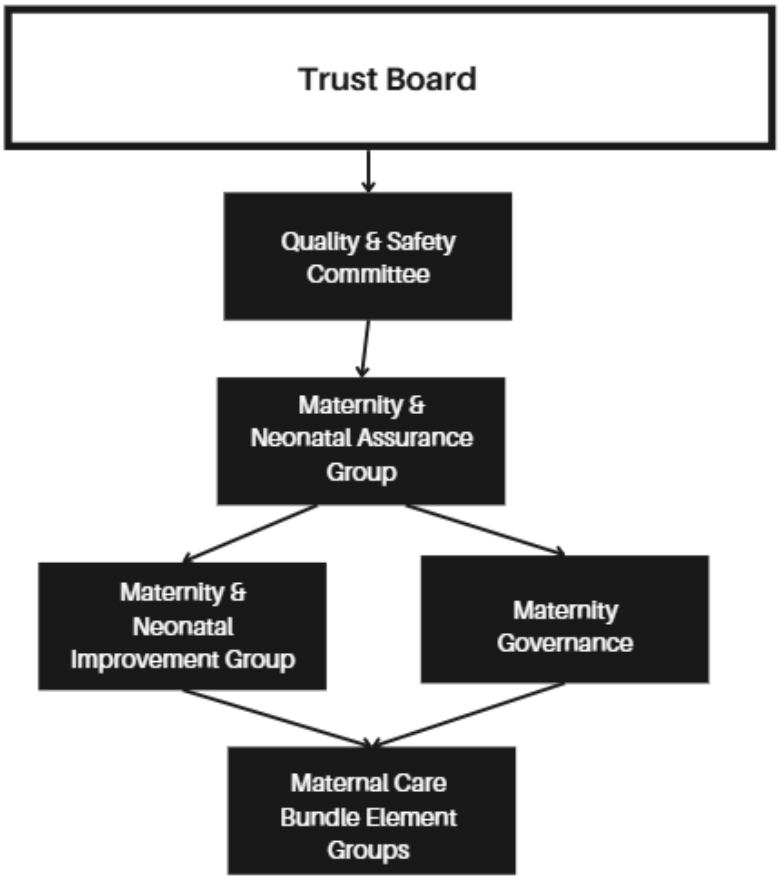
The implementation plan has therefore been developed as a multidisciplinary programme with clear executive accountability and governance oversight.

5. Governance and Assurance Arrangements

Executive Accountability

Role	**Lead**
Executive Sponsor	Chief Nurse
Programme Lead	Director of Midwifery
Clinical Lead	Clinical Director for Obstetrics

Governance Structure



Reporting Arrangements

Committee/Group	Frequency	Purpose
Maternal Care Bundle Element Groups	Monthly	Monitor actions and milestones
Maternity and Neonatal Improvement Group/ Maternity Governance Committee	Monthly	Monitor programme delivery and risk
Maternity and Neonatal Assurance Group	Quarterly	Receive assurance against delivery plan
Quality and Safety Committee	Quarterly	Review programme progress and exceptions
Trust Board	Quarterly	Strategic oversight and assurance

6. Programme Overview

Overall Programme Rating

AMBER- Partial Implementation

The programme is progressing as planned; however, there remain two high-risk workstreams requiring focused oversight and several external dependencies which may impact delivery timescales.

7. Delivery Plan

Element 1: Venous Thromboembolism (VTE)

RAG Status

AMBER- Partial Implementation

Risk

There is currently no fully implemented cross-system pathway to ensure women identified as high risk of VTE in early pregnancy consistently receive thromboprophylaxis within Maternal Care Bundle timescales.

Key Milestones

Action	Lead	Due Date
Complete VTE Standard Operating Procedure	Maternal Medicine Midwife	Dec 2026
Complete governance approval process	Director of Midwifery	Jan 2027
Agree prescribing pathway with ICB and Primary Care	Director of Midwifery	Jan 2027
Implement System C referral amendments	Digital Lead	Jan 2027
Launch Maternal Medicine Midwife-led pathway	Maternal Medicine Midwife	Jan 2027

Success Measure

Women identified as high risk of VTE receive timely assessment and thromboprophylaxis in accordance with national requirements.

Element 2: Pre-Hospital and Acute Care

RAG Status

AMBER- Partial implementation

Risk

Maternal medicine referral pathways require final ratification and embedding across all care settings.

Key Milestones

Action	Lead	Due Date
Ratify Maternal Medicine referral pathway	Clinical Director	Dec 2026
Complete Labour Ward signage review	Labour Ward Matron	Dec 2026
Complete annual MMN pathway review	Maternal Medicine Lead	Dec 2026
Undertake implementation audit	Governance Midwife	Jan 2027

Success Measure

Approved and embedded referral pathways for acutely unwell pregnant and recently pregnant women.

Element 3: Epilepsy in Pregnancy

RAG Status

RED Non-compliant

Risk

Current arrangements do not yet demonstrate full compliance with Maternal Care Bundle requirements for multidisciplinary epilepsy care.

Key Milestones

Action	Lead	Due Date
Review Epilepsy Action recommendations	Clinical Director	Dec 2026
Develop local epilepsy pathway	Maternal Medicine Midwife	Dec 2026
Agree pathway with Neurology and MMN	Clinical Director	Dec 2026
Review workforce competencies	Specialist Epilepsy Nurse and Clinical Director	Jan 2027
Implement pathway and monitoring arrangements	Director of Midwifery	Jan 2027

Success Measure

A fully operational multidisciplinary epilepsy in pregnancy service.

Element 4: Maternal Mental Health

RAG Status

AMBER- Partially compliant

Risk

Full compliance is dependent on implementation of EPDS functionality within national digital systems.

Key Milestones

Action	Lead	Due Date
Update local guideline	Perinatal Mental Health Lead Midwife	Dec 2026
Complete training needs analysis	Perinatal Mental Health Lead Midwife	Dec 2026
Develop interim local process for EPDS assessment	Perinatal Mental Health Lead Midwife	Dec 2026
Progress national digital escalation	Director of Midwifery	Ongoing

Success Measure

Consistent maternal mental health screening and referral pathways meeting Maternal Care Bundle requirements.

Element 5: Obstetric Haemorrhage

RAG Status

AMBER- Partially Compliant

Risk

Updated standards relating to cumulative blood loss measurement and escalation require further implementation and embedding.

Key Milestones

Action	Lead	Due Date
Ratify updated PPH guideline	Patient Safety Matron	Nov 2026
Implement collection drapes and equipment	Labour Ward Matron	Dec 2026
Update PROMPT programme	PROMPT Lead	Jan 2027
Complete compliance audit	Governance Midwife	Mar 2027

Success Measure

Demonstrable compliance with Maternal Care Bundle standards for haemorrhage management.

8. Programme Risks

Risk	Current Rating	Mitigation
Delayed implementation of VTE prescribing pathway	High (Red)	Joint programme with ICB, primary care and urgent care services
Delayed implementation of epilepsy pathway	High (Red)	Delivery of Epilepsy Action recommendations and MMN support
National EPDS digital functionality unavailable	Moderate (Amber)	Interim local arrangements and national escalation
Maternal Medicine Network approval delays	Moderate (Amber)	Regular review through regional governance
Implementation and training delays for haemorrhage guidance	Moderate (Amber)	Delivery through PROMPT and maternity training programme

9. Key Dependencies

The following dependencies sit outside the direct control of maternity services:

Integrated Care Board agreement on early pregnancy prescribing pathways.

Primary care engagement regarding VTE assessment and prescribing arrangements.

System C and BadgerNet digital developments.

Maternal Medicine Network pathway approvals.

Neurology service support for epilepsy pathway implementation.

These dependencies are monitored through the programme governance framework and escalated through exception reporting where required.

10. Equality and Quality Impact

Implementation of the Maternal Care Bundle is expected to improve the identification, escalation and management of key maternal conditions, contributing to reductions in maternal morbidity and improved outcomes for women and families.

No adverse equality impacts have been identified.

11. Conclusion

The Trust has established a comprehensive Maternal Care Bundle implementation programme with clear executive accountability, multidisciplinary leadership, risk management arrangements and governance oversight.

Whilst significant progress has been achieved, focused work remains within VTE prevention and epilepsy in pregnancy pathways. Subject to continued delivery of the identified actions and management of system-wide dependencies, the Trust remains on track to achieve full implementation.

Board Decision

The Board is asked to APPROVE the Maternal Care Bundle Implementation Plan and AGREE the proposed goal implementation date of October 2027 and NOTE the current programme status, risks and governance arrangements.

Appendix 1 - Maternal Care Bundle Assurance Metrics and Reporting Framework

Purpose

The purpose of this framework is to provide the Board, Quality and Safety Committee, and Maternity and Neonatal Assurance Group with a consistent set of assurance measures aligned to the Maternal Care Bundle process indicators and process measures. Progress against these metrics will be reported quarterly alongside programme milestone delivery and risk updates.

Element 1 - Venous Thromboembolism (VTE)

MCB Indicator	Assurance Metric	Data Source	Reporting Frequency
1.1a	VTE self-assessment questions incorporated into maternity referral pathway (Y/N)	Clinical guideline / digital configuration review	Quarterly
1.1b	Early pregnancy VTE assessment embedded in EPR (Y/N)	System audit	Quarterly
1.2a	Early pregnancy LMWH prescribing pathway approved (Y/N)	Governance records	Quarterly
1.2b	% of women with an identified early pregnancy VTE risk factor who received LMWH before booking appointment	Clinical audit	Quarterly
1.3a	Pathway for review and escalation of high-risk women operational (Y/N)	Audit and pathway review	Quarterly

Board Success Indicators

Early pregnancy VTE pathway approved and operational.

Evidence of prescribing within 72 hours for eligible women.

No overdue actions relating to pathway implementation.

Element 2 - Pre-Hospital and Acute Care

MCB Indicator	Assurance Metric	Data Source	Reporting Frequency
2.1a	National MEWS embedded within maternity electronic record (Y/N)	Digital system review	Quarterly
2.1c	Compliance with completion of MEWS observations (%)	Audit	Quarterly
2.1d	% of pregnant/recently pregnant women admitted outside maternity where MEWS used	Audit	Quarterly

2.2a	Labour Ward pre-alert process operational (Y/N)	SOP review	Quarterly
2.2b	Labour Ward signage assessment completed (Y/N)	Estates review	Quarterly
2.3a	Maternal Medicine referral pathway approved (Y/N)	Governance records	Quarterly
2.3b	Maternal Medicine Network pathway review completed within previous 12 months (Y/N)	MMN records	Quarterly

Board Success Indicators

Approved referral pathways across acute services.

Evidence of MEWS compliance.

Evidence of annual MMN review.

No outstanding ambulance pathway risks.

Element 3 - Epilepsy in Pregnancy

MCB Indicator	Assurance Metric	Data Source	Reporting Frequency
3.1a	Epilepsy in pregnancy pathway approved (Y/N)	Governance records	Quarterly
3.2a	Referral pathway to MMC agreed with MMN (Y/N)	MMN review	Quarterly
3.2b	Annual multidisciplinary epilepsy training undertaken (Y/N)	Training records	Quarterly
Expert Consensus Recommendation	% of women self-reporting epilepsy reviewed by specialist team within agreed timeframe	Case note audit	Quarterly
Expert Consensus Recommendation	Median waiting time to first epilepsy specialist appointment	Service review	Quarterly

Board Success Indicators

Epilepsy pathway ratified.

Neurology participation demonstrated.

Women reviewed within agreed timescales.

Workforce competency requirements met.

Element 4 - Maternal Mental Health

MCB Indicator	Assurance Metric	Data Source	Reporting Frequency
4.1b	% of women with recorded Whooley assessment at booking	BadgerNet/System C report	Quarterly
4.1c	% of women with recorded Whooley assessment at 25-28 weeks	BadgerNet/System C report	Quarterly
4.1d	% of women with recorded Whooley assessment at 31-34 weeks	BadgerNet/System C report	Quarterly
4.1e	% of women with recorded Whooley assessment at 10-14 days postnatal	BadgerNet/System C report	Quarterly
4.1f	Digital Whooley assessment embedded (Y/N)	System review	Quarterly
4.2a	% of women screening positive on Whooley who receive EPDS assessment within one week	Audit	Quarterly
4.2b	EPDS pathway/guideline approved (Y/N)	Governance records	Quarterly
4.3b	% of women screening positive on EPDS referred for further support	Audit	Quarterly

Board Success Indicators

Consistent Whooley compliance across all time points.

EPDS pathway implemented.

Positive screens receive timely referral and support.

Element 5 - Obstetric Haemorrhage

MCB Indicator	Assurance Metric	Data Source	Reporting Frequency
5.1a	Updated PPH guideline approved (Y/N)	Governance records	Quarterly
5.1b	% of women with blood loss >2L with evidence of cumulative blood loss measurement	Case note audit	Quarterly
5.1c	% of women with blood loss 1-2L with evidence of cumulative blood loss measurement	Case note audit	Quarterly
5.2a	% of women with blood loss >2L demonstrating escalation in line with guidance	Case review	Quarterly
5.2b	% of women with blood loss 1-2L demonstrating escalation in line with guidance	Case review	Quarterly
5.3a	% of women with blood loss >2L reviewed within one month	Governance review	Quarterly
Expert Consensus Recommendation	Clauss fibrinogen turnaround within one hour achieved (Y/N)	Laboratory audit	Quarterly
Expert Consensus Recommendation	Availability and utilisation of TEG/ROTEM pathway (where implemented)	Audit	Quarterly

Board Success Indicators

Compliance with cumulative blood loss measurement.

Timely escalation of major haemorrhage.

100% review of >2L PPH cases.

Evidence of MDT learning and system improvements.

Maternal Care Bundle (MCB) Implementation Plan 2026/27- Northern Lincolnshire and Goole NHS Foundation Trust

1. Purpose of Report

The purpose of this report is to present the Trust's Maternal Care Bundle (MCB) Implementation Plan for approval and provide assurance regarding governance arrangements, delivery milestones, identified risks and oversight arrangements.

The report has been developed in response to NHS Resolution Maternity Incentive Scheme (MIS) Year 8 requirement E2, which requires providers to demonstrate a Board-approved implementation plan with clear milestones, collaborative working across services, governance oversight, routine progress reporting and management of implementation risks.

2. Executive Summary

The Maternal Care Bundle consists of five clinical improvement elements aimed at reducing maternal morbidity and mortality through strengthened pathways for:

6. Venous Thromboembolism (VTE)
7. Pre-Hospital and Acute Care
8. Epilepsy in Pregnancy
9. Maternal Mental Health
10. Obstetric Haemorrhage

A Trust-wide implementation programme has been established with executive oversight through existing maternity governance arrangements.

Current programme status is assessed as **AMBER**.

Significant progress has been achieved through:

Implementation of National MEWS within maternity services.

Completion of epilepsy benchmarking and receipt of service review recommendations.

Use of blood collection drapes and Baby Lifeline haemorrhage bags.

Review and update of postpartum haemorrhage guidance.

The principal risks relate to:

Early pregnancy thromboprophylaxis pathways.

Epilepsy multidisciplinary pathways.

Dependency on national digital developments to support maternal mental health screening requirements.

3. Recommendation

The Board is asked to:

6. Approve the Maternal Care Bundle Implementation Plan and agree a goal implementation date of October 2027. *Note: NHS England had requested full implementation by March 2027, however this timeframe is not achievable*
7. Note the current programme RAG rating of AMBER.
8. Note the principal risks and mitigating actions.
9. Support continued engagement with system partners to achieve full compliance with Maternal Care Bundle requirements.
10. Devolve responsibility to Quality and Safety Committee to undertake quarterly deep dives of progress and evidence and to advise the board if they agree with the self-assessment ratings by the service.

4. Strategic Context

The Maternal Care Bundle supports delivery of national maternity safety standards through a series of evidence-based interventions designed to reduce avoidable maternal morbidity and mortality.

Implementation requires collaboration across maternity services, acute care, primary care, maternal medicine, neurology, mental health services, the Integrated Care Board (ICB) and regional Maternal Medicine Networks (MMN).

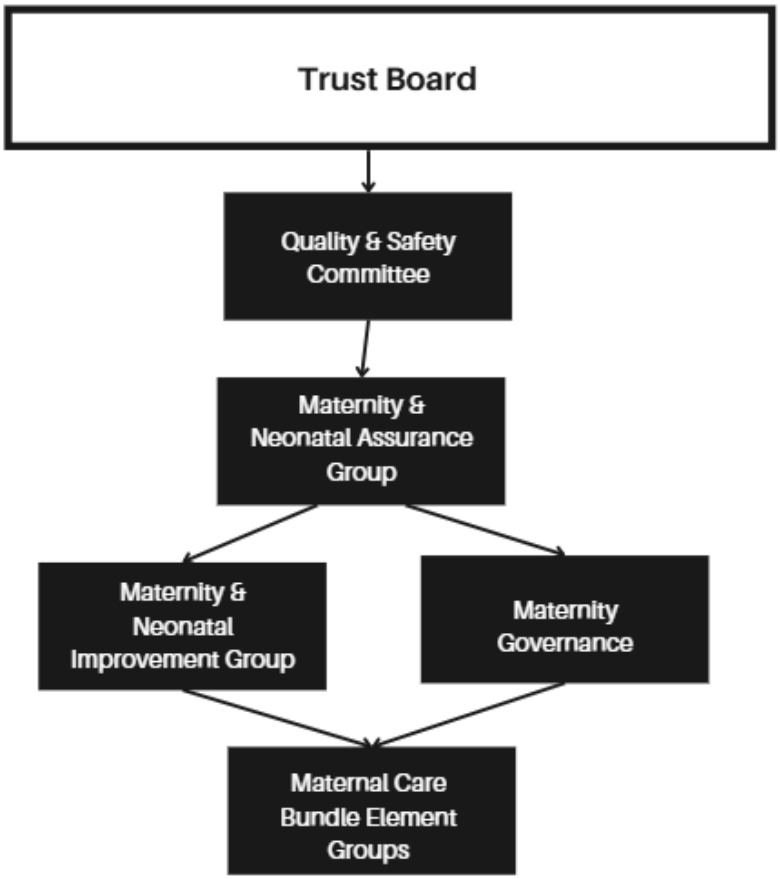
The implementation plan has therefore been developed as a multidisciplinary programme with clear executive accountability and governance oversight.

5. Governance and Assurance Arrangements

Executive Accountability

Role	**Lead**
Executive Sponsor	Chief Nurse
Programme Lead	Director of Midwifery
Clinical Lead	Clinical Director for Obstetrics

Governance Structure (will put this in a nice chart/graphic)



Reporting Arrangements

Committee/Group	**Frequency**	**Purpose**
Maternal Care Bundle Element Groups	Monthly	Monitor actions and milestones
Maternity and Neonatal Improvement Group/ Maternity Governance Committee	Monthly	Monitor programme delivery and risk
Maternity and Neonatal Assurance Group	Quarterly	Receive assurance against delivery plan
Quality and Safety Committee	Quarterly	Review programme progress and exceptions
Trust Board	Quarterly	Strategic oversight and assurance

6. Programme Overview

Overall Programme Rating

AMBER- Partial Implementation

The programme is progressing; however, there remain two high-risk workstreams requiring focused oversight, alongside site-specific gaps in pre-hospital pathways and obstetric haemorrhage assurance. Several external dependencies may affect delivery timescales.

7. Delivery Plan

Element 1: Venous Thromboembolism (VTE)

RAG Status

AMBER- Partial Implementation

Risk

There is currently no fully implemented cross-system pathway to ensure women identified as high risk of VTE in early pregnancy consistently receive thromboprophylaxis within Maternal Care Bundle timescales. NLAG will need to align with partnership pathways where appropriate.

Key Milestones

Action	Lead	Due Date
Complete Single Point of Access VTE risk assessment amendments	Digital Lead Midwife	Jan 2027
Agree an early pregnancy LMWH prescribing pathway with HUTH, ICB, Primary Care and urgent care services	Director of Midwifery	Jan 2027
Complete governance approval and adopt the early screening pathway/SOP	Director of Midwifery	Jan 2027
Implement a standardised dosing, referral and follow-up process for women at high risk of VTE	Obstetric Governance Lead	Jan 2027

Success Measure

Women identified as high risk of VTE receive timely assessment and thromboprophylaxis in accordance with national requirements.

Element 2: Pre-Hospital and Acute Care

RAG Status

AMBER- Partial implementation

Risk

Pre-alert arrangements with ambulance services and acute maternal medicine referral pathways are not yet fully implemented, and recruitment to the Maternal Medicine Midwife role remains outstanding.

Key Milestones

Action	Lead	Due Date
Agree and implement labour ward pre-alert arrangements with YAS and EMAS	Head of Midwifery	Jan 2027
Complete Labour Ward signage review	Head of Midwifery	Dec 2026
Agree acute maternal medicine referral pathways with the Maternal Medicine Network	Clinical Director	Jan 2027
Progress recruitment of the Maternal Medicine Midwife	Director of Midwifery	Mar 2027
Undertake MEWS and pathway implementation audit	Governance Lead Midwife	Jan 2027

Success Measure

Approved and embedded referral pathways for acutely unwell pregnant and recently pregnant women.

Element 3: Epilepsy in Pregnancy

RAG Status

RED Non-compliant

Risk

Current arrangements do not yet demonstrate full compliance with Maternal Care Bundle requirements for multidisciplinary epilepsy care.

Key Milestones

Action	Lead	Due Date
Review Epilepsy Action recommendations	Head of Midwifery	Dec 2026
Develop local epilepsy in pregnancy pathway	Head of Midwifery	Dec 2026

Agree pathway with Neurology and the Maternal Medicine Network	Clinical Director	Dec 2026
Review competencies and training requirements for the Specialist Epilepsy Nurse and Lead Obstetrician	Specialist Epilepsy Nurse & Clinical Director	Jan 2027
Implement pathway and monitoring arrangements	Director of Midwifery	Jan 2027

Success Measure

A fully operational multidisciplinary epilepsy in pregnancy service, with agreed neurology and Maternal Medicine Network pathways.

Element 4: Maternal Mental Health

RAG Status

AMBER- Partially compliant

Risk

Full compliance is dependent on implementation of EPDS functionality within national digital systems.

Key Milestones

Action	**Lead**	**Due Date**
Update local maternal mental health guideline	Perinatal Mental Health Lead Midwives	Nov 2026
Complete training needs analysis	Perinatal Mental Health Lead Midwives	Dec 2026
Develop an interim local process for EPDS assessment and documentation	Perinatal Mental Health Lead Midwives	Dec 2026
Progress national digital escalation with BadgerNet and System C	Director of Midwifery	Ongoing

Success Measure

Consistent maternal mental health screening and referral pathways meeting Maternal Care Bundle requirements.

Element 5: Obstetric Haemorrhage

RAG Status

AMBER- Partially Compliant

Risk

Updated standards for cumulative blood loss measurement, real-time documentation, escalation and multidisciplinary review are not yet fully embedded, with particular concern regarding documentation compliance at Scunthorpe General Hospital.

Key Milestones

Action	Lead	Due Date
Ratify updated PPH guideline	Governance Lead Midwife	Nov 2026
Complete audit and improvement plan for real-time haemorrhage documentation, including SGH	Governance Lead Midwife	Dec 2026
Add significant haemorrhage cases to the rapid review trigger list	Governance Lead Midwife	Dec 2026
Update PROMPT and community skills and drills content to reflect MCB escalation standards	PROMPT Lead	Jan 2027
Progress the planned TEG trial and associated clinical protocol	Obstetric Anaesthetic Lead	Mar 2027

Success Measure

Demonstrable compliance with Maternal Care Bundle standards for haemorrhage measurement, escalation, review and coagulation testing.

8. Programme Risks

Risk	Current Rating	Mitigation
Delayed implementation of VTE prescribing pathway	High (Red)	Joint working with HUTH, ICB, primary care and urgent care services

Delayed implementation of epilepsy pathway	High (Red)	Delivery of Epilepsy Action recommendations with Neurology and MMN support
Maternal Medicine Midwife recruitment delay	Moderate (Amber)	Active recruitment and interim clinical oversight
National EPDS digital functionality unavailable	Moderate (Amber)	Interim local arrangements and national escalation
Pre-alert and acute referral pathways not fully implemented	Moderate (Amber)	Engagement with YAS, EMAS and the Maternal Medicine Network
Haemorrhage documentation and review processes not fully embedded	Moderate (Amber)	Targeted audit, rapid review triggers and delivery through PROMPT

9. Key Dependencies

The following dependencies sit outside the direct control of maternity services:

- Integrated Care Board agreement on early pregnancy prescribing pathways.
- Primary care, urgent care, YAS and EMAS engagement regarding VTE and pre-alert pathways.
- System C and BadgerNet digital developments.
- Maternal Medicine Network pathway approvals.
- Neurology service support and recruitment of a Maternal Medicine Midwife.

These dependencies are monitored through the programme governance framework and escalated through exception reporting where required.

10. Equality and Quality Impact

Implementation of the Maternal Care Bundle is expected to improve the identification, escalation and management of key maternal conditions, contributing to reductions in maternal morbidity and improved outcomes for women and families.

No adverse equality impacts have been identified.

11. Conclusion

The Trust has established a comprehensive Maternal Care Bundle implementation programme with clear executive accountability, multidisciplinary leadership, risk management arrangements and governance oversight.

Whilst progress has been achieved, focused work remains within VTE prevention, epilepsy in pregnancy, pre-hospital pathways and obstetric haemorrhage assurance. Subject to delivery of the identified actions, recruitment to the Maternal Medicine Midwife role and management of system-wide dependencies, the Trust will continue to work towards full implementation.

Board Decision

The Board is asked to APPROVE the Maternal Care Bundle Implementation Plan and AGREE the proposed goal implementation date of October 2027 and NOTE the current programme status, risks and governance arrangements.

Appendix 1 - Maternal Care Bundle Assurance Metrics and Reporting Framework

Purpose

The purpose of this framework is to provide the Board, Quality and Safety Committee, and Maternity and Neonatal Assurance Group with a consistent set of assurance measures aligned to the Maternal Care Bundle process indicators and process measures. Progress against these metrics will be reported quarterly alongside programme milestone delivery and risk updates.

Element 1 - Venous Thromboembolism (VTE)

MCB Indicator	Assurance Metric	Data Source	Reporting Frequency
1.1a	VTE self-assessment questions incorporated into maternity referral pathway (Y/N)	Clinical guideline / digital configuration review	Quarterly
1.1b	Early pregnancy VTE assessment embedded in EPR (Y/N)	System audit	Quarterly
1.2a	Early pregnancy LMWH prescribing pathway approved (Y/N)	Governance records	Quarterly

1.2b	% of women with an identified early pregnancy VTE risk factor who received LMWH before booking appointment	Clinical audit	Quarterly
1.3a	Pathway for review and escalation of high-risk women operational (Y/N)	Audit and pathway review	Quarterly

Board Success Indicators

Early pregnancy VTE pathway approved and operational.

Evidence of prescribing within 72 hours for eligible women.

No overdue actions relating to pathway implementation.

Element 2 - Pre-Hospital and Acute Care

MCB Indicator	Assurance Metric	Data Source	Reporting Frequency
2.1a	National MEWS embedded within maternity electronic record (Y/N)	Digital system review	Quarterly
2.1c	Compliance with completion of MEWS observations (%)	Audit	Quarterly
2.1d	% of pregnant/recently pregnant women admitted outside maternity where MEWS used	Audit	Quarterly
2.2a	Labour Ward pre-alert process operational (Y/N)	SOP review	Quarterly
2.2b	Labour Ward signage assessment completed (Y/N)	Estates review	Quarterly
2.3a	Maternal Medicine referral pathway approved (Y/N)	Governance records	Quarterly
2.3b	Maternal Medicine Network pathway review completed within previous 12 months (Y/N)	MMN records	Quarterly

Board Success Indicators

Approved referral pathways across acute services.

Evidence of MEWS compliance.

Evidence of annual MMN review.

No outstanding ambulance pathway risks.

Element 3 - Epilepsy in Pregnancy

MCB Indicator	Assurance Metric	Data Source	Reporting Frequency
3.1a	Epilepsy in pregnancy pathway approved (Y/N)	Governance records	Quarterly
3.2a	Referral pathway to MMC agreed with MMN (Y/N)	MMN review	Quarterly
3.2b	Annual multidisciplinary epilepsy training undertaken (Y/N)	Training records	Quarterly
Expert Consensus Recommendation	% of women self-reporting epilepsy reviewed by specialist team within agreed timeframe	Case note audit	Quarterly
Expert Consensus Recommendation	Median waiting time to first epilepsy specialist appointment	Service review	Quarterly

Board Success Indicators

Epilepsy pathway ratified.

Neurology participation demonstrated.

Women reviewed within agreed timescales.

Workforce competency requirements met.

Element 4 - Maternal Mental Health

MCB Indicator	Assurance Metric	Data Source	Reporting Frequency

4.1b	% of women with recorded Whooley assessment at booking	BadgerNet/System C report	Quarterly
4.1c	% of women with recorded Whooley assessment at 25-28 weeks	BadgerNet/System C report	Quarterly
4.1d	% of women with recorded Whooley assessment at 31-34 weeks	BadgerNet/System C report	Quarterly
4.1e	% of women with recorded Whooley assessment at 10-14 days postnatal	BadgerNet/System C report	Quarterly
4.1f	Digital Whooley assessment embedded (Y/N)	System review	Quarterly
4.2a	% of women screening positive on Whooley who receive EPDS assessment within one week	Audit	Quarterly
4.2b	EPDS pathway/guideline approved (Y/N)	Governance records	Quarterly
4.3b	% of women screening positive on EPDS referred for further support	Audit	Quarterly

Board Success Indicators

Consistent Whooley compliance across all time points.

EPDS pathway implemented.

Positive screens receive timely referral and support.

Element 5 - Obstetric Haemorrhage

MCB Indicator	Assurance Metric	Data Source	Reporting Frequency
5.1a	Updated PPH guideline approved (Y/N)	Governance records	Quarterly
5.1b	% of women with blood loss >2L with evidence of	Case note audit	Quarterly

	cumulative blood loss measurement		
5.1c	% of women with blood loss 1-2L with evidence of cumulative blood loss measurement	Case note audit	Quarterly
5.2a	% of women with blood loss >2L demonstrating escalation in line with guidance	Case review	Quarterly
5.2b	% of women with blood loss 1-2L demonstrating escalation in line with guidance	Case review	Quarterly
5.3a	% of women with blood loss >2L reviewed within one month	Governance review	Quarterly
Expert Consensus Recommendation	Clauss fibrinogen turnaround within one hour achieved (Y/N)	Laboratory audit	Quarterly
Expert Consensus Recommendation	Availability and utilisation of TEG/ROTEM pathway (where implemented)	Audit	Quarterly

Board Success Indicators

Compliance with cumulative blood loss measurement.

Timely escalation of major haemorrhage.

100% review of >2L PPH cases.

Evidence of MDT learning and system improvements.

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)287

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12th November 2026
Director Lead	Sam Peate, Group Chief Delivery Officer
Contact Officer / Author	Rob Stones, Director of Performance, Planning & Business Intelligence
Title of Report	National Operating Framework Report
Executive Summary	This report provides an assessment of the National Oversight Framework (NOF) position for Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) at Quarter 1 2026/27, together with an early indication of Quarter 2 performance and analysis of opportunities to improve future segmentation. Both organisations are currently rated in Segment 4 under the framework, with financial concerns preventing progression beyond Segment 3. Performance challenges remain across several operational metrics, particularly cancer standards, elective recovery, urgent and emergency care, and workforce indicators. Early Quarter 2 data suggest mixed performance, with some improvement in cancer and diagnostic measures, but continued pressures in elective waiting times and other key indicators. The report identifies priority areas where targeted improvement activity could have the greatest impact on NOF scores. The Boards are asked to note the current position, areas of risk, and the improvement opportunities identified to support future performance and oversight discussions.
Background Information and/or Supporting Document(s) (if applicable)	The National Oversight Framework is NHS England's principal mechanism for assessing provider performance and organisational oversight. It brings together measures across quality, access, operational performance, workforce and finance to determine an overall segmentation rating for NHS trusts. This report summarises Quarter 1 2026/27 performance for HUTH and NLaG, compares current performance with Quarter 4 2025/26 where comparable data are available, and provides an early assessment of Quarter 2 trends. The report also analyses key opportunities for performance improvement and their potential impact on future segmentation. Supporting analysis, benchmarking information and trust-specific assessments are contained within the accompanying National Operating Framework Report and appendices
Prior Approval Process	Reviewed in Exec and SLT meetings
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A

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

National Oversight Framework (NOF) – HHP Q1 26/27 position and forward look

Paper for discussion at Execs meeting, 13th October 2026

Exec Summary

This paper provides an assessment of the latest published NOF position, relating to Q1 2026/27, for HUTH and NLaG, together with an early indication of Q2 performance and an analysis of opportunities to improve segment positioning.

- **Overall position**: both organisations are in segment 4, with both having financial concerns which would prevent progression beyond Segment 3 under the framework rules. From a performance perspective, both trusts would need to deliver material improvement across multiple KPIs in order to be eligible to improve into segment 3.
- **Q1 performance**: NLaG's position has deteriorated in most of the metrics that can be directly compared with Q4 2025/26. Performance worsened across a range of operational measures, including cancer standards, elective waiting times, UEC performance and IPC indicators. Improvements were limited to 18w RTT performance and sickness absence rates.
  HUTH presents a more mixed picture. Improvements were seen in faster cancer diagnosis, 12h ED waits, sickness absence and IPC measures. However, 4h A&E performance deteriorated, while cancer treatment, RTT and long-wait metrics showed mixed performance, with some scores improving despite weaker performance because of relative improvements elsewhere in the provider sector.
- **Q2 to date**: Early, provision data for Q2 shows signs that NLaG's 28d cancer performance has improved, while 62d cancer performance and elective recovery measures have worsened. Diagnostic performance has also slipped slightly. HUTH shows modest improvements in cancer and diagnostic performance, with UEC broadly stable, although elective waiting times continue to deteriorate.
- **Key improvement opportunities**: For NLaG, the largest opportunities are concentrated in cancer pathways, workforce experience measures, elective waits, diagnostics and UEC. However, achieving lower-quartile performance across all identified areas would not be sufficient to drive the required improvement for segment 3, so improvements beyond that level will therefore be required.
  For HUTH, the improvement opportunities are broader, and achieving lower quartile would be sufficient to reach the Segment 3 threshold. The most significant opportunities relate to delayed induction data quality, electives, cancer, diagnostics and staff survey measures.

In summary, both trusts face particular challenges in cancer and elective performance and workforce indicators. HUTH currently has a clearer route to achieving Segment 3, whereas NLaG is likely to require more substantial performance gains.

Introduction to the NHS Oversight Framework (NOF)

The NOF comprises six domains, each of which includes a variable set of metrics dependent on the type of Trust being assessed and the services provided.

Given that some metrics are first aggregated before being used to create domain and overall scores, in 2026/27, NLaG's assessment uses 28 metrics. As HUTH does not provide community services and therefore doesn't have scores for the two community-based eighteen weeks related metrics, HUTH has 26.

NOF coverage has also changed compared to 2025/26. NLaG was assessed by 18 metrics last year, of which 14 were applied in both years. Similarly, HUTH was assessed by 16 metrics during 2025/26, of which 13 applied in both years.

Furthermore, although many of the indicators used in NOF are updated monthly, some are refreshed quarterly or annually, with updates not always available during quarters or even from one quarter to the next for annually updated metrics.

Of the 13 (HUTH) or 14 (NLaG) metrics included in both years, 5 have not been refreshed between Q4 and Q1. Further details of both those indicators included in each year's oversight framework and the frequency that refreshed data are made available, are outlined in **Appendix 1**.

Those metrics that were used in both years, and where figures have been re-assessed for Q1 are summarised below.

Q1 26/27 vs Q4 25/26 Assessment – NLaG

Of the 9 metrics with values for both Q4 25/26 and Q1 26/27 at NLaG, 7 have seen performance worsen in terms of values observed (and where relevant, scores and rankings received):

- Percentage of cases meeting the 28 day faster diagnosis standard
- Percentage of cases treated within 62 days of referral
- Percentage of cases where a patient is waiting more than 52 weeks for elective treatment
- Percentage of cases where a patient is waiting more than 52 weeks for community treatment
- Percentage of A&E patients admitted, transferred or discharged within four hours of arrival
- Percentage of patients spending 12 hours or longer in an emergency department without being admitted, discharged or transferred
- Infection Prevention & Control aggregate measure (cases of MRSA, e-coli, and *c-difficile*)

The following two metrics have seen values observed, and scores and rankings received improve:

- Percentage of cases where a patient is waiting 18 weeks or less for elective treatment
- Sickness absence rate

Further details are available in **Appendix 2** below.

Q1 26/27 vs Q4 25/26 Assessment – HUTH

Of the 8 metrics with values for both Q4 25/26 and Q1 26/27 at HUTH, the following saw performance worsen in terms of values observed and scores and rankings received:

- Percentage of A&E patients admitted, transferred or discharged within four hours of arrival

The following 4 metrics have seen values observed, scores and rankings improve:

- Percentage of cases meeting the 28 day faster diagnosis standard
- Percentage of patients spending 12 hours or longer in an emergency department without being admitted, discharged or transferred
- Sickness absence rate
- IPC aggregate measure (cases of MRSA, e-coli, and *c-difficile*)

The remaining 3 metrics have more mixed results:

- Percentage of cancer cases treated within 62 days of referral – although observed performance has reduced, the ranking and score have improved due to movement at other Trusts
- Percentage of elective cases where a patient is waiting more than 52 weeks – although performance and score have worsened, the ranking has remained the same
- Percentage of elective cases where a patient is waiting 18 weeks or less – although performance has improved slightly, the score remains the same and the ranking has improved slightly

Further details are available in **Appendix 3** below.

Q2 2026/27 – Early Findings

Whilst we work to establish data flows and analysis of in-quarter performance, early indications of Q2 performance are available via the Public View website, at least for the Access to Services sub-domain which includes Cancer, Community Services, Diagnostics, ED and RTT metrics. Until robust data flows are in place to support within-quarter analyses, these figures should be treated with caution. Screen shots are included for NLaG and HUTH at appendices 4 and 5 below however in summary:

NLaG

Three areas are indicating improvement are broadly stable performance:

- 28d cancer performance appears to have improved from 62% to 70% in Q1; 62d performance however appears to have worsened from 64% to 58%
- Community performance remains broadly in line with Q1
- ED performance is broadly in line with Q1

There has been performance deterioration in two areas:

- Diagnostics performance has worsened slightly from 32.6% to 33.6% of patients waiting over six weeks
- RTT performance has worsened compared to Q1 for both % waiting less than 18 weeks (down from 62% to 59%) and % waiting over 52 weeks (from 2.9% to 3.7%)

HUTH

One area has maintained broadly stable performance:

- ED performance on both the 4- and 12-hour targets has remained broadly in line with Q1

Three areas have shown deterioration:

- Cancer 62-day and 28-day performance have improved slightly although scores appear to have worsened
- Diagnostics performance has improved slightly although again the score looks to have worsened
- RTT performance on both the 18 weeks or less, and 52 weeks and over metrics, has worsened slightly compared to Q1

Thresholds

For 2026/27, boundaries or thresholds have been set for the four segments based on 2025/26 outturn. Both Trusts are in segment four for Q1 of 2026/27. The threshold for getting into Segment three is 2.77 points per metric. Trusts also cannot be higher than segment three if there are financial concerns. Both Trusts have financial concerns.

NLaGs's current average score is 2.93 points. Across 28 metrics, the total score is therefore 82.05 points. To get to the threshold of 2.77, NLaG therefore needs to improve by or 'lose' a total of 4.49 points.

HUTH's current average score is also 2.93 points. Across 26 metrics, the total score is therefore 76.27 points. To get to the 2.77 threshold, HUTH therefore needs to improve by or 'lose' a total of 4.25 points.

One approach to measuring potential improvement is to identify those metrics where each Trust is performing below the lower quartile. By quantifying these gaps, we can determine whether this could enable each Trust to reach the 2.77 average points per metric threshold. Gaps on each metric will be attainable to greater or less extents; this approach intends to provide a starting point from which to explore.

Opportunities to Improve – NLaG

As outlined above, for segment 3, NLaG would need to improve performance by 4.49 points. The following 11 metrics are all below lower quartile:

- Percentage of cases meeting the 28 day faster diagnosis standard - by improving performance from 61.96% (current) to 75.18% (lower quartile), the Trust could gain 0.88 points towards the overall target.
- National Education and Training Survey overall experience sub-score - by improving performance from 64.44% (current) to 73.54% (lower quartile), the Trust could gain 0.51 points towards the overall target.
- Percentage of cases where a patient is waiting more than 52 weeks for elective treatment - by improving performance from 2.9% (current) to 1.85% (lower quartile), the Trust could gain 0.41 points towards the overall target.
- Percentage of patients spending 12 hours or longer in an emergency department without being admitted, discharged or transferred - by improving performance from 15.45% (current) to 12.69% (lower quartile), the Trust could gain 0.37 points towards the overall target.
- Percentage of referrals where the patient is waiting six weeks or longer for a test or procedure - by improving performance from 32.58% (current) to 27.3% (lower quartile), the Trust could gain 0.32 points towards the overall target.
- NHS staff survey engagement theme sub-score - by improving performance from 6.46% (current) to 6.55% (lower quartile), the Trust could gain 0.31 points towards the overall target.
- NHS staff survey advocacy sub-score - by improving performance from 6.03% (current) to 6.19% (lower quartile), the Trust could gain 0.27 points towards the overall target.
- NHS staff standards sub-score - by improving performance from 7.38% (current) to 7.42% (lower quartile), the Trust could gain 0.22 points towards the overall target.
- NHS Staff survey - raising concerns sub-score - by improving performance from 6.09% (current) to 6.13% (lower quartile), the Trust could gain 0.18 points towards the overall target.

- Percentage of cases where a patient is waiting 18 weeks or less for elective treatment - by improving performance from 61.62% (current) to 62.32% (lower quartile), the Trust could gain 0.14 points towards the overall target.
- Percentage of cases treated within 62 days of referral - by improving performance from 64.41% (current) to 65.21% (lower quartile), the Trust could gain 0.12 points towards the overall target.

Overall, with a total improvement of 3.73 points, this approach isn't enough to move NLaG into Segment 3. On some metrics, it may be feasible to go further than lower quartile and thus bridge the gap.

Opportunities to Improve – HUTH

As outlined above, for segment 3, HUTH would need to improve performance by 4.25 points. The following 12 metrics are all below lower quartile:

- Delayed inductions rate - by improving performance from 609.4% (current) to 55.5% (lower quartile), the Trust could gain 0.76 points towards the overall target. This issue has already been flagged and explored with the relevant Care Group and appears to be a data definition / recording issue on data submissions. The team is putting in place improved guidance for midwifes to record only women who should be included as delayed inductions going forward. This should yield more accurate data over the coming weeks and enable estimated scores and rankings to be determined. In parallel the team are exploring whether historic data can be corrected although this seems unlikely.
- Percentage of cases where a patient is waiting 18 weeks or less for elective treatment - by improving performance from 56.76% (current) to 62.32% (lower quartile), the Trust could gain 0.68 points towards the overall target.
- Percentage of cases meeting the 28 day faster diagnosis standard - by improving performance from 69.67% (current) to 75.18% (lower quartile), the Trust could gain 0.62 points towards the overall target.
- Percentage of cases treated within 62 days of referral - by improving performance from 52.26% (current) to 65.21% (lower quartile), the Trust could gain 0.51 points towards the overall target.
- Percentage of cases where a patient is waiting more than 52 weeks for elective treatment - by improving performance from 3.79% (current) to 1.85% (lower quartile), the Trust could gain 0.49 points towards the overall target.
- NHS staff survey engagement theme sub-score - by improving performance from 6.4% (current) to 6.55% (lower quartile), the Trust could gain 0.47 points towards the overall target.

- NHS staff survey advocacy sub-score - by improving performance from 5.92% (current) to 6.19% (lower quartile), the Trust could gain 0.45 points towards the overall target.
- Percentage of referrals where the patient is waiting six weeks or longer for a test or procedure - by improving performance from 37.18% (current) to 27.3% (lower quartile), the Trust could gain 0.41 points towards the overall target.
- NHS Staff survey - raising concerns sub-score - by improving performance from 6.04% (current) to 6.13% (lower quartile), the Trust could gain 0.27 points towards the overall target.
- NHS staff standards sub-score - by improving performance from 7.37% (current) to 7.42% (lower quartile), the Trust could gain 0.27 points towards the overall target.
- National Education and Training Survey overall experience sub-score - by improving performance from 71.47% (current) to 73.54% (lower quartile), the Trust could gain 0.24 points towards the overall target.
- Percentage of A&E patients admitted, transferred or discharged within four hours of arrival - by improving performance from 70.7% (current) to 71% (lower quartile), the Trust could gain 0.02 points towards the overall target.

Overall, with a total improvement of 5.19 points, actions that delivered the above improvements would be enough to move HUTH into Segment 3. As with NLaG though, on some metrics, it should be feasible to go further than lower quartile.

Opportunities to Improve – Conclusion

In should be noted that other Trusts will be looking to improve also, so these targets are moving to some extent. By establishing processes to monitor metrics in-quarter we should be able to build early understanding of how the field is moving and thus forecast our positioning therein. As touched on above, it may also be feasible to go further than lower quartile. By developing scenarios around say median performance also, it may be possible to identify further, attainable opportunities to improve.

Furthermore, some metrics are only refreshed on an annual basis, for example NHS Staff Survey, so monitoring these in-year will not be possible. However, this should not of course prevent actions being identified to raise standards in the identified areas.

This approach to identifying areas of opportunity, and relevant owners for each, should enable relevant actions to be developed and impacts monitored.

Appendix 1 – Underlying data publication frequencies and metric usage

Metric Description	Update Freq	Used in 2025/26	Used in 2026/27	Applies at NLaG	Applies at HUTH
Percentage of cases meeting the 28 day faster diagnosis standard	Monthly	Yes	Yes	Yes	Yes
Percentage of cases treated within 62 days of referral	Monthly	Yes	Yes	Yes	Yes
Percentage of referrals where the patient is waiting six weeks or longer for a test or procedure	Monthly	No	Yes	Yes	Yes
Percentage of cases where a patient is waiting less than 18 weeks for community treatment	Monthly	No	Yes	Yes	No
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Monthly	Yes	Yes	Yes	Yes
Percentage of cases where a patient is waiting more than 52 weeks for community treatment	Monthly	Yes	Yes	Yes	No
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Monthly	Yes	Yes	Yes	Yes
Percentage of A&E patients admitted, transferred or discharged within four hours of arrival	Monthly	Yes	Yes	Yes	Yes
Percentage of patients spending 12 hours or longer in an emergency department without being admitted, discharged or transferred	Monthly	Yes	Yes	Yes	Yes
Percentage of patients readmitted within 30 days of discharge	Annual	No	Yes	Yes	Yes
Summary Hospital Mortality Indicator	Monthly	Yes	Yes	Yes	Yes
Delayed inductions rate	Quarterly	No	Yes	Yes	Yes
Percentage of inpatients referred to and seen by an in-house tobacco treatment services who make a supported attempt to stop smoking	Monthly	No	Yes	Yes	Yes
NHS staff survey advocacy sub-score	Annual	No	Yes	Yes	Yes
CQC inpatient survey satisfaction rate	Annual	Yes	Yes	Yes	Yes
Combined finance	Quarterly	Yes	Yes	Yes	Yes
Percentage of clinical trials set up within 90 days	TBC	No	Yes	Yes	Yes
Overall Data Quality Maturity Index	Monthly	No	Yes	Yes	Yes
Relative cost difference (National Cost Collection Index)	Annual	No	Yes	Yes	Yes
Clinical audit outlier (banded score)	TBC	No	Yes	Yes	Yes
NHS Staff survey - raising concerns sub-score	Annual	Yes	Yes	Yes	Yes
Sickness absence rate	Monthly	Yes	Yes	Yes	Yes
NHS staff survey engagement theme sub-score	Annual	Yes	Yes	Yes	Yes
Percentage of frontline healthcare workers to receive a flu vaccination	Weekly	No	Yes	Yes	Yes
National Education and Training Survey overall experience sub-score	Annual	No	Yes	Yes	Yes
NHS staff standards sub-score	Annual	No	Yes	Yes	Yes
Temporary staffing cost relative band	N/A	No	Yes	Yes	Yes
Infection Prevention & Control aggregate measure (cases of MRSA, e-coli, and *c-difficile*)	Monthly	Yes	Yes	Yes	Yes

Appendix 2 – NLaG Q1 2026/27 compared to Q4 2025/26

	Q1 2026/27			Q4 2025/26			Comparison		
Metric Description	**Score**	**Rank**	**Value**	**Score**	**Rank**	**Value**	**Score**	**Rank**	**Value**
Percentage of cases meeting the 28 day faster diagnosis standard	3.94	114	61.96	3.78	110	66.21	Worse	Worse	Worse
Percentage of cases treated within 62 days of referral	3.53	95	64.41	3.15	83	66.63	Worse	Worse	Worse
Percentage of referrals where the patient is waiting six weeks or longer for a test or procedure	3.56	112	32.58						
Percentage of cases where a patient is waiting less than 18 weeks for community treatment	1	26	85.5						
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	3.89	122	2.9	3.43	113	2.05	Worse	Worse	Worse
Percentage of cases where a patient is waiting more than 52 weeks for community treatment	2.45	34	0.31	1	1	0	Worse	Worse	Worse
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	3.39	103	61.62	3.44	106	61.57	Better	Better	Better
Percentage of A&E patients admitted, transferred or discharged within four hours of arrival	3.31	87	72	2.86	73	72.81	Worse	Worse	Worse
Percentage of patients spending 12 hours or longer in an emergency department without being admitted, discharged or transferred	3.63	107	15.45	3.16	88	10.77	Worse	Worse	Worse
Percentage of patients readmitted within 30 days of discharge	4		0						
Summary Hospital Mortality Indicator	2		0	2	0	0	no change		
Delayed inductions rate	2.4	56	30.1						
Percentage of inpatients referred to and seen by an in-house tobacco treatment services who make a supported attempt to stop smoking	1.29	15	57.14						
NHS staff survey advocacy sub-score	3.53	113	6.03						
CQC inpatient survey satisfaction rate	2		0	2	0	0	no change		
Combined finance	4		0	4	0	0	no change		
Percentage of clinical trials set up within 90 days	4	104	0						
Overall Data Quality Maturity Index	2.89	85	91.8						
Relative cost difference (National Cost Collection Index)	1	40	95.29						
Clinical audit outlier (banded score)	1		0						
NHS Staff survey - raising concerns sub-score	3.44	109	6.09	3.44	109	6.09	no change		
Sickness absence rate	2.04	58	5.11	2.32	74	5.79	Better	Better	Better
NHS staff survey engagement theme sub-score	3.57	115	6.46	3.57	115	6.46	no change		
Percentage of frontline healthcare workers to receive a flu vaccination	2	50	51.7						
National Education and Training Survey overall experience sub-score	4	134	64.44						
NHS staff standards sub-score	3.48	111	7.38						
Temporary staffing cost relative band	3		0						
Infection Prevention & Control aggregate measure (cases of MRSA, e-coli, and c-difficile)	3.71			3.48			Worse		

Appendix 3 – HUTH Q1 2026/27 compared to Q4 2025/26

	Q1 2026/27			Q4 2025/26			Comparison		
Metric Description	**Score**	**Rank**	**Value**	**Score**	**Rank**	**Value**	**Score**	**Rank**	**Value**
Percentage of cases meeting the 28 day faster diagnosis standard	3.68	106	69.67	3.69	107	68.02	Better	Better	Better
Percentage of cases treated within 62 days of referral	3.92	114	52.26	3.95	116	53.44	Better	Better	Worse
Percentage of referrals where the patient is waiting six weeks or longer for a test or procedure	3.65	116	37.18						
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	3.97	127	3.79	3.9	127	3.45	Worse	Same	Worse
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	3.93	126	56.76	3.93	127	56.31	Same	Better	Better
Percentage of A&E patients admitted, transferred or discharged within four hours of arrival	3.42	93	70.7	3.14	85	71.16	Worse	Worse	Worse
Percentage of patients spending 12 hours or longer in an emergency department without being admitted, discharged or transferred	2.09	45	7.96	3.28	93	11.29	Better	Better	Better
Percentage of patients readmitted within 30 days of discharge	4		0						
Summary Hospital Mortality Indicator	2		0	2	0	0	no change		
Delayed inductions rate	4	119	609.4						
Percentage of inpatients referred to and seen by an in-house tobacco treatment services who make a supported attempt to stop smoking	1.23	12	60.56						
NHS staff survey advocacy sub-score	3.71	121	5.92						
CQC inpatient survey satisfaction rate	2		0	2	0	0	no change		
Combined finance	4		0	4	0	0	no change		
Percentage of clinical trials set up within 90 days	4	28	71.43						
Overall Data Quality Maturity Index	1.36	12	96.4						
Relative cost difference (National Cost Collection Index)	1	15	91						
Clinical audit outlier (banded score)	3		0						
NHS Staff survey - raising concerns sub-score	3.53	113	6.04	3.53	113	6.04	no change		
Sickness absence rate	1.34	21	4.54	1.51	33	4.88	Better	Better	Better
NHS staff survey engagement theme sub-score	3.73	122	6.4	3.73	122	6.4	no change		
Percentage of frontline healthcare workers to receive a flu vaccination	2.04	53	51.6						
National Education and Training Survey overall experience sub-score	3.73	116	71.47						
NHS staff standards sub-score	3.53	113	7.37						
Temporary staffing cost relative band	1		0						
Infection Prevention & Control aggregate measure (cases of MRSA, e-coli, and c-difficile)	2.41			3.03			Better		

Appendix 4 – NLaG Q2 2026/27 Early Findings

Access to Services — 9 Scoring KPIs — Mean Score: 3.33

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Cancer - Patients treated within 62 of referral QTD	Q2 26/27	80.00%	**56.65%**			3.84
Cancer - Urgent referrals diagnosis within 4 weeks QTD	Q2 26/27	80.0%	**68.7%**			3.71
Community Services - Patients waiting less than 18 weeks	Jul 26	78.00%	83.46%	L		1.00
Community Services - Patients waiting over 52 weeks	Jul 26	-	0.25%			2.23
Diagnostics - 6 Week Standard	Jul 26	-	33.51%	H		3.61
ED - Attendances managed within 4 hours - Acute trust footprint QTD	Q2 26/27	82.00%	**72.22%**			3.21
ED - Attendances over 12 hours in department QTD	Q2 26/27	-	17.2%			3.78
RTT - Patients waiting 18 weeks or less	Jul 26	-	59.78%			3.65
RTT - Patients waiting over 52 weeks	Jul 26	0.00%	**3.31%**	H		3.92

Appendix 5 – HUTH Q2 2026/27 Early Findings

Access to Services

9 Scoring KPIs Mean Score: 3.52

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Cancer - Patients treated within 62 of referral QTD	Q2 26/27	80.00%	**53.23%**			3.96
Cancer - Urgent referrals diagnosis within 4 weeks QTD	Q2 26/27	80.0%	**71.3%**			3.57
Community Services - Patients waiting less than 18 weeks	Jan 25	-	0.00%			4.00
Community Services - Patients waiting over 52 weeks	Jan 25	-	0.00%			1.00
Diagnostics - 6 Week Standard	Aug 26	-	39.12%			3.70
ED - Attendances managed within 4 hours - Acute trust footprint QTD	Q2 26/27	82.00%	**70.65%**			3.42
ED - Attendances over 12 hours in department QTD	Q2 26/27	-	7.8%			2.09
RTT - Patients waiting 18 weeks or less	Aug 26	-	55.44%			3.93
RTT - Patients waiting over 52 weeks	Aug 26	0.00%	**4.04%**			3.97

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)288

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12th November 2026
Director Lead	Sam Peate, Group Chief Delivery Officer
Contact Officer / Author	Sam Peate, Group Chief Delivery Officer
Title of Report	Performance & Accountability Framework
Executive Summary	This paper presents the Performance and Accountability Framework for Humber Health Partnership for consideration by the Trust Boards-in-Common. It sets out a clear approach to ward-to-board accountability, including how responsibilities are structured, how performance is overseen, and how risks and issues are escalated through governance. The framework supports transparency, assurance, and improvement, and is aligned to the Partnership's strategy, values, and existing committee structures. It reflects the response to the June 2026 CQC Well-Led inspection and the Section 29A warning notice, and incorporates learning from the 2025 Value Circle external report.
Background Information and/or Supporting Document(s) (if applicable)	This paper provides the context for the Performance and Accountability Framework for Humber Health Partnership. It has been developed following a recent regulatory requirement and reflects the need for a clear, consistent approach to holding the organisation to account from ward to board. The framework draws on best practice from other NHS organisations and is aligned to the Partnership's strategy, values, and governance arrangements. It sets out how responsibilities are structured, how performance is overseen, and how risks and issues are escalated through formal committees to support transparency, assurance, and improvement. It is being brought forward in response to the recent CQC Well-Led inspection in June 2026, where a Section 29A warning notice was issued, and also reflects recommendations and learning from the Value Circle external report undertaken in 2025.
Prior Approval Process	SLT, Execs and Audit Review Committee
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

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Scope

1.1 This document sets out the overarching approach to the performance management and the accountability framework arrangements in place within Humber Health Partnership (Northern Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust – referred to as HHP throughout the document). This performance and accountability framework is an HHP document which applies to all members of staff.

Purpose and key aims

1.2 The purpose of this Performance and Accountability Framework (the 'Framework') is to support the achievement of the HHP strategic objectives in a way which is consistent with the HHP Strategy and values, by providing clarity on how HHP is organised, where responsibilities for decision making lie, how issues and risks are escalated, and how progress is reported and monitored in an open and transparent way.

1.3 It is the framework by which the HHP Board (and Unitary Boards) will hold the Executive Team, the Care Groups and corporate functions to account for their performance.

1.4 The framework provides assurance aligned to the National Oversight Framework (NoF) covering the domains of Access, Finance, Effectiveness, Safety and People emphasizing the HHP position against each domain for focused recovery and sustainability. This will be at aggregate, Care Group and Service level including the corporate services contribution.

1.5 The framework enables assurance for delivery. It also outlines Tier 2 meetings such as the Planned Care Board and Unplanned Care Board chaired by the Chief Delivery Officer reporting into the Tier 1 Board sub-committees ultimately reporting to the Trust Board (committee in Common).

1.6 The key aims of the Framework are to promote good governance to support HHP in:

- Assessing performance against clear standards, goals, targets and outcomes based on the NOF domains.
- Driving and supporting successful and sustainable delivery of national standards for performance, contractual targets, quality requirements and the annual strategic objectives agreed as part of the annual planning round.
- Predicting future performance and forecast outturn (financial and non-financial).
- Informing strategic decisions and supporting continuous improvement.
- Focusing resources and improvement efforts in required areas.
- Holding effective Quality and Performance Reviews (QPRs) that include escalation/intervention as necessary and appropriate, or enabling the use of earned autonomy.
- Focus on waste reduction and productivity programmes for safe and sustainable delivery of care.

Introduction

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The Humber Health Partnership (HHP) Accountability framework is intended to bring together the distinct ways of working for Ward to Board accountability within the organisation. The document supports the strategic intentions of HHP and is in keeping with our values. The document should enable key alignment to the Board Assurance Framework (BAF).

Our values

1.7 Our values were developed with input from over 3,000 staff working at NHS Humber Health Partnership:

- Compassion
- Respect
- Honesty
- Teamwork

They are the foundation for our staff charter which sets out clear behavioural expectations of everyone working for HHP.

1.8 A key element of the Framework is distributed leadership which is supported through accountability and autonomy – being clear about where there is authority to make decisions independently within Care Groups and Corporate Departments, where decisions must be escalated to the HHP Executive Team and under what circumstances this may be reviewed and changed accordingly. This is clearly set out in the **Standing Financial Instructions** and **Scheme of Delegation** which must be always complied with.

Standing Financial Instructions (SFIs) are formal rules and procedures that guide how NHS organisations manage their finances, ensuring they operate legally, ethically, and efficiently. This document details the responsibilities of staff and the Board to uphold probity, accuracy, economy, efficiency, and effectiveness in all financial transactions, ultimately protecting public money and ensuring value for money for the taxpayer.

Standing Financial Instructions and Scheme of Delegation are available on the Trust's intranet site.

1.9 The framework is of equal importance to ensuring there is an organizational culture that supports delivery and ongoing transformation. HHP is working to develop the Learning Improvement Safety Academy (LISA) that will support development of improvement methodologies, capability and support cultural change and improvement.

Organisational and governance structure

1.10 During the annual planning cycle, the Humber Health Partnership Board sets the strategic direction and the annual strategic objectives, which will be reviewed annually. All Care Groups will have defined their key local objectives for the operating financial year contributing to the overall HHP 3-year plan. **Appendix A** shows the operating model and accountability framework.

The key governance arrangements and cadence for the organisation are:

- **Executive team meeting (Weekly)** is the senior executive decision-making body.
- **Senior Leadership Team (SLT) (fortnightly)** is the assurance, coordination and

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decision-making forum bringing together the Care Group Chiefs of Service (or nominated deputy). This meeting runs in accordance with an approved annual cycle of business.

- **Clinical Policy Group** consists of the senior clinical leaders (Chiefs of Service, Clinical Directors, Clinical Leads, Nurse Directors, AHP and Midwifery representatives and Senior Operational leads) along with the Executive Directors to develop and monitor clinical strategy, use of capital expenditure, winter planning, deliver PSIRF and to influence related policy formulation. The Clinical Policy Group will advise the SLT on these items to strengthen clinical leadership and engagement.
- **Care Groups Performance and Accountability meetings (6 weekly)** are formal performance review meetings chaired by the Group Chief Delivery Officer to review each Care Group's delivery in each domain of Quality and Safety, Performance and Access, Finance and workforce. These meetings are attended by the Care Group triumvirate / quadrumvirate and their core business partners, the Group Chief Medical Officer, Group Chief Nursing Officer, Group Chief People Officer and Group Chief Finance Officer.
- **Care Group Board Meetings** are formal monthly board meetings chaired by the Chief of Service for the Care Group along with their triumvirate / quadrumvirate review their Care group's performance across each domain of Quality and Safety, Performance and Access, Finance and workforce. Each Care group is expected to have appropriate Clinical quality and Governance meeting arrangements in place to support clinical governance of the services they are responsible for – these meetings should feed directly into the Care Group Board Meetings.
- **Service Meetings** are formal monthly directorate meetings led by the Clinical Director and their triumvirate reviewing their Quality and Safety, Performance and Access, Finance and workforce.
- **Planned Care Board (monthly)** chaired by the Chief Delivery Officer seeking assurance against clinically led and agreed work programmes covering elective care including cancer pathways and diagnostics. This is a Tier 2 meeting reporting to the Performance, estates and finance Board sub-committee and the quality and safety Board sub-committee as Tier 1.
- **Unplanned Care Board (monthly)** chaired by the Chief Delivery Officer seeking assurance against clinically led and agreed work programmes covering non-elective care including unscheduled care pathways and diagnostics such as access to stroke services, general surgical and emergency specialist surgical pathways. This is a Tier 2 meeting reporting to the Performance, estates and finance Board sub-committee and the quality and safety Board sub-committee as Tier 1.
- **Director of Ops meeting** will take place weekly between all Care Group Operations Directors (collective meeting to demonstrate the duty to collaborate) and the meeting will allow corporate services to attend and provide key updates on a rolling cycle of business to ensure clear connectivity.
- **Director of Nursing** meetings will take place weekly between all Care Group Directors of Nursing ensuring clear professional communication channels and duty to collaborate beyond Care Group Boundaries.
- An informal **Chiefs of Service meeting** will take place weekly to ensure dty to collaborate and connection on cross cutting themes. The Executive will join this session on request of the CMO or the wider group.
- **Appendix B** shows the governance accountability framework which ensures

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there is a clear alignment to the strategic direction of what teams and individuals are required to support achievement.

1.11 The Ward to Board oversight is underpinned by the governance structure, to support and ensure that all patients, staff and key stakeholders can influence and inform the way HHP works and its future vision and strategy.

1.12 Organisational structures are included in Appendix A and Appendix B. Within each care Group it is expected each Directorate will hold regular meetings with a clear agenda outlining core items, service specific priorities including escalation, led by the Clinical Director and with consistent line of escalation into the monthly Care Group board meetings. A chairs log from Care Group board meetings should be provided to the SLT meeting to ensure clear oversight and escalation of risks and issues from Ward to Board in the organization enabling oversight and ability to act.

1.13 The Terms of Reference to be added to appendices.

Board of Directors/Council of Governors

1.14 A copy of the approved Constitutions for each Unitary Trust are provided in the hyperlink below. Any aspect of the Constitutions can be discussed with the Company Secretary.

1.14.1 HUTH – To add
1.14.2 NLAG – To add

Chief Executive Officer (CEO)

1.15 The CEO is the Accountable Officer, responsible for the overall running of the organisation. This includes ensuring that HHP meets all quality, operational performance and financial requirements.

HHP Executive Team (Senior Decision-Making Body)

1.16 HHP Executive Team Meeting supports the CEO in delivering HHP strategic plan with responsibility for the approval and implementation of the Performance and Accountability Framework.

1.17 HHP Executive Team consists of Executive Directors (voting) and Directors (non-voting) who attend HHP/Unitary Trust Board meetings.

1.18 HHP Executive Team is responsible for ensuring appropriate oversight mechanisms and processes for the management of performance, including the application of corrective actions in relation to:

1.18.1 Delivery of strategic priorities, focused critical improvements, HHP programmes including the relevant task and finish projects.
1.18.2 Operational, quality and financial performance.
1.18.3 Digital innovation including major programmes such as the Electronic Patient Records (EPR)
1.18.4 Organisational capability and capacity to deliver the priorities, including an appropriately skilled and supported workforce.

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1.18.5 Compliance with statutory, mandatory and regulatory requirements.

1.19 As the senior decision-making body, HHP Executive Team is accountable to the HHP Board for the executive oversight and performance of the organisation. Meetings are held weekly and are chaired by the CEO.

HHP Senior Leadership Team

1.20 The Senior Leadership Team (SLT) includes all Care Group Chiefs of Services (unless unavailable and a nominated deputy will attend) from the Care Groups and supports clinically-led arrangements. The SLT meeting has been established in 2025/26 financial year, to ensure that there is a clinically led model of leadership across HHP strengthening the decision-making process. An annual cycle of business is included in the terms of reference for this group. These meetings focus on clinical, operational and emerging issues with strong oversight escalating into the Executive Team Meeting and subsequently to the board via the CEO update and/or regular Board reporting.

Group Executive Risk and Assurance Committee

1.21 HHP Executive Risk and Assurance Committee will be chaired by the Group Chief Patient Safety Officer. The Group will meet monthly and provides check and challenge to risks across HHP Care Groups/Corporate Services. This includes the oversight of compliance with the HHP Risk Management Policy, including trend analysis and identifies areas of focus for additional support. The Chair's Escalation Report is presented to the HHP Executive Team and Audit Committee.

Clinical Policy Group

1.22 The Clinical Policy Group (CPG) will meet monthly and is chaired by the Chief Medical Officer. The CPG will operate within approved Terms of Reference and informed by a cycle of business. Attendance will include all Chief's of Service, Care Group representatives, Clinical Directors, Senior Nursing Teams and senior clinical leaders. The meeting will also be attended by Executive Team members. CPG is responsible for developing and implementing clinical policy across HHP and advising the Executive Team on relevant matters, supporting clinically led arrangements. Accountability is through the chair of the meeting with issues escalated to HHP Executive Team as required. The CPG is accountable to the HHP Exec and a CPG Chair's Escalation Report will be presented to each HHP Board Meeting.

Care Groups and Directorates

1.23 The HHP Board is driving to enable distributed clinical leadership across all sites, using the Care Groups as the vehicle for delivery of operational priorities.

1.24 Services across HHP are split across Care Groups with all having responsibility for horizontal delivery of services across all sites. Each Care Group is led by the Chief of Service who is accountable for operational service delivery to the Group Chief Delivery Officer for delivery of the annual plan and agreed objectives. Business plans will be developed annually and monitored via the Care Group Performance and Accountability meetings. Professional accountability within the Care Group management team sits with the

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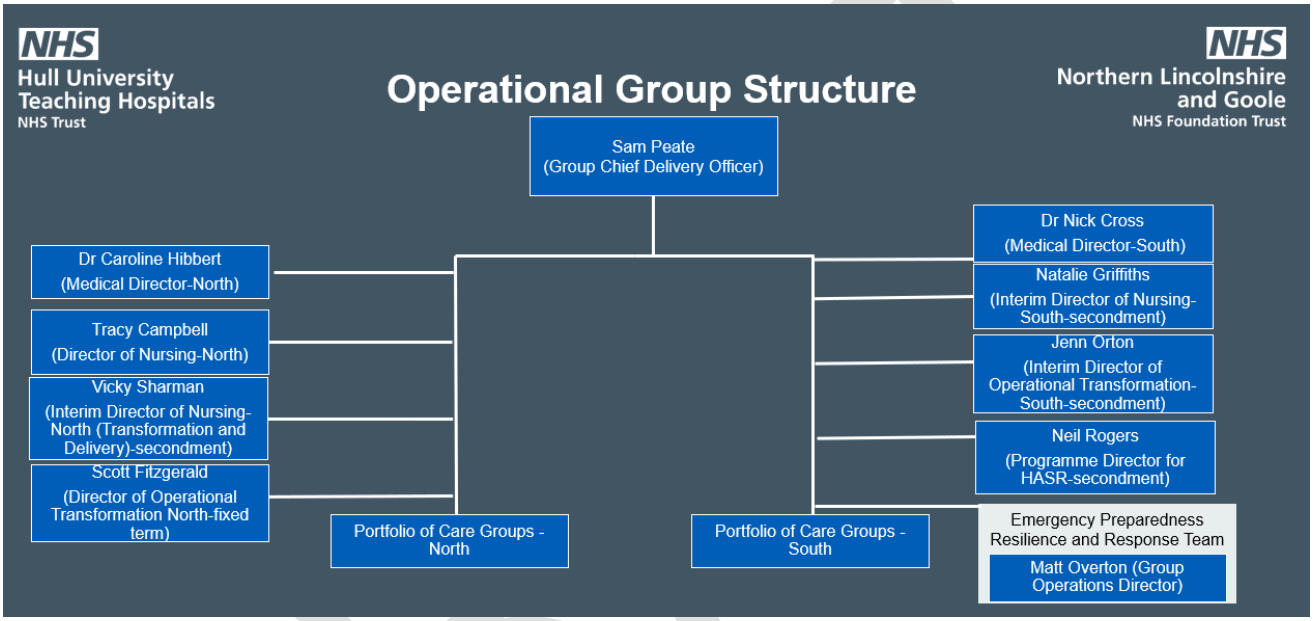
Group Chief Medical Officer, Group Chief Nursing Officer and Group Chief Delivery Officer respectively.

1.25 Care Group Accountability Structure:



1.26 The Chief of Service for each Care Group (including Directorates) is responsible for the leadership of the Care Group to support the delivery of patient care according to the HHP vision and strategy (including future strategic direction) and is responsible for ensuring that quality and safety of patient care remain the primary objective of all staff of the Care Group. The Chief of Service is also accountable for ensuring robust quality and safety arrangements are in place where there are gaps, exercising their responsibility to correct these to the expected standards.

1.27 As agreed with HHP Executive Team, representatives from Care Groups may also provide support for specific strategic areas, such as Outpatient Transformation, Development of Tertiary Services, Urgent and Emergency Care, Elective Care, Out of Hospital Care, Cancer and Diagnostic Care aligned to corporate improvement programmes.

1.28 The Chief of Service is accountable for all aspects of the performance of the Care Group, which will meet on a weekly basis (minimum of the triumvirate/quad) and will chair a monthly Care Group Board meeting. They also have operational line management responsibility for the Care Group Director of Operations, Care Group Director of Nursing and Clinical Directors within the Care Group.

1.29 Reporting to the Chief of Service (operationally) and the Group Chief Delivery Officer (professionally), the Director of Operations is responsible for overall operational delivery, interpreting and delivering overall health service policy and strategy, and has a key role in supporting the Chief of Service in the leadership of the Care Group (and its Directorates). The Director of Operations is also responsible for providing high-level operational and strategic business planning and leadership to ensure that the Care Group provides high quality patient care and achieves its performance objectives.

1.30 Each Care Group is managed in accordance with a common governance framework, specifically in relation to arrangements for quality governance. The Care Group will need to ensure there are effective arrangements in place with its Directorates, and this is supported by standard agendas. The following section outlines how the Care Groups are held to account for the delivery of annual performance, workforce and financial plans.

1.31 The Care Group Nurse Director is operationally responsible to the Chief of Service and professionally accountable to the Group Chief Nursing Officer.

1.32 The Clinical Directors within each Care Group are accountable to the Chief of Service for the performance of the Directorate within their responsibility. The Clinical Directors, have line management responsibility for any clinical leads within their clinical directorate and have access to appropriate resources to support necessary performance and governance outputs. This includes responsibility for the budget of the clinical directorate.

1.33 The Care Group triumvirate/quad (dependent upon Directorates) are collectively responsible for overseeing effective operation and delivery of services across all Care Group activities including operational performance, quality, workforce and finance. In addition to individual monthly Care Group Board meeting. This must be aligned to the NoF addressing the relevant domains requiring mitigation and improvement whilst sustaining areas of success.

1.34 The Care Group triumvirate/quad is also responsible for ensuring that there are robust governance arrangements in place throughout the Care Group (including within clinical directorates and specialties) to ensure that key issues and risks are identified, managed and escalated as necessary in an effective way.

1.35 The Ops Directors, Chief of Service and Nurse Director collective meetings between the Care Groups, demonstrate delivery of the '**duty to collaborate**'. The administration of these forums sits with the appropriate Director. These meetings will also provide the opportunity for Corporate Services to attend the meeting and provide updates.

1.36 Planned Care Board will be held monthly chaired by the Chief Delivery Officer with a set priority agenda based on the clinically agreed work programmes reflecting the NoF domains, Clinical operational standards and models of care including Getting It Right First Time (GIRFT) standards supported by agreed terms of reference. This is a key assurance meeting and will take place prior to the Tier 1 Board sub-committees as an agreed cadence to enable flow of assurance to Board.

1.37 Unplanned Care Board will be held monthly chaired by the Chief Delivery Officer with a set priority agenda based on the clinically agreed work programmes reflecting the

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NoF domains, Clinical operational standards and models of care including Getting It Right First Time (GIRFT) standards supported by agreed terms of reference. This is a key assurance meeting and will take place prior to the Tier 1 Board sub-committees as an agreed cadence to enable flow of assurance to Board.

Site Leadership Triumvirates

1.38 The Site Leadership Triumvirates will be led by the Group Chief Delivery Officer. Objectives for each member of the Site Leadership Triumvirates with the Group Chief Delivery Officer to enable focus on delivery of key strategic objectives across each site. The Site Leadership Triumvirates will provide ongoing support to the Care Groups, which will include coaching, advice and development to provide added value. The Site Leadership Triumvirates will establish positive and supportive work arrangements with the Care Groups and will attend Care Group meetings as required.

Corporate Directorates & Site Leadership Triumvirates

1.40 Each member of HHP Executive Team leads a corporate directorate comprising teams with functional responsibilities for providing corporate support on decisions across HHP. HHP Executive Team is accountable to the CEO for the performance of their corporate directorates and will also be held to account under the Performance and Accountability process.

1.41 While this Framework focuses on the levels of the organisational structure outlined above, it is important to recognise that clarity of accountability is vital at all levels of the organisation, including teams and individuals within HHP who all should have clear objectives which are linked to HHP objectives.

1.42 Corporate Directorates will organise their teams to align to each of the Care Groups to ensure that they have support to deliver their functions.

Performance and Accountability Meetings (Holding to account)

1.43 The primary means by which HHP Executive Team holds the Care Groups and corporate directorates to account for progress against contractual and national performance requirements is through six weekly Performance and Accountability Meetings. The regularity may increase or decrease, depending on the autonomy level assigned. These meetings are also an important mechanism through which Care Groups and corporate directorates can escalate issues to and seek support from HHP Executive Team and Site leadership Teams.

1.44 Performance and Accountability meetings take place with each Care Group separately. They are chaired and administered by the Group Chief Delivery Officer, with the expectation that Group Chief Nurse, Group Chief Medical Officer and Group Chief Finance Officer will attend, additional directors may attend if required to support specific areas. Where an Executive Director cannot attend it is expected that their deputy attends. Each Care Group, is expected to be represented and led by the Chief of Service, supported by the Care Group management team (triumvirate/quad). It is expected that escalation of items from the Care Groups' Board meetings are formally raised at the Performance and Accountability Meetings.

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1.45 Core attendees should prioritise Performance and Accountability meetings but, if they are not available, they should send a representative who is appropriately briefed to participate fully in the meeting. It is expected that core members of each Performance and Accountability Meeting (as outlined above) should attend a minimum of 75% of meetings a year.

1.46 The Performance and Accountability meetings focus on five domains (including any risks associated with each):

1.46.1 Quality and safety
1.46.2 Performance – including activity and access targets
1.46.3 People
1.46.4 Finance including current year position and financial recovery
1.46.5 Strategy and service developments

1.47 Key summary metrics (in dashboard format) within each of these domains are used to track progress. This underpins the key principle of distributed leadership and autonomy. These will be aligned to the NoF domain areas.

1.48 The focus of the Performance and Accountability Meetings is on issues and metrics by exception, with the information and data provided for reference. In advance of planned meetings, each Care Group will be provided with a monthly performance report (dashboard format and based on Care Group metrics) from the Performance Team. To get the most from Performance and Accountability Meetings, the Care Group leadership team are required to prepare a pack of information circulated 3 working days in advance to enable the attendees to have the information required to undertake the review to the appropriate depth. This process is supported by Corporate Teams as required and covers all aspects of the agenda. Notes and action points will be the responsibility of the Care Group triumvirate for circulation within 7 days of the meeting taking place. Nominated action owners are responsible for following up their actions ahead of the next meeting.

1.49 It is expected that each Care Group will have in place a formal structure for regular Performance and Accountability Meetings with their directorates and this should be reported directly into their Care Group Board.

1.50 The Performance and Accountability Meetings, will also consider and ensure updates relating to:

- Report on recruitment decisions.
- Report Care Group Business Case developments (including updates on proposed consultation where appropriate).
- Provide assurance on establishment changes (within allocated budget) to transfer resources between budget lines, skill mix.
- Being prepared to reconsider decisions if required.

1.51 Where items of escalation affect more than one Care Group these will be noted in SLT and will be tracked either through the SLT meeting or one of the Unplanned Care Board, Planned Care Board and EPR Board as appropriate. A Chair's Escalation Report from the Executive-Led Performance and Accountability meetings will be produced monthly and presented to HHP Weekly Executive Team meetings and relevant Board committees for assurance purposes (as required).

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1.52 HHP Executive Team will monitor and review the need for additional training, support and capacity to facilitate the effective operation of the Performance and Accountability Framework.

Performance Management and Reporting

1.53 The HHP Integrated Performance Report (IPR) provides data to Board level, with selected key performance indicators (KPIs) forming the basis for the Performance and Accountability Meetings with the Care Groups. These reports are regularly updated as performance expectations change, and new targets set (subject to Board approval). The KPIs and thresholds for performance success of Care Groups are formally reviewed at the Performance and Accountability meetings and will be reported to HHP Senior Leadership Team.

1.54 Where Care Groups demonstrate an ability to maintain high levels of performance, the principle of maximum earned autonomy will apply. As Care Groups are formed, they will be assigned to a segment in the National Oversight Framework based on available information to inform the metrics. The levels of autonomy are outlined below:

Autonomy level	Assessment criteria	Level of Support	Autonomy level
1. Maximum Autonomy	Consistently high performing across the review domains.	No specific support needs	Full autonomy within the scope of the Framework, Standing Financial Instructions and Scheme of Delegation.
2. Enhanced autonomy	Majority of the review domains are high performing and improvement plans are in place for the other domains	Specific support needs on request of the Care Group	Additional oversight on specific domains of concern. This may include escalation to corporate oversight of recruitment and investment decisions.
3. Reduced autonomy		Mandated additional support from relevant Corporate Teams/ Operational Support Function	

Principles of Autonomy and Accountability

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1.55 The following are principles that the Care Group teams should have regard to when decision making:

- Consider the impact on other Care Groups, as well as on patients and staff.
- Determine who are the relevant stakeholders and identify whether they have been consulted.
- Act in the overall interests of HHP.
- Ensure effective resource management.
- Avoid setting new precedent without HHP Executive Team agreement.
- Comply with governance arrangements locally.
- Commit to sharing learning to improve wider organisational decision making.
- Contribute to external reporting assurance as necessary.
- Ensure compliance with Standing Financial Instructions and Scheme of Delegation.
- Ensure completion of EQIA.

Triggering and managing performance escalations

1.56 There are several levels and routes of escalation, which can be at Directorate Performance and Accountability level, Care Group Performance and Accountability level or Executive-Led Performance and Accountability level:

1.57 Stepping up interim Performance and Accountability Meetings:

1.57.1 Care Groups are required to escalate in-month of any deterioration across the IPR that impacts on their level of autonomy.

1.57.2 HHP-wide oversight and performance monitoring identifies a Care Group concern.

1.57.3 IPR identifies a need for a focused review of finance, workforce, quality and patient safety or operational performance. These meetings will be scheduled in between Performance and Accountability meetings with members of the corporate team/operational support function and the Care Group Triumvirate/Quad.

1.58 Escalation to the HHP Executive Team should occur when:

1.58.1 There are specific items of escalation to HHP Executive Team **for noting** i.e. breach of a national requirement, however assurance can be provided that a recovery action plan is place and will no longer be an issue within a specified timeframe.

1.58.2 Specific items of escalation to HHP Executive Team **for action** i.e. breach of a national requirement and there is no credible recovery plan in place and support is required. The Executive Team will agree to the next course of action directly with the Care Group.

1.58.3 Care Groups and other corporate leadership teams can make a direct escalation to an appropriate forum i.e. a Senior Leadership Forum or directly into HHP Executive Team rather than wait for a Performance and Accountability Meeting.

1.58.4 If there is ongoing slippage against an action plan, there will be a further escalation to the Group Chief Delivery Officer and the relevant Executive Director pending the nature of the escalation.

1.58.5 A further escalation can be made to include the CEO to mediate a resolution or set out the next steps.

1.58.6 Where appropriate recovery plans will be provided into the Board Committees to ensure clear oversight of actions being undertaken.

1.59 As the framework relies on robust governance arrangements being in place, any

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governance concerns can and should be highlighted through other routes including, the Company Secretary, Group Chief Patient Safety officer and/or the GERAC or any management groups that are formed. Members in attendance are expected to triangulate information and raise concerns if there is contradictory information presented. In this instance, HHP Executive Team/ SLT will review and determine whether a governance review of the Care Group is required.

Reserved Matters for HHP Executive Team

1.60 The following matters are reserved for HHP Executive Team discussion and decision:

- 1.60.1 Capital spend to be centrally controlled given the Capital Departmental Expenditure Limit (CDEL) and cash flow.
- 1.60.2 Minimum Performance and Quality ambitions.
- 1.60.3 Pay Terms and Conditions, the regrading and job evaluation process, and the job planning policy.
- 1.60.4 Use of the Very Senior Manager (VSM) grade.
- 1.60.5 Redundancy.
- 1.60.6 Changes to ward based Safer Nursing Care Toolkit (SNCT) levels.
- 1.60.7 Use of Agency staff for non-clinical roles, above cap and off framework.
- 1.60.8 Business cases where there is no funding / income available.
- 1.60.9 Procurement of Digital Systems.
- 1.60.10 Overall decision making on financial requirements and HHP-wide policy decisions.

Risk Management

1.61 This Framework aims to align with the Risk Management Policy. The Trust recognises that there are unavoidable and inherent risks to providing healthcare services and are committed to supporting a dynamic, proactive, and transparent approach to risk management across HHP.

1.62 The Board of Directors with the support from its Committees of the Board have a key role in ensuring robust risk management systems and processes are effectively implemented, and maintained, as well as to promote a culture whereby risk management is fully embedded across all HHP activities through its policy, strategy and management plans.

1.63 All Care Group leadership teams are responsible for ensuring the implementation of the Risk Management Policy within their Care Groups, including establishing effective risk management governance to support the continual management of risks and risk registers as set out within the Risk Management Policy which can be found in the intranet policy directory.

1.64 All staff play a vital role in considering risk and helping to ensure it does not prevent the delivery of safe and effective care. Effective risk management is the responsibility of every member of staff, and the escalation of risk should be encouraged and managed separately using an appreciative enquiry approach.

Monitoring compliance with and the effectiveness of this document

1.65 The Framework will be reviewed annually and in readiness for 2027/28 a review of

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the effectiveness of the Framework will be completed by the end of March 2027.

Disclaimer

1.66 It is the responsibility of the individual to ensure that the most recent version of this document is being used. This can be checked on the intranet site policy section.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)289

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	12 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 Report	**Audit, Risk and Governance Committees-in-Common Highlight / Escalation Report – October 2026 - Public**
Executive Summary	The attached highlight / escalation report summarises the key matters presented to and discussed by the meeting of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting on 15 October 2026. The Trust Boards-in-Common are asked to: • Note the public highlight report from the October 2026 ARC CiC meeting and consider as necessary.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – 15 October 2026
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ✓ Other – please detail below: For noting and consideration as necessary

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Committees-in-Common Highlight / Escalation Report to the Trust Boards

	12 November 2026 – Public
	Audit, Risk and Governance Committees-in-Common
	15 October 2026
	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 15 October 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 External Auditor Routine Updates
- NLAG and HUTH External Auditor Recommendations – Status Updates – Finance & VFM
- NLAG & HUTH Annual Review of External Auditor Performance
- Group Internal Audit Progress Report 2026/27
- Annual Review of Group Internal Audit Service Performance
- Group LCFS Progress Report
- Group Annual LCFS Progress Report 2025/26
- IIP Progress Update (Governance Workstreams)
- Draft Accountability Framework
- Draft Group Board Assurance Framework
- Group Risk Register
- Governance re HHP MoU
- Draft Board Governance Manual
- Group Losses and Compensations Report
- Group Document Control Report
- Group Waiving of Standing Orders Report
- Proposed ARG CiC Workplan Revisions
- Highlight Reports and Action Logs from Board Sub-Committees-in-Common
- Group Data Protection & IG Report (Private item)
- External Audit Services – Proposed Procurement Exercise Timeline (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 TRUST BOARDS:

a) **Group Internal Audit Progress Report 2026/27** –
The ARG CiC received the Contract Management and Tender Waivers Internal Audit Report and noted the assurance rating of '*partial assurance with improvements required*'. The Committees endorsed the need for strict 'No Purchase Order / No Pay' enforcement by both Trusts. This report also linked to the routine Waiver report received by the Committees at the meeting, during which the Committees discussed improving the understanding of end users for formal procurement exercises and ensuring sufficient time is given to conducting such exercises.

- The ARG CiC noted that there were 21 Internal Audit actions outstanding and were frustrated at the lack of responses from management regarding the implementation status of some agreed actions. The ARG CiC will continue to push for Internal Audit actions to be implemented in line with agreed timescales, and request Trust officers to attend the ARG CiC meetings where this is not the case. In particular, the ARG CiC asked for further assurance with regards to the implementation of recommendations regarding the Mortuary Audit. The Pathology Operations Director attended the meeting and provided positive assurance that actions had been taken at HUTH. Further assurance was requested regarding the NLAG actions,

- KPMG provided national benchmarking data from their clients on the Cyber Assurance Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) results for 2025/26, which the ARG CiC had requested at the previous meeting, and found interesting. This data showed that both Trusts were performing below the benchmark in some of the areas (i.e. other organisations were more compliant with the DSPT requirements) with a slight difference between HUTH and NLAG. However, in terms of the most common types of issues (resilience recovery capabilities, ID controls, asset management, etc.) KPMG advised that neither Trust was an outlier. An NHSE approved action plan is being implemented through 2026/27 to improve the DSPT rating.

b) **HHP Memorandum of Understanding (MoU) Governance** – This was developed at the formation of the Group arrangement to set out the principles by which HHP would function. One of the workstreams within the transition programme relates to governance and legal requirements, and Trust legal advisors were advising on the principles in relation to this, including MoU timescales and interim decision rights.

c) **Group Document Control Report** – The ARC CiC were concerned with continuing out of date policy documents, particularly in relation to high-risk clinical policies which were significantly overdue their review dates (i.e. over a year out of date). The Committees asked for action to be taken on this and it was agreed to raise it at the next Group Executive Risk and Assurance Committee (GERAC) meeting as well as alert the Boards to this issue.

ITEMS TO ADVISE THE TRUST BOARDS ON:

a) **Audit Completion Certificate 2025/26 – NLAG & HUTH** – Audit Completion Certificates remain unissued until the National Audit Office (NAO) complete their work on the national Group accounts.

b) **Draft Board Assurance Framework (BAF)** – The Committees received the refreshed draft BAF, noting it had been mapped to a more traditional BAF template. The ARG CiC considered that it was an improvement and there was now a need for the Trust Boards to agree how it should be used at Trust Boards and in Committees for maximum effect.

c) **Draft Accountability Framework** – The draft Accountability Framework was received by the ARG CiC for comment, following discussion at the Group Executive Team meeting that week. Gaps in the draft document would be addressed and it would then be presented to the next meeting of the Trust Boards for approval. The ARG CiC were grateful to the Group Chief Delivery Officer for his work on this matter which could be used in both Trusts.

d) **Group Risk Register Report** – At the previous ARG CiC meeting it had been requested that the next Group Risk Register report include 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 the inclusion of this data and thanked those involved for providing this. In relation to the new age profile data, it highlighted 22 high level risks (scoring 15+) over four years old. The Committees discussed the appropriateness of some of these risks remaining on the register and asked that these be reviewed again by the Interim Board Secretary and the Associate Director of Quality Governance.

e) **Draft Board Governance Manuals HUTH & NLAG** – The ARG CiC were advised that these had been drafted with support from The Value Circle and were presented to the Committees for review and comment. It was anticipated that these would provide an early aid to both Trust Boards in considering their Board governance arrangements going forward as separate organisations. Work is also underway by the Interim Board Secretary to provide a draft Scheme of Delegation for each organisation.

f) **Losses, Compensations and Special Payments Report** – The Committees expressed concern at the significant pharmacy stock loss due to a fridge failure. Further details were awaited as to how this had occurred and actions being taken to prevent any further losses.

g) **ARG CiC Workplan Revisions** – a limited number of revisions were proposed to the existing ARG CiC workplan, and these were duly agreed.

ITEMS FOR ASSURANCE:

a) **Integrated Improvement Plan (IIP) Governance Stream Update** – The ARG CiC were assured by the report received, noting that lots of actions should be complete by the time of the next ARG CiC meeting in January 2027.

b) **External Audit Recommendations Action Plan Updates – NLAG and HUTH** – The Committees were assured by the progress reports on the implementation of the External Audit recommendations, both finance and VFM related, arising from the year end audit work for both Trusts.

c) **Annual Review of External Auditor Performance – NLAG and HUTH** – The ARG CiC received the annual performance review details and were assured that there were no concerns identified with the NLAG External Auditor. It was noted that some minor operational issues had been experienced during the HUTH year end audit, but a constructive de-brief session had been held between the Trust and the HUTH External Auditor to discuss and agree a way forward for the 2026/27 audit.

d) **Annual Review of Group Internal Auditor Performance** – The ARG CiC received the annual performance review details and were assured that overall it was a positive evaluation. Issues do however persist with the electronic action tracker operated by the Group Internal Auditor, and these are addressed where possible in liaison between the Group and the Internal Auditor.

e) **Group Local Counter Fraud Specialist (LCFS) Reports** – The Committees were assured by the routine progress report on counter fraud activity within the Group, and also the Annual LCFS Report received for 2025/26. It was noted that a new full time LCFS had recently commenced in post.

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 refreshed draft Board Assurance Framework (BAF) was received – see section 3.

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
15 October 2026

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26) 291

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	Thursday 12 November 2026
Director Lead	David Sulch, Committee Chair of Quality & Safety CiC
Contact Officer / Author	David Sulch, Committee Chair of Quality & Safety CiC
Title of Report	Quality & Safety Committees-in-Common Minutes - September 2026
Executive Summary	The Quality & Safety Committees-in-Common minutes from the meeting held on 24 September 2026
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees-in-Common held on 29 October 2026
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 24 September 2026 at 9.00am to 1.00pm via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

David Sulch	Group Non-Executive Director - Chair
Julie Beilby	Group Non-Executive Director
Jo Ledger	Interim Group Chief Nurse
Dr Peter Sedman	Group Deputy Chief Medical Officer

In Attendance:

Sam Peate	Group Chief Delivery Officer
Hilda Gwilliams	Group Chief Patient Safety Officer
Rebecca Crashley	Group Deputy Director of Assurance
Richard Dickinson	Associate Director of Quality Governance (NLaG)
Michela Littlewood	Associate Director of Quality Governance (HUTH)
Yvonne McGrath	Group Director of Midwifery
Dr Deborah Wearmouth	Consultant Microbiologist
Nicola Buckle	Senior Matron IPC
Michelle Lawtie	Senior Matron IPC
Michelle Drinkell	Lead Nurse – Projects
Debbie Bray	Nurse Director Paediatrics
Vicky Thersby	Head of Safeguarding
Ryan Sutton	Associate Director of Quality Improvement
Wendy Krstenic	Nurse Director Specialist Cancer and Support Services Management
Ian Reekie	Governor Observer
Jo Palmer (Minutes)	PA to the NLaG NEDs & Committees-in-Common

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NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

0.1 Patient Story

Wendy Krstenic presented a patient story relating to an end of life patient. The clinical lead and deputy nurse director had met with the patient's daughter and the main issues around the complaint were all too common, such as communication and pain management. The family felt that they had not been listened to whilst the patient was clearly deteriorating and there had been a delayed referral to the specialist palliative care team. It was acknowledged that interventions could have been made earlier to better support the patient and family.

Wendy Krstenic explained that there was a close working relationship in place with the complaints department to work through required actions following complaints. She spoke of the Advanced Communications course which had been running for many years but was expensive but she was pleased to advise that the Cancer Alliance had kindly sponsored six courses this year with further funding provided for next year. She also spoke of the Enhancing Therapeutic Communications course which had also been in place for some time and stressed that it was difficult to register all appropriate staff onto these courses when they were so limited. Unfortunately, there was no end of life training at HUTH and some bespoke training was being set up purely for the end of life nurses as well as some study days throughout the year for other staff, with the support of specialist palliative care, oncology and haematology consultants. Scenarios and complaints were actively worked through during these sessions. Feedback was positive and staff believed they lacked experience to be able to have a conversation with a patient or family and perhaps avoided a conversation for fear of saying something wrong. Wendy Krstenic also shared that newly qualified nurses were finding peer support very helpful in terms of lack of confidence and experience.

Jo Ledger added that actions around communication covered not only conversations with patients but also the clear communication of management plans with families and Michela Littlewood spoke of the learning from other organisations rated as “Good”, reaching out to families when there has been an early death brings comfort to families and can provide an early opportunity for questions to be answered.

David Sulch asked whether there had been any delays in seeing referred patients due to staffing constraints and Wendy Krstenic replied that she was not aware of any delays despite an increasing demand for the specialist palliative care service. Jo Ledger advised that she was due to meet with Sam Peate to look at capacity and demand for the service and noted that at HUTH, the team were dealing with work which could be dealt with by certain ward staff if they had had the appropriate training.

Hilda Gwilliams reminded colleagues of the importance of extracting the necessary learning from different themes and aligning it to the Integrated Improvement Plan (IIP). She was keen to emphasise the significant improvement made within the end of life service which had been recognised by the Care Quality Commission (CQC).

Wendy Krstenic left the meeting at this point.

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee Chair, David Sulch, welcomed those present to the meeting. No apologies were received.

1.2 Staff Charter & Values

The Chair reminded colleagues to be mindful of these throughout the course of the meeting.

1.3 Declarations of Interest

No declarations of interest were received in respect of any of the agenda items.

1.4 **To approve the minutes of the meeting held on 23 July 2026**

The minutes of the meeting held on 23 July 2026 were confirmed as a true and accurate record.

1.5 **Matters Arising**

The committee Chair invited committee members to raise any matters requiring discussion not captured on the agenda.

David Sulch was keen for an update on the floor replacement project at Hull Royal Infirmary (HRI) ED and the impact this may have had on ED performance. Sam Peate replied that the planned work had been completed and performance had been positive around the volume of patients being triaged into different places and the process had provided some key learning that was being worked through with the Yorkshire Ambulance Service (YAS) on patients coming in through Majors who could effectively be diverted through the emergency care assessment route. Additional work was planned for the next phase, including some replacement flooring of resuscitation areas and associated corridors but it would not lead to the same level of disruption. He reported that some of the Execs had spent some time in the department and there had been some positive feedback from staff on daily operations. Sam Peate added that throughout August and early September, the department had been under greater pressure than was usually expected at this time of year.

Michelle Lawtie joined the meeting at 9.16am

1.6 **Review of Action Tracker**

The following updates to the Action Tracker were noted:

Item 4.3 – 30 April 2026 – Jo Ledger confirmed that the Safer Staffing paper had been removed from the September 2026 Trust Board agenda and would be discussed at the Quality & Safety CiC in October 2026 first before discussion at Trust Board in November 2026.
Item 4.4b) – 30 April 2026 – David Sulch confirmed that he met with Yvonne McGrath on 23/9/26 and hopefully one of the new NLaG NEDs would be taking up the role of Maternity Safety Champion for NLaG. Action closed
Item 3.2a) – 25 June 2026 – Dr Peter Sedman reported that there was now a new Coroner who he had not yet had the opportunity to meet. Update to be provided at the October meeting.
Item 4.7 – 25 June 2026 – to remain on action tracker until evident that IPC has been scheduled into future Board Development sessions.
Item 4.1 – 25 June 2026 – Jo Ledger reported that data was being collated but there appeared to be no issues as all patients follow the same pathway. To be integrated into a Falls update which needs to be added to the workplan.
Items 01a) & 0.1b) – 23 July 2026 – actions closed.
Item 4.5a – 23 July 2026 – David Sulch to action.
Items 4.5b) and 4.5c) – 23 July 2026 - actions closed.
Item 4.6a) – 23 July 2026 - action closed

1.7 **Operational Pressures Update**

Sam Peate updated colleagues that the winter plan was being developed and a version brought to Trust Board in September 2026. There had been a recent regional winter deep dive session which he had attended with colleagues and had provided an opportunity to test plans and processes that were currently in place. On the North bank, there were further planned ward moves which would allow movement for the Medical SDEC expansion to take place December/January time. He also anticipated that the UTC at HRI provided by CHCP would move to a 24/7 service in the middle of October 2026. At NLaG, the acute emergency medicine team presented a briefing paper at SLT to enable discussion on a proposed change to flow models and ways of working with a view to establishing an emergency EMAC facility at both EDs to enable a more continuous flow model. He reported that the volume of 12-hour waits was excessive at both NLaG EDs and as little progress had been made, a change in process was needed and this was expected to go-live from 12 October 2026. Sam Peate also shared that national funding had been allocated for a UTC at DPoW and this was currently in the design phase and would enable improved streaming of patients into a dedicated facility. This was expected to go-live nearer the end of the current financial year.

In terms of the increased pressures referred to earlier in the meeting, he was pleased to share that key partners were working closely with the organisation, specifically East Riding local authority who were making some amendments to the discharge pathways and a meeting with the ICBs, NHSE and the Lincolnshire local authority was planned for the following week to discuss potential additional plans. He was pleased to announce that HUTH had made such good progress that it was the most improved Trust nationally and against a 12-hour standard in the last twelve months, albeit with more work clearly to be done.

In terms of elective care, a paper was being finalised for submission to Execs and ultimately Trust Board in October relating to the RTT. There had been a significant deterioration in the number of longest waiters specifically in some speciality areas, varying across the Group and the team were keen to demonstrate some options to improve this. Cancer performance was largely on plan, slightly ahead of plan at HUTH.

Jo Ledger advised colleagues that norovirus and Covid cases were already increasing, particularly on the North bank, with the South bank tending to be flu driven. She also added that new nurses and midwives had commenced this week in roles Group-wide.

Hilda Gwilliams referred to the previous meeting and David Sulch’s question about diagnostics and whether the CDCs were having a positive impact. Staffing was still proving to be a challenge, although some capital had been received for kits and so on. Sam Peate added that some progress had been seen in relation to the four new CDCs over the first part of the year and a briefing paper had been circulated as a Trust Board action relating to delivery against plan. For Scunthorpe and the East Riding community hospital, activity levels were increasing. Sam Peate also talked about spirometry testing, which was not currently being provided at any of the CDCs despite having been commissioned originally and discussions were ongoing with the contractor around this. MRI provision on the North bank featured a resource gap and options were being looked at to be able to close this.

Hilda Gwilliams also advised colleagues that a letter had been received from the ICB in terms of retinal screening and a possible gap in provision. Dr Peter Sedman added that the ICB appeared to want to commission the service with the organisation under normal commissioning principles, but it would be a £2m investment which the organisation was currently unable to commit to. He was pleased to advise that no clinical harm had been identified from not having such a programme.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

There were no matters referred.

3. RISK & ASSURANCE

3.1 Review of Relevant External & Internal Audit Report(s) & Recommendation(s)

There were no external or internal audit report & recommendations to note.

3.2 Review of Relevant External Reports, Recommendations & Assurances

There were no External Reports, Recommendations or Assurances to note.

3.3 IPC BAF Q1 & General Overview, including:

- **IPC Annual Report & Workplan**

  Dr Deborah Wearmouth shared a presentation relating to the annual DPSI report, reminding colleagues that the organisation was under scrutiny for infection control. Progress was being made to improve the service but there were still gaps and performance remained an issue across the Group. A significant amount of work had been done around governance aspects, with a good deal of investment, time and resources put into digital surveillance and the alignment of policies. The main concern was around hospital infections. Dr Wearmouth emphasised that the aim was for a clear plan in terms of action owners and measurable trajectories and explained that there was a significant amount of work undertaken relating to governance and the Board Assurance Framework (BAF). Progress was being made in relation to compliance, with no areas of non-compliance at HUTH and for NLaG, the gap was specifically around face fit testing.

  In relation to healthcare acquired infections, data around staph aureus highlighted that HUTH was an outlier from a regional perspective. C.diff was the main area of concern and the plan for this was a main part of the Integrated Improvement Plan (IIP). There had been a focus on learning, looking at themes and although individual cases could be complex, some of the infections could have been avoided. In terms of compliance with basic practice, this remained poor and recent PLACE reviews had demonstrated a deterioration in environmental equipment cleanliness.

  Dr Wearmouth pointed out that there was a lot of information in the report relating to outbreaks and operational impact and a significant amount of

work had been undertaken to understand the impact over the winter period. There was noted correlation between corridor care and outbreaks, and an ageing estate and ward layout were clearly contributing to the number of outbreaks. She acknowledged that these issues were more difficult to change so it was important to focus on areas that could be changed. She reassured colleagues that learning from previous outbreaks was being embedded into normal practice.

IV use at HUTH continued to remain too high, along with using more total antibiotics than the baseline but at NLaG less than the baseline were being used which needed action to reach the 70% level by 2029.

In relation to current performance for April to August 2026, unfortunately the C.diff position at HUTH had deteriorated although there was good progress relating to bacteremias. In early Spring, there was a significant number of C. diff cases around the same time as high norovirus activity. At NLaG, the thresholds for MRSA, C.diff and pseudomonas had already been exceeded. The high rate of C.diff was partly attributable to a gap in the laboratory testing policy which had now been fixed.

Dr Wearmouth added that there were currently fifteen open risks, eight of which were high and seven moderate. There was new national guidance relating to norovirus and a business case would be required to enable additional testing due to the recommendation that all symptomatic patients in hospital should be tested for norovirus. In terms of governance, policies and education, good progress was being made. Apart from one, all policies were up to date, competence-based training was being favoured as being more effective than mandatory training. There continued to be workforce challenges.

She asked the CiC that the improvement plan be managed through the IIP and to emphasise the IPC message from top level as a priority. There was potential for a non-executive director champion and the opportunity for a development session but added that there would no doubt be future requests for investment.

Jo Ledger acknowledged the huge amount of work undertaken by the team and spoke of the recent NHSE and ICB visit where it was agreed that IPC recommendations would feature within the IIP to be followed up through IQIG. They had recommended that there were a few more actions around AMS which could be included in the IIP and a focussed piece of work relating to roles and responsibilities of ward staff, charge nurse and clinical lead and this would be undertaken by the internal auditors and presented to the Execs.

Hilda Gwilliams thanked Dr Wearmouth for her excellent presentation and noted the triangulation between the data, required areas of focus and how it linked to the IIP, with a good focus on learning.

Dr Wearmouth also added that a gap analysis had been undertaken in relation to the IPC element of the CQC Section 29 and would be included within the IIP.

Julie Beilby also thanked Dr Wearmouth for her report and asked whether the funding for the ICNet IT system for NLaG had been provided and what the timescale was for go-live. Dr Wearmouth responded that it was hoped to be provided at the time of the new EPR, hopefully to be funded from the EPR budget and if this was not possible, a business case would be needed.

Julie Beilby also asked whether consequences were yet in place for those members of staff who repeatedly did not follow procedure. She also stressed to colleagues that Trust Board take IPC very seriously and whilst appreciating the usefulness of an IPC champion, she did not consider that now was the right time in light of the impending organisational change for NEDs to take on another champion role until the new NEDs had been onboarded and individual roles agreed. In terms of consequences, Dr Wearmouth agreed this was needed but with caution, ensuring staff had received the appropriate levels of support and documentation was thorough. Jo Ledger confirmed that a process had been agreed at SLT and she also acknowledged the current position regarding a safety champion and that this could be a future consideration. David Sulch considered this for discussion at Trust Board within a focussed IPC session.

Hilda Gwilliams referred to the work Sam Peate had undertaken on the Performance and Accountability framework which the CQC had concerns around and Sam Peate confirmed that this was in draft form to be submitted to Execs and then to the Audit, Risk & Governance CiC (ARG).

David Sulch praised the quality of the papers and the improved position within IPC, strong IPC leadership and improved compliance at ward level, although acknowledging infection rates were still rising which were possibly in relation to poor PLACE findings. Michelle Lawtie added that compliance was known to vary within self-assessments compared to audit and official observations.

David Sulch summarised that the CiC was impressed with the range of work being undertaken and the progress made but recognised the challenges in preventing patients contracting infections and was keen for Trust Board to continue being sighted on this.

The running order of the agenda was changed at this point to enable discussion of Item 4.3

COMMITTEE SPECIFIC BUSINESS ITEMS

4.

PATIENTS – SAFETY

Quality & Safety

Quality Priorities Q1

4.3

Jo Ledger advised colleagues that approval had been received in principle for the vascular access business case. She spoke of pilot wards across the Group having been chosen where testing of the education and strategies that have been worked

up could be undertaken, engaging with clinical and nursing teams to progress. She confirmed that all workstreams now had named leads and KPIs were being worked up

Hilda Gwilliams added that subject matter experts from clinical and nursing teams were now involved in all training sessions to ensure a high quality of training. At HUTH the SHMI had improved considerably but there was still a concern around sepsis, although this had improved by 5%, whereas at NLaG there had been no real movement therefore some focus and support was required. Dr Peter Sedman considered that the Group under reports compared to other benchmarked organisations in terms of timely reporting and recording.

Julie Beilby noted that the next Trust Board development session would relate to Digital and asked what the Digital priorities for safety were. Hilda Gwilliams responded that she would confer with Dr Sedman, Sam Peate and Jo Ledger and update both Julie Beilby and David Sulch in time for the development session on 10 October 2026.

ACTION: Hilda Gwilliams to forward details of the top Digital priorities for safety to David Sulch and Julie Beilby

Sam Peate considered if would be helpful for Kieran Baker, Group Chief Digital Officer, to revisit the original business case for the EPR rollout to look at the safety improvement measures indicated to confirm they were still appropriate.

David Sulch was concerned to note that sepsis continued to be an issue, despite being a Quality Priority for the last 3 years. Screening and medication rates were still slow. Hilda Gwilliams reminded colleagues that there were now Senior Responsible Officers (SROs) leading the workstreams who had the authority to escalate and manage issues themselves rather than rely on the IPC team. She did agree that Digital issues were a problem needing a resolution. Dr Wearmouth was disappointed to share that one of the sepsis education packages was no longer available and considered there was a resulting gap in the education of rotational and new staff. In terms of planning, there was a gap in relation to a sepsis lead which needed some discussion as the role could be fulfilled by a member of staff outside the IPC team, like other organisations.

Dr Wearmouth, Nicola Buckle and Michelle Lawtie left the meeting at 10.29am

Jo Ledger spoke a little on work around the prevention of deconditioning in terms of the pilot wards and KPIs being agreed as well as an observational audit on patients, families and staff. She added that some members of the team were due to attend a conference the following week to learn how other organisations were dealing with this workstream. David Sulch recognised that a rise in the number of falls may come as a result of this work to get patients out of bed.

In terms of insulin medication and patient safety, there had been a recent awareness week which had received some positive feedback, with pre and post audits being completed. Jo Ledger was pleased to share that there had been a 10% reduction in harms related to the prescription of insulin and work was underway to trial patient involvement in the administering of their own insulin.

In relation to safer surgery, Dr Peter Sedman reported that there had been two Never Events so far this year therefore it was imperative that focus on this continued. He stressed that the Group were doing the right things quickly and effectively and hoped that the impending restructure of the organisation would not lessen the focus.

Hilda Gwilliams added that there had been a recent presentation to Private Trust Board on how the organisation was tackling Never Events and she was pleased to report that there had been a significant improvement on last year in terms of an embedded programme of safety days and education within Theatres and Critical Care (TACC) which had been the main source of Never Events.

Richard Dickinson joined the meeting at 10.39am

David Sulch summarised that the CiC remained concerned about sepsis and the Group's limited progress in this area but were pleased to see an improved SHMI and good progress in terms of the remaining Quality Priorities.

The agenda resumed normal running order at 10.40am

4.1 **Integrated Performance Report (IPR): Quality & Safety Metrics**

Richard Dickinson confirmed that the new IPR was still in development following the CQC's recommendation after a well-led visit earlier in the year. There was some emphasis on finalising the dashboard element and working with the information services team on varying elements. Once completed, it would be shared with the appropriate staff members to ensure everything was correct and approved before presentation to the CiCs and Trust Board.

David Sulch asked that colleagues forward any comments on the current draft format directly to Richard Dickinson. Sam Peate shared that a meeting was scheduled for himself, Jo Ledger and Hilda Gwilliams to go through the draft with Richard Dickinson.

ACTION: Feedback on the format of the draft IPR to be forwarded to Richard Dickinson

Julie Beilby questioned why there was data relating to corridor care in ED when this had had to be phased out nationally by the end of July 2026 and Jo Ledger responded that unfortunately this would continue to occur until other work had been completed, mainy expansion of the estate. Sam Peate advised that there were two measures being reported on which were the volume of patients in temporary escalation spaces (TES) within ED and those in a non-ED area across the Group and reported that there had been no breaches in corridor care and the data Julie Beilby referred to was in relation to a number of patients at different times within ED that had been risk-assessed and staffed appropriately.

4.2 **Learning from Experience and Reviewing Never Events**

Hilda Gwilliams updated colleagues that reports had now been completed and feedback provided to families in terms of the historic patient safety cases with an

aim for no outstanding historical cases by December 2026. There had been improvement within the PALS service and a slight improvement in the number of complaints.

She was pleased to advise that Phase 1 of the Never Event Improvement Programme relating to theatres had been undertaken and work now centred around the implementation of Phase 2 which focussed on invasive procedures performed in several areas outside of theatre. She spoke of the national tool LocSSIPs and that this would be reviewed to enable improvement in the same way as within theatres. She also shared that there was a planned safety summit for October 2026 where the quality governance team would share the improvements made in theatres with representatives from the Care Groups.

She spoke of the most recent Never Event and that there had been an error in communicating details of the patient around shift change. It was clear there needed to be improvement in safety checks and the tools used to record data. She confirmed that consequences were in place with support provided around training. She also acknowledged that there had been an increase in harms over the previous few weeks and this appeared to be because of the impending organisation restructure and staff concerns so it was vital that work continued to ensure focus remained on the patient.

Yvonne McGrath and Michelle Drinkell joined the meeting at 10.55am

The running order of the agenda was amended at this point to enable discussion of Item 4.5

4.5 **Putting Patients First**

Michelle Drinkell reported that the pilot had been successful in its initial objectives and had been used on twenty-three inpatient wards. There was a strong framework in place with positive feedback from staff, noting a preference to an improvement journey model as opposed to the unannounced visit model used previously and also preferred by NHSE. A gap analysis had highlighted some issues which would be reviewed at the clinical governance steering group. As the project was not processed on an automatic system, this had been highlighted as an alert as there was no function to be able to identify themes and trends. Agreement had been provided at the Exec meeting to look at digital options and subsequently a bespoke digital option had been favoured with it being considered user-friendly on the wards, less time-consuming for the team and would provide the required oversight and assurance. Development was in progress and it was hoped training would commence in December 2026 and Michelle Drinkell reassured colleagues that any delays to the initiative would soon be recovered once the digital system was in use hopefully by January 2027. Wards had been asked to complete a self-assessment and improvement plans developed with action plans to work through towards accreditation.

Hilda Gwilliams thanked Michelle Drinkell for the report and reflected that this programme was the driver for quality and safety improvements at ward level. She added that accreditation had been added as a standard agenda item at the Care Group P&A meetings

Michela Littlewood acknowledged that the extraction of data for the Friends & Family Tests had been difficult and offered to provide details of the confirmed provider once available whose dashboards may be able to link in with the new digital system.

Julie Beilby was fully supportive of a move to a digital platform and asked who would be developing this. Michelle Drinkell responded to advise it was a company named Audit R who were designing a bespoke platform for accreditation and it had been agreed to have specific versions for ED, theatres, critical care and so on and had provided a similar system for another organisation which was proving beneficial.

The meeting paused at 11.10am for 10 minutes
The running order of the agenda was again amended to enable discussion of Item 4.6

4.6 **Maternity & Neonatal Assurance Report (including Ockenden, CNST, MIS, incidents/MNSI), including:**

Yvonne McGrath updated colleagues in terms of performance, workforce, safety, training and risks. In terms of workforce and staffing, there were ongoing concerns around scan and caesarean capacity, induction of labour, BSOTS compliance and the Maternity and Neonatal Voices Partnership (MNVP) function. She added that significant rota changes were being introduced at both Hull and NLAG sites to address safety and performance issues. She reported that August had been challenging for neonatal staffing with significant concerns around neonatal nursing levels, particularly at DPoW and advised that temporary measures were being explored to mitigate workforce shortages.

In terms of training compliance, maternity was generally good, but there were concerns about doctors not attending mandatory training. Non-attendance could adversely affect compliance scores, and escalation processes were being used where necessary.

Pre-term birth rates were improving, and some worsening trends were being monitored. Compliance continued across MIS elements, with assurance processes being developed to challenge and verify evidence. Yvonne McGrath advised that the organisation had been paired with Buckinghamshire Trust to undertake peer-review work around maternal care bundle elements. There had been no specific CQC actions reported.

She advised that key risks included compliance with Fuller Inquiry recommendations, baby abduction where mitigations were improving with the risk rating expected to reduce, mortuary and estates-related work arising from maternity recommendations, and staffing-related concerns raised through Freedom to Speak Up processes.

There was discussion around the low uptake of mandatory training and difficulties caused by the absence of a single partnership-wide job planning policy as opposed to the completion of job plans.

Debbie Bray joined the meeting at 11.33am

Julie Beilby questioned the level of staff engagement relating to the rota changes at HUTH and Yvonne McGrath reported that the staff there were happy with the proposal, however at DPoW, the draft rota had been re-presented to staff to ensure their safety and individual working pattern concerns had been addressed. Julie Beilby was disappointed that mandatory training was still proving to be an issue across all domains but was pleased to note that the Fuller recommendations were highlighted as a high risk with actions being taken.

David Sulch expressed strong concerns that staff arguing over job planning arrangements should not prevent compliance with mandatory patient-safety training, stating that this issue should be escalated to Board.

ACTION: Mandatory training compliance to be escalated to Trust Board

Hilda Gwilliams referred to an alert received from the RCOG in terms of the organisation being an outlier for maternity and perinatal audit status and reflected that a response had not been provided. Yvonne McGrath replied that she had only recently been made aware, but a response had now been made. It was agreed that the process for sending, receiving and responding to such alerts needed to be strengthened.

- **Maternity & Neonatal 10 Point Plan and Triage Submissions**

These were approved by the CiC.

Ryan Sutton joined the meeting at noon

Children & Young People Assurance Report

4.7 Deborah Bray highlighted workforce, service sustainability, duty of candour and patient experience issues across Children's Services. The first phase of a workforce gap analysis against national standards had been completed, and significant workforce gaps were reported in general paediatric inpatient staffing, clinical and shift leadership, children's community nursing and critical care staffing. Gaps were being mitigated through staffing arrangements and variable pay usage, but Deborah Bray noted that the greatest concern was the financial impact of maintaining safe staffing levels rather than evidence of direct patient harm. There was also a major concern relating to the Children's Hospital at Home service which was suspended in the DPoW area and SGH provision was low. Deborah Bray shared that a proposal was being developed to review and redesign children's ambulatory services across the South Bank.

Duty of candour compliance and oversight was improving but medical mandatory training compliance remained an issue.

Hilda Gwilliams commended the team for the improvement, noting that once duty of candour timeframes were missed they could not be recovered and thanked the team for its focus on compliance.

Julie Beilby referred to the cross system learning themes and pointed out that although North Lincolnshire was noted, Lincolnshire was not, despite the fact the Trust footprint does include Lincolnshire. This was a point made several times at previous meetings and was acknowledged by Deborah Bray.

Deborah Bray confirmed that a new Children & Young People's Assurance Group was being established, with the first meeting planned for 30 October 2026 and the Terms of Reference and attendance list were being developed.

Julie Beilby drew attention to poor sepsis compliance figures at NLAG. In response, Deborah Bray identified paediatric inpatient services at Grimsby as her main area of concern and explained that targeted improvement work was underway with additional support programmes in place and expected that improvements would be visualised before the next report.

The committee agreed this concern should be escalated to Trust Board alongside the other alert issues noted on the front sheet of the paper.

The running order of the agenda was amended to enable discussion of item 4.10

EQIA update

4.10 Ryan Sutton advised colleagues that the process had been reviewed against national guidance and updated as a result, subsequently having been approved by Execs. It was due for implementation over the next few weeks. Training and Development was in place. He alerted colleagues to the fact that EQIAs continued to be completed later than they should be and also the need to ensure there was a good balance between CIP related and non-CIP related EQIAs, as currently there were low numbers of the latter.

Julie Beilby asked that when quality improvement programmes were being undertaken, whether an EQIA should be completed as standard and Ryan Sutton confirmed that this should be the case.

Ryan Sutton left at 12.13pm

Safeguarding, including MCA & DOLS

4.11 Vicky Thersby spoke of the Attorney General Northern Island's Supreme Court ruling and changes related to the Deprivation of Liberty, placing greater emphasis on robust mental capacity assessments, best interest decision making, restraint documentation and care planning. In response, an implementation plan was being developed, including policy reviews, governance reviews, new assessment and documentation processes, along with staff training and communications. However, the Trust was still awaiting updated Department of Health guidance and training materials before full implementation could proceed. Vicky Thersby shared that an updated paper would be presented to the Safeguarding Board in October 2026.

In terms of workforce capacity, there were pressures including recruitment challenges, though there was some progress in terms of recruiting to the safeguarding vacancies in September 2026. In relation to the named nurse for safeguarding children on the South bank, there was a plan for succession planning and in terms of the North bank, this would either be on a two day per week Band 6 basis or to go for advertisement. A longer-term workforce strategy over the next six to eighteen months was required to prevent any gaps.

Training and supervision compliance was being monitored through the Safeguarding Board.

Joanne Ledger added that CPD funding was being used to provide development opportunities, including secondments and experience within safeguarding teams to support future succession planning.

Hilda Gwilliams asked whether a gap analysis had been undertaken around the safeguarding elements highlighted within the Fuller Inquiry and the escalation in terms of raising safety concerns. There were national processes that organisations should be following and Vicky Thersby agreed to review this. She also reassured the committee that safeguarding concerns involving staff were escalated immediately and received executive oversight.

ACTION: Vicky Thersby to undertake a gap analysis in relation to the escalation process when raising safety concerns

Julie Beilby commented on the continuing issue of mandatory training, but also regarding the size of the workforce within the safeguarding team as well as specialist nurses. She asked whether there was another Trust that could be contacted via the ICB in terms of looking at what had been undertaken in terms of the new guidance. Vicky Thersby replied that the team were linked in with MCA DOLS leads within local authorities but would ask that other NHS Trusts were contacted also.

In terms of clinical holding and restrictive practice, Julie Beilby asked for clarification on whether it needed to be recorded on the South bank Risk Register as well as the North bank Risk Register. Vicky Thersby advised there were no similar concerns on the South bank. Jo Ledger added that restraint training should be considered more broadly because of its specialist nature and relevance across both organisations and would pick this up with Vicky Thersby.

Julie Beilby was also concerned that the Homeless Health service was potentially ending considering the vulnerability of the people it was supporting and asked whether there was a way to link in with the provider and showcase its benefits. Vicky Thersby replied that she would need to speak with Rachel Kemp, Deputy Director Community Collaborative, as it was outside the safeguarding remit. She believed it was an ICB-led commission and Sam Peate clarified it was commissioned currently by Hull City Council and provided by Modality and the Group had been approached to take over service provision as part of transfer of care. A business case had recently progressed through the business case review group to continue to support the service but the funding to be provided by Hull City Council. Work was underway to ensure the service could continue rather than cease.
Julie Beilby also asked whether safeguarding policies have been upgraded in light of the Fuller Inquiry regarding deceased patients and Vicky Thersby responded that this was on the workplan to do.

David Sulch expressed concern that patients who would previously have met DoLS criteria may no longer meet the new threshold, potentially creating risks if patients left hospital without appropriate safeguards. Victoria Thersby explained that the new test required consideration of the person's overall circumstances, restrictions, duration and compliance, rather than relying on the previous "acid test" approach.

The committee agreed that this issue should be escalated to Trust Board, along with the implications of the AGNI ruling and changes to deprivation of liberty arrangements, ongoing safeguarding workforce and succession-planning pressures, training and supervision compliance, restrictive practice and specialist restraint training requirements as well as learning arising from the Fuller Inquiry review.

Vicky Thersby left the meeting at 12.27pm

The meeting agenda reverted to discussion of Item 4.4

CQC Improvement Plan

4.4 Hilda Gwilliams confirmed that the gap analysis had been completed in terms of the CQC Section 29A and gaps assigned to each of the domains within the IIP. Improvements were noted across all sites from 2023 to 2026. She had had a meeting with CQC representatives who suggested they meet with the Chair and CEO regarding the recent decision on the organisational structure and she also shared that the well-led reports were drafted and should be available by mid-October 2026.

Quarterly Quality Theme Triangulation, Learning and Improvement Report Q1 (including Patient Safety themes and analysis, including PSII, PSIRF and legal)

4.8 Hilda Gwilliams introduced the item noting that it would be an evolving report, improving the triangulation of themes across the sources of legal, incidents, complaints and PALS. Richard Dickinson asked for feedback and noted it was important to look at what was common across both Trusts as well as what was individual to each Trust.

Julie Beilby asked that, for future consideration, the conclusion could be more In line with an Executive summary and considered it would also be helpful to have shared Group priorities and the themes separately as currently the structure remained as is and there would be some element of collaboration in some areas.

David Sulch felt that there appeared to be many themes and priorities across many different areas but that they did align quite well in the governance framework.

Hilda Gwilliams asked that the CQC Section 29A warning notices that had been discussed at the CiC and at Trust Board be part of a focussed discussion at the October 2026 meeting.

ACTION: CQC Section 29A notice to be featured as an agenda item on the October 2026 agenda

Learning from Deaths Quarterly Report

4.9 Dr Peter Sedman advised colleagues that overall, the SHMI and HMSR scores were positive for all hospital sites. He was pleased to report there was a healthy culture and a good number of SJRs reported. Since the appointment of a deputy Medical Examiner on the North bank, the rate of SJRs and their timeliness had also increased. He advised that there had been two Regulation 28s in the reported quarter, relating to sepsis and a fall, both on the North bank.

David Sulch reflected on how UTCs tend to respond to people who may have sepsis and how they are able to deal with them but also important to recognise that not all healthcare providers are set up to implement sepsis screening and may need to send patients elsewhere.

Patient Experience

Patient Experience Report Q1 (including learning from complaints)

Michela Littlewood reported on an improved position and updated that some planned pieces of work would now not go ahead due to the pending restructure. The Value Circle (TVC) would be undertaking some value and demand work with her in terms of staffing within her team. She reflected that the Perfect Week initiative held in August 2026 had possibly made the greatest difference with HUTH
4.12 PALS. An EQIA and business case would also be developed.

The CiC agreed to take the paper as read.

Clinical Effectiveness Report Q1 (including clinical audit, NICE compliance & deviations, PROMS etc)

This paper was taken as read.

HIGHLIGHT REPORTS

4.13 **Patient Safety & Learning Group**

This was noted by the CiC.

Patient Experience Learning Group

5.

This was noted by the CiC.

5.1

Safeguarding

This was noted by the CiC.

5.2

Maternity & Neonatal Assurance Group

This was noted by the CiC.

5.3

Risk & Compliance

This was noted by the CiC.

5.4

ITEMS FOR INFORMATION

Planned Care Board Minutes

5.5

These were noted by the CiC.

Unplanned Care Board Minutes

6.

These were noted by the CiC.

6.1

ANY OTHER BUSINESS

Any Other Urgent Business

There was no other urgent business.

MATTERS TO BE REFERRED BY THE COMMITTEES

7.

Matters to be referred to other Board Committees

7.1

8.

8.1

There were no matters to be referred to other Board Committees.

8.2 **Matters to be escalated to the Trust Boards including any proposed changes to the BAFs**

The following items would be escalated to Trust Board:

Alert

- IPC Annual Report and current position
- Quality Priorities, specifically around Sepsis and Safer Surgery
- Learning from Deaths
- Never Events
- LocSSIP Phase 2 implementation
- Maternity & Neonatal – training engagement, job planning, 10 Point Plan submission approval
- Children & Young People – compliance and training engagement from the medics
- Safeguarding – compliance and training engagement from the medics
- CQC Section 29A gap analysis completed and linked to the IIP. Well-led reports expected mid-October 2026
- Learning from Deaths, Regulation 28, overall SHMI scores were positive

The CiC wished to highlight that engagement in training continues to be an issue across several areas including maternity & neonatal, safeguarding, Children & Young People.

Advise

- IPR – work ongoing

- Quarterly Quality Theme Triangulation – incidents, legal, complaints and PALS had some Group-wide themes noted, enabling some key learning points and which were linked to the IIP

Assure

Putting Patients First

Julie Beilby shared that at the recent Workforce, Education & Culture (WEC) meeting, it had been agreed to escalate to Trust Board the issue of having the WEC and Quality & Safety CiCs on consecutive days, considering the amount of papers to be read and the problem of late papers and the opportunity to read them all in good time.

9.

DATE OF THE NEXT MEETING

9.1

The next meeting of the Quality & Safety Committees-in-Common will be held on Thursday 29 October 2026 at 9.00am-1.00pm via MS Teams

The Chair closed the meeting at 12.50pm.

Cumulative Record of Attendance at the Quality & Safety Committees-in-Common 2026/2027

Name	Title	2026 / 2027											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

CORE MEMBERS													
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	Y		Y						
Julie Beilby	Non-Executive Director (NLaG)	Y	Y	Y	Y		Y						
Dr Kate Wood	Group Chief Medical Officer	D	D	N	D								
Jo Ledger	Interim Group Chief Nurse	Y	D	Y	Y		Y						
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	N	N	N								
Rebecca Crashley	Group Deputy Director of Assurance	Y	Y	Y	Y		Y						
Yvonne McGrath	Group Director of Midwifery	Y	Y	Y	Y		Y						
Sam Peate	Group Chief Delivery Officer	Y	D	Y	Y		Y						
Hilda Gwilliams	Group Chief Patient Safety Officer	Y	Y	N	N		Y						
Michela Littlewood	Associate Director of Quality Governance (HUTH)	N	Y	N	Y		Y						
Richard Dickinson	Associate Director of Quality Governance (NLaG)	Y	Y	Y	Y		Y						
Kevin Allen/ Corinn Manaley/Ian Reekie	Governor Observer	Y	Y	Y	Y		Y						
OTHER BOARD ATTENDEES													
Murray MacDonald	Interim Group Chairman	N	N	N	N		N						

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)292

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Tuesday 12th November 2026**
Director Lead	Murray Macdonald, Vice Chair & Chair Performance, Estates and Finance Committees-in-Common
Contact Officer / Author	Lauren Rowbottom, Personal Assistant
Title of Report	Minutes from the Performance, Estates and Finance Committees-in-Common held on 29th September 2026
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	The minutes attached are for information.
Prior Approval Process	Minutes from the Performance, Estates and Finance Committees-in-Common held on the 3rd November 2026.
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 29th September 2026 at 09:00 to 12:30 hours via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Murray Macdonald	Vice-Chair - Chair
Julie Beilby	Non-Executive Director (NLaG)
Emma Sayner	Group Chief Financial Officer
Imran Devji	Programme Director
Sam Peate	Group Chief Operating Officer

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Lauren Rowbottom	Personal Assistant (Minute Taker)
Philippa Russell	Deputy Group Chief Financial Officer
Tom Myers	Group Director of Estates, Facilities and Development
Alastair Pickering	Interim Group Chief Digital Officer (Item 4.1)
Rob Stones	Group Director of Planning and Performance
Helen Knowles	Director of People Services (item 4.10)
Sarah Todd	Group Head of Rostering, Temp. Staffing & Medical Management (item 4.10)
Ryan Sutton	Associate Director of Quality Improvement (Item 4.8)

Observers

Ian Reekie	Public Governor (NLaG)
Jo Gander	Non-Executive Director (NLaG)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Murray Macdonald, welcomed those present to the meeting. Apologies

for absence were noted for Peter Sedman, Interim Chief Medical Officer, and Jane Hawkard, Non-Executive Director (HUTH).

1.2 Staff Charter and Values

Murray Macdonald noted the Staff Charter and Group Values and reminded everyone to follow and live these throughout the meeting. He welcomed Jo Gander, Non-Executive Director (NLaG) and Rob Stones, Group Director of Planning and Performance, to the meeting.

1.3 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.4 To approve the minutes of the meeting held on 1st September 2026.

The minutes of the meeting and private meeting held on 01st September 2026, were accepted as a true and accurate record.

1.5 Matters Arising

No matters arising.

1.6 Committees-in-Common Action Tracker

Updates to the Action Tracker were provided within the agenda items.

MATTERS REFERRED

2

2.1 Matters referred by the Trust Board(s) or other Board Committees

None to note.

3. RISK & ASSURANCE

3.1 Board Assurance Framework / Risk Register Report (including estates risks)

Rebecca Crashley reported that development of the Board Assurance Framework (BAF) was nearing completion. A draft framework, including initial risk scores, was being finalised by Executive's and would be presented to the Audit, Risk and Governance Committee-In-Common on the 15th October. It was anticipated that the BAF would be available for consideration at the next meeting.

Murray Macdonald noted that, until the new BAF was agreed, the CiC would continue to identify and consider emerging risks rather than assess individual reports against the BAF. He highlighted that the decision to begin the process of separating the two organisations was likely to create additional uncertainty and risk across several areas.

3.2 Review of Relevant Internal & External Audit Report(s), Recommendation(s) & Assurances as appropriate

None to note.

3.3 Review of Relevant External Report(s), Recommendation(s) & Assurances as appropriate

None to note.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 RTT Deep Dive

Imran Devji highlighted the ongoing challenges with Referral to Treatment (RTT) performance. He reported that waiting lists continued to grow across both Trusts and that 18-week performance was materially below plan. He emphasised the need for closer alignment between planned activity and expected performance, with this to be strengthened through the planning process to ensure future plans were realistic and progress could be effectively monitored.

Imran Devji highlighted that RTT recovery needed to consider both financial and workforce pressures. He reported that demand continued to grow and, although overall clock stops had reduced, there remained significant variation between specialties. He advised that detailed analysis was underway to identify the areas requiring greatest focus. A recovery proposal had also been developed for consideration by the Board, with particular focus on reducing long waits and achieving the target of no more than 1% of patients waiting over 52 weeks by March 2027. Some specialties also had waits of over 40 weeks for a first appointment, which would form part of the recovery work.

Imran Devji explained that the RTT recovery approach would focus both on clearing the existing backlog and preventing patients approaching 52 weeks from becoming long waiters. He highlighted the need to address delays earlier in pathways, particularly first appointments and diagnostics, as these were contributing to longer overall waits.

Rob Stones presented the detailed RTT analysis, focusing on the overall waiting list, 18-week performance and long waits. He reported that the waiting list was at its highest level across the Partnership, with 18-week performance expected to fall behind plan and patients waiting over 52 weeks accounting for almost 4% of the waiting list.

He advised that validation work was ongoing to improve the accuracy of waiting lists, supported by automated tools to identify issues such as potential duplicate pathways.

Rob Stones highlighted that demand continued to exceed the number of patients being removed from waiting lists in some areas, with significant variation between specialties. He noted that better alignment between demand and available capacity would be central to improving RTT performance.

Rob Stones reported that 18-week RTT performance remained well below the 92% constitutional standard, with the improvement expected within the annual plan not yet being achieved. He highlighted an opportunity to make better use of existing outpatient activity to support RTT recovery. At HUTH, around 20,000 additional outpatient appointments had been delivered year to date, but this had not resulted in a corresponding increase in patients being removed from the RTT waiting list. Further work was underway to understand how more outpatient capacity could be directed towards RTT patients and improve performance.

Rob Stones highlighted continued deterioration in long waits across both Trusts, particularly for patients waiting over 52 and 65 weeks. He noted that 65-week waits were concentrated in specific specialties, particularly plastics at HUTH and gastroenterology and endocrinology at NLaG, with targeted work underway in these areas.

He also raised concerns about whether patients were consistently being treated in chronological order, subject to clinical priority. Further analysis would be undertaken to ensure that longer-waiting patients were appropriately prioritised and that shorter waits were not being treated ahead of them without a clinical reason.

Imran Devji outlined the RTT recovery plan for the remainder of 2026/27. He reported that specialty-level reviews would focus on the whole patient pathway, including referrals, first appointments, diagnostics, long waits and follow-up activity. He emphasised the need for stronger operational control and clear accountability across Care Groups, supported by clinical leadership. Each specialty would have clear activity and performance expectations, with progress monitored regularly.

Imran Devji advised that the recovery approach would focus on reducing the overall waiting list, improving 18-week performance and reducing 52-week waits, while ensuring clinical prioritisation and patient safety remained central. The aim was to achieve a sustainable position by March 2027 and move into business-as-usual arrangements from April.

Murray Macdonald thanked Imran Devji and Rob Stones for the detailed analysis and asked whether Care Group teams had sufficient capacity to manage the range of improvement priorities and performance requirements.

Imran Devji acknowledged the concern and reported that existing arrangements had been reviewed. Separate RTT and diagnostic meetings had been replaced with combined Care Group performance meetings to reduce duplication, improve focus and avoid conflicting priorities. He advised that the recovery plan would

reflect significant capacity pressures, including a 35% workforce gap at NLaG and an estimated shortage of 55,000 first-appointment slots across both Trusts. The recovery proposal would be presented to the Board to support realistic performance expectations and strengthen leadership, accountability and delivery.

Rob Stones agreed that elective recovery was a key organisational priority, but recognised the significant demands already placed on Care Group teams. He emphasised the importance of providing teams with clear priorities, reliable data and appropriate tools, while creating sufficient capacity for them to focus on the areas requiring greatest improvement.

Julie Beilby asked about the timescale for improving clinical engagement and the main barriers to delivering the RTT recovery plan. Imran Devji reported that clinical engagement had started across both Trusts, supported by clinical and workforce leaders. He identified workforce shortages, pathway redesign and engagement with clinicians and primary care as key challenges. He emphasised that clinicians needed to be involved in developing the recovery approach and acknowledged that this would require careful management. Julie Beilby highlighted the urgency of achieving in-year recovery. Imran Devji agreed and advised that the recovery proposal being presented to the Board would be critical, as further delays would increase the number of patients waiting for treatment.

Jo Gander asked whether additional support was available to address the workforce gap at NLAG, noting that staffing capacity would affect delivery of the recovery plan. Imran Devji agreed that this was a significant risk. He advised that short-term options, including safe insourcing, would need to be considered to support in-year recovery, while longer-term workforce planning was being developed for 2027/28. He noted that workforce pressures affected performance, quality and safety and would require continued oversight.

Sam Peate highlighted that the planned activity levels across both Trusts had not been sufficient to deliver the performance trajectories agreed at the start of the year. He emphasised the importance of ensuring future plans accurately reflected demand, capacity and gaps within individual specialties.

4.2 Operational Planning Process 2027/28

Imran Devji introduced the operational planning update and advised that lessons from the current year's recovery work would inform a different approach to planning for 2027/28. He reported that detailed demand and capacity modelling had been completed for outpatient and admitted activity, identifying variations at Trust, specialty and sub-specialty level. Similar work for diagnostics would be refreshed, with the longer-term aim of having demand and capacity plans across all patient-facing services.

Imran Devji advised that future plans would bring together quality and safety, workforce, operational performance and finance, ensuring that commitments were realistic and deliverable. Clear criteria were also being developed to support investment decisions, taking account of regulatory requirements, constitutional

standards, patient impact and available funding. He emphasised the importance of working with the ICB and NHS England to ensure plans were aligned across the wider system, with clear governance and performance expectations.

Rob Stones reported that demand and capacity modelling would be central to developing realistic plans for 2027/28. He noted some staffing pressures within the planning team but was confident that the team had the capability to support the work. He emphasised that future plans needed to balance activity, workforce and finance while remaining both achievable and sufficiently ambitious to improve performance. Rob Stones advised that updated national planning guidance was expected around the end of October or early November but confirmed that internal planning work would continue in advance of this.

Murray Macdonald emphasised that future operational plans needed to be developed from specialty and site level, reflecting actual capacity and capability rather than relying solely on national benchmarks or modelling. He noted that this was particularly important given the proposed separation of the two organisations, as each Board would need to understand and take ownership of its respective plan.

Murray Macdonald also stressed that Boards, clinical leaders and operational teams needed to be involved much earlier in the planning process. He highlighted that difficult choices between financial and performance priorities were likely to be required and that early involvement would ensure plans were collectively understood, owned and supported, while protecting quality and patient safety.

Julie Beilby supported the proposed approach and welcomed the focus on demand and capacity planning. She emphasised the importance of linking this work with consultant job planning to ensure workforce capacity aligned with future activity requirements. She also highlighted the need to ensure the Committee timetable supported the planning process and suggested that an additional Workforce and Education CiC meeting should be arranged if required to avoid delaying key decisions.

Jo Gander agreed that clinical support would be essential to delivering a challenging recovery plan. She highlighted the financial pressures and questioned whether existing resources could be redirected or services delivered differently, rather than relying solely on additional investment. She noted that involving clinicians in redesigning services and agreeing how resources were used could also help strengthen clinical engagement and ownership of the recovery plan.

Imran Devji agreed that strong clinical engagement was central to the recovery approach and advised that further face-to-face engagement with clinicians across both Trusts would support ownership of the changes required. He noted that clinical prioritisation was taking place, but further work was needed to strengthen the management of patients according to how long they had waited and to ensure consistent application of the clinical harm and access policies. He emphasised that reducing long waits was not simply a performance target but was important for patient experience and outcomes.

Murray Macdonald noted the discussion and confirmed that the CiC approved the proposed approach, subject to the suggestions raised during the discussion.

4.3 Group Performance Report

Imran Devji provided an update on urgent and emergency care, diagnostics and cancer performance. He reported that urgent and emergency care performance remained relatively static across both Trusts, with four-hour performance reducing by 1.2% in August. However, 12-hour waits at HUTH had improved significantly compared with previous years.

He highlighted the planned rollout of the continuous flow model at NLAG in October, alongside the recently introduced frailty Same Day Emergency Care service at HUTH. He emphasised that clinical engagement, internal professional standards and ownership would be important to successful implementation.

On diagnostics, Imran Devji reported that around 37% of patients were waiting more than six weeks, which remained significantly below the required position. He highlighted the importance of maximising Community Diagnostic Centre capacity and integrating diagnostics more closely with elective care pathways.

For cancer, he reported that 62-day performance at HUTH remained static but on plan, while 31-day first treatment performance had improved. The 28-day Faster Diagnosis Standard had also improved, with confidence that the required standard could be achieved during the year. A cancer recovery expert was joining the team to support further improvement.

Overall, Imran Devji emphasised the need for greater consistency across both Trusts and continued system working, particularly ahead of winter.

Julie Beilby highlighted the importance of clinical engagement in implementing the continuous flow model on the South Bank, particularly the associated red lines and Internal Professional Standards. She noted that the CiC would welcome evidence of improved engagement and implementation. Imran Devji agreed that further clinical engagement was required and advised that this needed to begin urgently. He emphasised the importance of working directly with clinical colleagues to build support and ownership of the changes required.

Jo Gander asked whether there were any capacity constraints that could limit use of the Community Diagnostic Centres (CDCs). Imran Devji reported that the main constraint was not equipment, but the revenue and workforce required to operate the four CDCs effectively. He advised that staffing pressures on acute sites had resulted in CDC staff being redeployed, limiting capacity and contributing to performance pressures.

Imran Devji advised that the original business cases and funding arrangements were being reviewed to establish the baseline position and identify any gaps. He noted that CDC income was approximately £1.8 million behind plan and

emphasised that the CDCs needed to operate as core services, with staff redeployment occurring only in exceptional circumstances.

Murray Macdonald noted that workforce capacity remained a recurring concern, particularly the ability to recruit to the significant number of vacant permanent posts. He confirmed that the key performance alerts to the Board remained urgent and emergency care, cancer, diagnostics and RTT, as constitutional standards continued to be missed. While improvements were evident in some areas, performance remained inconsistent and had fluctuated over the previous 12 months.

The CiC agreed that the Board should continue to be alerted to these areas until sustained improvement was demonstrated.

The agenda was taken out of order from this point

4.5 Directorate of Estates, Facilities and Development Update: including HRI Tower Block Update

Tom Myers introduced the Estates and Facilities report and highlighted workforce pressures, with vacancy levels higher than usual and around 25% of Estates posts at Scunthorpe vacant. He advised that this had affected reactive and planned maintenance performance. Recruitment was progressing following recent approvals, although delays had resulted in the Estates team missing its usual apprentice intake for the year. He also highlighted the ageing workforce profile, with 42% of Estates staff aged over 55 and 52% aged over 50, reinforcing the importance of apprenticeships and workforce succession planning.

Tom Myers reported that AccessAble was undertaking accessibility surveys across the main hospital sites to assess compliance with the Equality Act and develop accessible guides. Surveys had been completed at Hull, Castle Hill, Goole and Grimsby, with Scunthorpe due for completion by 16 November. Initial findings had identified 293 areas for consideration, which would be reviewed and developed into an action plan through existing governance arrangements.

Tom Myers reported that installation of the new Scunthorpe Energy Centre was progressing well, with the gas boilers expected to become operational in October. The electric boilers had been delayed following damage to equipment during delivery. Wider energy efficiency works, including solar panels and roof insulation, were also progressing.

He also reported concerns relating to staff accommodation at Scunthorpe following issues raised by the local authority, including fire safety, mould and cleanliness. These were being addressed with the Council.

Tom Myers advised that a fire had occurred in an individual flat. Fire safety arrangements had operated as expected and the incident had not spread, with the

investigation into the cause ongoing.

Tom Myers reported that significant water leaks at Castle Hill had resulted in a Section 75 notice from Yorkshire Water. The leaks had been addressed, reducing water usage and allowing the notice to be removed. However, ongoing water infrastructure issues remained at the site and additional monitoring and metering were being introduced.

He advised that 65 high-priority actions remained outstanding following independent Authorising Engineer reviews, including 32 relating to mechanical and pressure systems and 23 to medical gases. Many related to documentation and assurance requirements and were being addressed through existing governance arrangements, with progress to be reported monthly.

Tom Myers also confirmed that flooring works within Hull Royal Infirmary Emergency Department had been completed.

Tom Myers reported significant sickness absence within the decontamination service, which had transferred to Estates and Facilities in May 2026. Business continuity arrangements, including support from other Trusts, had been used where required, with no impact on clinical services.

On capital, Tom Myers reported forecast slippage of £7.4 million at HUTH and £3.1 million at NLAG, largely due to delays affecting the Lansdowne Block and SDEC schemes. Mitigations included bringing forward other projects and equipment purchases, and the position remained manageable. A further £2 million risk remained relating to funding for the Hull Royal Infirmary Tower Block, with a decision expected in October.

Tom Myers also reported that the car parking and security contract had been approved, although a late challenge had been received and legal advice was being sought. The Group fleet service tender had been evaluated, with appointment of a single provider across both Trusts planned.

Work was also underway to improve use of the estate through occupancy monitoring, with early improvements identified at Scunthorpe. Preparations had also commenced for the future handback of PFI contracts.

Jo Gander asked whether the ageing Estates workforce, combined with older estate infrastructure, created difficulties in recruiting and training new staff. She also asked whether stronger links with local colleges could support future recruitment through apprenticeships. Tom Myers confirmed that the age and complexity of some estate systems required additional training for new staff, making apprenticeships particularly valuable. He noted that the ageing workforce was a wider NHS Estates challenge and that work was underway nationally to strengthen apprenticeships and attract younger people into the profession.

Tom Myers advised that links with local colleges and careers events were already in place but agreed to consider whether more specific Estates partnerships could be developed. He also noted that vacancy controls had delayed progression of existing apprentices and resulted in the Estates team missing its usual apprentice intake for the current year.

Murray Macdonald welcomed the accessibility work and highlighted the importance of involving Governors and volunteers, who regularly supported patients and visitors with navigating hospital sites. Tom Myers advised that separate digital wayfinding work was also underway to support patients and visitors.

Murray Macdonald asked whether Estates vacancies and vacancy controls required escalation to the Board. Tom Myers advised that, although these had caused operational pressures, they did not currently require a Board-level alert. He noted that recent progress through vacancy controls and revised approval arrangements should help address key vacancies.

4.5.1 Access Able Report following Accessibility Survey

Update captured within item 4.5.

4.6 Security Annual Report

Tom Myers presented the security update and reported an increase in reported incidents across both Trusts during the previous year. At HUTH, incidents had increased by 13.4% to 3,326, while NLAG had recorded 674 incidents, an increase of around 17%. He noted that NLAG had nevertheless seen reductions in key categories including physical assaults, verbal abuse, absconding and disruptive behavior.

At HUTH, violent and aggressive incidents had increased significantly, although it remained unclear how much of this reflected improved reporting and the change in incident reporting systems. Hull Royal Infirmary remained the main area of concern. Work with Hull City Council and Humberside Police, including extending the Public Space Protection Order, had helped reduce antisocial behavior around the hospital entrance.

Tom Myers also highlighted recent concerns regarding disruptive incidents within the Emergency Department involving young people with mental health and substance misuse needs. Discussions were underway with Humber Teaching NHS Foundation Trust regarding possible investment to strengthen mental health provision.

He advised that learning from NLAG's CCTV arrangements would inform planned

improvements to camera coverage at HUTH.

Tom Myers also updated the CiC on preparations for Martyn's Law, advising that a working group had been established and an emergency preparedness exercise involving over 50 colleagues had been undertaken. Further work included strengthening lockdown procedures while national NHS guidance was awaited.

Murray Macdonald highlighted the significant increase in security incidents involving aggression and violence and raised concern about the impact this could have on staff. Julie Beilby confirmed that these issues were being considered through the workforce agenda, including the organisation's zero-tolerance approach. She noted that existing targets relating to violence and aggression were being revisited to ensure they better reflected the zero-tolerance position.

4.4 Digital Update including Key Cyber and Risks and EPR Programme Update

Alastair Pickering provided an update on the Electronic Patient Record (EPR) programme. He advised that the supplier had provided a more detailed assessment of current functionality and future development requirements. A detailed impact assessment was underway to understand the implications for clinical services, patients, expected productivity benefits, programme costs, existing systems and cyber resilience. The proposed way forward would be considered at the Board development session on 9th October.

Alastair Pickering also reported a recent cyber incident affecting the public-facing website. He confirmed that there had been no impact on internal clinical systems, no breach of the internal network and no known access to patient or personal data. Relevant cyber, Information Governance and external teams were managing the incident.

He also outlined the digital implications of the proposed separation of the two Trusts. Work was underway to identify critical decisions relating to shared digital infrastructure and systems, including server infrastructure, data warehousing and other Group-wide solutions. Alastair Pickering emphasised that decisions would prioritise patient safety and service continuity, while avoiding irreversible commitments that could restrict either Trust's ability to operate independently in future.

Murray Macdonald highlighted that Digital was facing significant strategic decisions arising from the proposed separation of the two Trusts, particularly around future investment and shared infrastructure. He welcomed the principles outlined to maintain patient safety and service continuity but recognised that some decisions could not be delayed.

Alastair Pickering advised that the October Board development session would focus primarily on the EPR, while also identifying the wider key digital risks arising from the proposed separation.

Murray Macdonald proposed that the need for strategic decisions on future digital arrangements should be escalated to the Board, recognising that these decisions required Board-level direction informed by professional advice.
Julie Beilby agreed that decisions on the future Group digital model required Board involvement and suggested that key decisions should be mapped against critical timescales. She noted that similar issues applied to Estates and considered Digital and Estates to be immediate areas requiring clarity as the organisations separated.

Julie Beilby raised significant concerns about the EPR programme, particularly the proposed timetable, associated risks and implications for patient safety. She emphasised the need for a detailed and challenging discussion at the Board development session and for the EPR risk assessment and scoring to reflect the current position.

She also highlighted work from the Quality and Safety Committee to identify the highest-priority digital improvements for patient safety and the need to understand whether these would be delivered through the EPR or as separate projects.
Alastair Pickering confirmed that existing quality priorities had been mapped against the EPR requirements and agreed to ensure this was aligned with the further patient safety prioritisation work.

Imran Devji emphasised the importance of maintaining resilience and sufficient capacity across Digital services as the organisations separated, noting that shared arrangements could continue where these provided benefits. He stressed that future arrangements needed to provide equitable services across both Trusts while allowing appropriate local flexibility. Imran Devji also sought assurance on the future of WebV at NLAG and its integration with other systems.
Alastair Pickering confirmed that the EPR was intended to replace WebV and incorporate the relevant system integrations. However, he cautioned that delivery by April 2027 would be significantly challenging and that it was unlikely all originally planned EPR functionality would be available by that date.

Murray Macdonald summarised two clear alerts for escalation to the Board. The first related to the EPR programme, where a delay was increasingly likely and there was a risk that not all planned functionality would be available. The second related to the strategic direction for digital integration during the transition and the need for timely Board decisions. He also requested a review of the risk profile relating to the EPR and its dependent systems, together with the wider risk to quality and safety if essential digital improvements were delayed during the transition.

Murray Macdonald noted that similar strategic considerations would apply to Estates and would require further consideration as the transition progressed.

4.7 Group Finance Report: Month 5

Emma Sayner presented the financial update and highlighted the importance of firming up the forecast position for year-end. She advised that the current scenarios ranged from a best-case deficit of £102.6 million, to a mid-case of £119

million and a worst-case of £137.8 million, compared with the planned £63 million deficit.

She reported that Grant Thornton and the Financial Improvement Director were supporting delivery of the financial recovery programme, with the mid-case remaining a challenging and ambitious position. An independent assessment had indicated a potential deficit of around £112 million, although further work was required to confirm that the identified savings could be delivered.

Emma Sayner advised that the NHS England mid-year review had been particularly challenging, with expectations for further improvement to the forecast. She noted that the Group had experienced a 5.4% year-on-year reduction in income and had already set stretching requirements around workforce, variable pay and non-pay expenditure.

Further discussions with NHS England and the financial recovery team would focus on strengthening delivery of the major savings opportunities and improving the year-end position.

Philippa Russell reported that the year-to-date deficit was £50.5 million, representing a £16.4 million adverse variance against plan. While the improved run rate seen in July had been sustained in August, it had not improved further and was insufficient to close the financial gap.

She highlighted the significant challenge of delivering additional activity to improve RTT and long-wait performance while also reducing costs, particularly variable and medical staffing expenditure. She noted a potential conflict between the financial recovery requirements and the additional activity needed to improve performance, particularly approaching winter.

Philippa Russell advised that the risk-adjusted CIP forecast at Month 5 was £57 million, leaving a significant shortfall against requirements. She also highlighted further financial risks, including Community Diagnostic Centre income.

Philippa Russell highlighted further financial risks, including Community Diagnostic Centre (CDC) income, which could be reallocated by commissioners if planned activity was not delivered. She also noted increasing operational pressures ahead of winter, with no additional financial capacity available to respond. She raised particular concern regarding the cash position, advising that the September cash allocation had been £15 million less than requested, requiring significant prioritisation of supplier payments. Although this had so far avoided late payment charges or suppliers placing the Trusts on stop, the number of priority payments was increasing.

Philippa Russell recommended that the cash risk score be increased from 8 to 12, reflecting the increased financial pressure and potential need to use capital cash temporarily to support revenue requirements.

Emma Sayner added that the financial position was particularly challenging because the organisations were spending above planned levels while also not achieving the required performance standards.

Murray Macdonald agreed that the position remained largely unchanged from the previous month. He questioned whether reducing variable pay and aligning staffing to establishment would deliver the level of savings anticipated and noted that the developing demand and capacity modelling should provide greater clarity on this.

Julie Beilby emphasised that demand and capacity modelling and ensuring the right workforce establishment were fundamental to improving both performance and the financial position. She noted that reducing extra contractual payments, bank and agency usage alone would not address the underlying issues if services did not have the right workforce in place.

Julie Beilby also highlighted the importance of transformation, noting that longer-term planning needed to focus on redesigning services and accelerating new ways of working, rather than relying on additional staffing to deliver existing models of care.

Emma Sayner agreed that transformation would be central to improving the financial position. She highlighted urgent and emergency care as an area where significant expenditure was not delivering the required patient outcomes and noted that improving pathways could benefit patients and staff while reducing costs. She advised that savings from transformation could support financial recovery while allowing resources to be redirected to services requiring further investment. This would need to be driven by the developing clinical and operational strategies.

Emma Sayner also highlighted the financial implications of the organisational transition. Her priority was to separate the financial recovery programme into two Trust-specific programmes and ensure future financial planning and resources were aligned to the needs of each organisation.

Murray Macdonald summarised the finance discussion and identified four alerts for escalation to the Board: the forecast year-end financial position, the savings programme and associated delivery gap, the immediate cash pressure, and the lack of sufficient progress in reducing variable pay against the 30% target.

Murray Macdonald also highlighted the increasing risk around the organisations' ability to meet future cash requirements and requested that the cash risk score and description be reviewed to ensure they reflected the current position.

4.8 CIP and Transformation Programme Update

Ryan Sutton provided an update on the Financial Recovery Programme, advising that the programme was moving from mobilisation into implementation from 1st October. Key workstreams included strengthened controls over expenditure and variable pay, increased procurement scrutiny and further support to Care Groups to accelerate delivery of savings schemes.

He advised that a formal change control process was being introduced for changes to CIP schemes, with variations above £10,000 subject to further challenge and review. Work was also ongoing to establish the financial impact of the vacancy pause and other measures aimed at reducing variable pay.

Ryan Sutton also reported that up to 600 WTE vacant posts were being reviewed for potential removal from budgets where they had not been substantively filled or backfilled through variable pay for at least four months. He noted that increased support and scrutiny were being provided to move paused schemes into financial delivery, with the impact expected to become clearer as the programme moved into implementation.

Murray Macdonald raised concern that Non-Executive Directors did not yet have sufficient visibility or understanding of the overall Financial Recovery Programme, particularly given the pace of work and the decisions Boards would be required to make. He emphasised the need for earlier engagement with Board members on both the current recovery work and development of future plans.

Ryan Sutton agreed to raise this with the Financial Recovery Programme team and suggested a dedicated session for Non-Executive Directors. He clarified that the 2027/28 pipeline currently captured schemes that had been delayed during the current year, ensuring these were retained for future consideration rather than representing the full 2027/28 savings programme.

Jo Gander supported the proposal for a dedicated session to give Non-Executive Directors greater visibility and understanding of the Financial Recovery Programme. Murray Macdonald agreed that this should be explored more widely given the programme's impact across the organisation.

Murray Macdonald concluded that, while significant analysis, governance and support were now in place, the key requirement was to begin seeing tangible financial benefits and savings delivered through the recovery programme.

4.9 Annual Business Plan – Timetable Approval (Operational & Financial) including CIP

Covered within the finance section of the meeting.

4.10 Contract Approvals

Linen and Laundry Contract

Tom Myers presented the linen and laundry contract proposal and explained that the UK healthcare market had limited provider options. Following negotiations with the existing supplier, the proposed contract extension would increase the cost per item and create an estimated additional annual pressure of £575,800 across the Group, comprising £422,400 at HUTH and £153,400 at NLAG.

He advised that work was underway to reduce linen usage and associated costs, including reviewing the frequency of linen changes and working with the supplier on a joint innovation and savings programme.

The CiC was asked to endorse the proposal for onward approval by the Trust Boards.

Jo Gander sought assurance that Infection Prevention and Control (IPC) supported the proposal to reduce the frequency of linen changes and asked about the potential financial benefit. She also questioned whether national procurement work was underway given the limited number of suppliers.

Tom Myers confirmed that IPC had supported less frequent linen changes where linen was not soiled, with indicative savings of around £60,000. He advised that NHS England was reviewing the resilience of several restricted Estates and Facilities markets, including linen and laundry, and exploring longer-term options.

Jo Gander suggested that the Board paper should clearly set out the work underway to reduce future costs, alongside the associated risks, to provide a fuller picture when considering the proposed contract extension.

Philippa Russell questioned why the HUTH contract costs were being backdated to April when the existing contract had not expired until July, noting that uplifted charges had already been submitted for Quarter 1. Tom Myers advised that he would seek clarification from Procurement on the reason for the backdating.

Murray Macdonald recognised the unavoidable cost pressure and confirmed that the proposal required Board approval due to its value. He requested that Tom Myers and Philippa Russell resolve the outstanding financial queries before the paper was submitted to the Board, ensuring that Finance and Estates had an agreed position.

RL Datix Contract

Helen Knowles presented the proposal to renew the electronic rostering contract, noting an additional cost pressure of £201,000 over three years, primarily relating to HUTH. The current contract was due to expire on 30 November 2026, with quoted prices held until 28 October 2026.

She advised that the preferred option was a 2+1-year contract, providing flexibility to review future arrangements after two years while securing available discounts. The arrangement would also allow the Trusts to explore alternative medical and dental rostering systems during the contract period.

Helen Knowles confirmed that the proposed organisational separation would not prevent the two Trusts from making independent decisions in future and recommended that the CiC support the 2+1-year contract for onward approval.

Jo Gander asked why a competitive procurement exercise had not been undertaken through the new framework. Helen Knowles explained that the timing of the new procurement framework, alongside the current contract ending on 30th November 2026, did not allow sufficient time to complete a competitive exercise. She advised that a direct award to RL Datix under the framework was therefore the available option to secure the identified discounts within the required timescale.

Imran Devji highlighted the opportunity to strengthen the link between consultant job planning and rostering, noting that current job planning arrangements lacked sufficient detail. Helen Knowles confirmed that job plans could be linked with rostering. She noted that HUTH consultants were not currently included on a roster, but the planned procurement for medical and dental rostering provided an opportunity to address this. At NLaG, both job planning and rostering were in place, although the systems had not yet been integrated.

Emma Sayner asked that the potential operational and financial benefits of integrating job planning and rostering were quantified to support the decision-making process. Helen Knowles agreed and advised that this could be explored further through the planned medical and dental rostering procurement. Sarah Todd noted that there were currently some technical challenges in integrating detailed job plans with rostering, which reinforced the need to consider alternative solutions.

Murray Macdonald confirmed in-principle support for the proposed contract, subject to feedback from SLT. He emphasised that the longer-term aim should be greater integration between job planning, demand and capacity modelling, and rostering to support more effective use of workforce resources.

4.11 Emerging Issues

None to note.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

This was shared for information.

5.2 Planned Care Board Meeting Minutes for August 2026

This was shared for information.

5.3 Unplanned Care Board Meeting Minutes for August 2026

This was shared for information.

5.4 MSDEC tender return

This was shared for information.

5.5 Financial Recovery Programme Board Action Log Update

No item received for sharing.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

None to note.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

None to note.

7.2 Matters for Escalation to the Trust Boards including any proposed changes to the BAF

Key highlights were noted during the meeting. Any Alerts, Assurances and Advisories would be included in the Highlight Report submitted to the Board following the meeting.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and time of the next PEF CiC meeting:**

The next meeting will take place on Tuesday 3rd November 2026 via Microsoft Teams.

The meeting closed at 12.30pm

Cumulative Record of Attendance at PEF CiC 26/2027

Name	Title	2026/27											
		Apr No Meeting	May	Jun	Jul	Sept 1	Sep 29	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Murray MacDonald	Chair / Vice Chair		D	Y	Y	Y	Y						

Jane Hawkard	NED (HUTH)		Y	Y	Y	Y	N						
Julie Beilby	NED (NLaG)		Y	Y	Y	Y	Y						
Emma Sayner	Group Chief Financial Officer		Y	Y	Y	Y	Y						
Dr Kate Wood	Group Chief Medical Officer		N	D	D	D	N						
Sam Peate	Group Chief Delivery Officer		Y	D	Y	D	Y						
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates		Y	D	Y	D	Y						
David Sharif	Group Director of Assurance or deputy		N	D	D	D	D						
Philippa Russell	Deputy Group Chief Finance Officer		Y	Y	Y	Y	Y						
Ian Reekie	Governor Observer (NLaG)		D	Y	Y	Y	Y						

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)293

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 November 2026
Director Lead	**Emma Sayner, Group Chief Financial Officer**
Contact Officer / Author	**Philippa Russell, Group Deputy Director of Finance** **Brian Shipley, Operational Director of Finance**
Title of Report	**Finance Report – Month 6**
Executive Summary	This report highlights the reported financial position for September 2026
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	Presented at Performance, Estates & Finance Comittees-in Common November 2026
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓Information ☐ Assurance ☐ Other – please detail below:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committees-in-Common Front Sheet

Agenda Item No: CIC(26)4.7

Name of Meeting	**Performance, Estates & Finance Committees-in-Common**
Date of the Meeting	**3 November 2026**
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Philippa Russell, Group Deputy Director of Finance Brian Shipley, Operational Director of Finance
Title of Report	**Group Finance Report Month 6**
Executive Summary	The purpose of this report is to highlight the reported financial position for September 2026. Also attached is a highlight report from the October Cash Committee meeting and the September Group Capital Committee. **Alert** • 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 which will have to be mitigated internally. • Increased in month deficit versus M5 at HUTH – a £4.5m adverse variance to plan. No further improvement for NLAG, but in month deficit in line with plan. • Whilst the Group is formally forecasting a plan compliant position, the forecast includes an unidentified and unmitigated gap of (£43.1m) and this is currently assessed to be the best-case scenario. Mid-case forecast is currently assessed to be a (£119.0m) deficit, a (£55.9m) adverse variance to plan. • Year to date adverse variance and slippage on identification of CIP is adversely impacting both the financial position and the cash forecast. Forecast Revenue Support PDC required for Q3 for the Group is £68.49m, £25.43m higher than the planned value, but £7.01m lower than the value approved at PEF / Board in September. **Assure** A new Financial Recovery Programme (FRP) started at the

	beginning of September with a fortnightly FRP Board meeting, chaired by the CEO and a fortnightly FRP Delivery Group chaired by the Financial Improvement Director. The Delivery Group 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. Financial Recovery Plan progress: - Agreed a targeted 30% / £30m reduction in variable pay with associated Care Group targets – the majority of Care Groups have developed plans to achieve this target, but further work required to deliver with c. 10% reduction YTD. - Introduced weekly tracking of a range of metrics including CIP progress, variable pay and vacancy approvals alongside increased visibility and scrutiny of run rates. - Approved expansion of Locum's Nest digital solution which will facilitate electronic approval for variable pay including Extra Contractual Payments – implemented 1st July 2026 - Recovery Action Plan's escalated to Performance & Finance Committee for the Care Groups' of greatest concern. - Business Case in-development for Voluntary Redundancy programme. - 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. - 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. - New Non-Pay Panel set up 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. **Advise** • November requests for external cash support for both HUTH (£8.26m) and NLAG (£3.55m) are pending approval. • Underlying deficit position of £152.3m. • The revised profile and cost for the Tower Block scheme has been agreed with £10.1m slipped to 2027/28 along with associated PDC funding. • Internal Capital slippage has been agreed for HRI SDEC, the ITU at DPOW and the Gamma Camera for HUTH. Mitigation has been identified with schemes brought forward from 2027/28: theatre improvements, Linac and additional backlog maintenance at HUTH; Goole Fire Alarms, SGH lifts and other backlog maintenance at NLAG. • There is a risk of further slippage to manage of £5.7m HUTH and £3.6m NLaG due to EPR implementation delays if there is no opportunity to defer the return of the brokerage agreed last year with system partners • Capital expenditure is £20.9m behind plan at Month 6 due to delays in progressing HRI SDEC and Tower Block schemes and the ITU at DPOW.
Background Information and/or Supporting Document(s) (if applicable)	**Attached:** M6 Finance Report Cash Committee Highlight Report Capital Committee Highlight Report
Prior Approval Process	Not applicable
Financial Implication(s) (if applicable)	As detailed in the report
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**-**
Recommended action(s) required	☐ Approval by CiC ☐ Information ☐ Endorse for approval by Trust Board(s) ✓ Assurance ☐ Other – please detail below:

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

NHS
Humber Health
Partnership

Finance Report Month 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 29 to 30 for Detailed I&E Position

Financial Performance Summary: By Care Group

Directorate	Directorate 2	Care Group	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	In Month Variance £'000's	% Overspend	% CIP Identified (Forecast)	Escalate	% Overspend movement M6
Central Income			752,936	748,932	(4,004)	(762)	-0.5%			→
					(1,693)	(800)	-1.3%	55.0%		↓
Finance Technical			(44,665)	(39,687)	4,977					
Operations	**Operations North**	Acute And Emergency Medicine North	(22,715)	(24,997)	(2,281)	(270)	-10.0%	46.5%	Y	↑
						42	1.2%	20.3%	N	↑
					(1,373)		-5.2%	111.5%	Monitor	↑
					(230)		-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)			0.6%	84.9%	N	↓
		Patient Services	(22,907)	(23,164)	(257)		-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)			7.1%	0.0%	N	↑
					(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)			-0.5%	75.8%	N	↓
							-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)				

See Appendix A on Page 33 for Detailed I&E Position

Care Group Escalations: Acute & Emergency Medicine North M6 Financial Position

A&EM North and Major Trauma (Financial Position £000)	YTD (M6)
Budget Allocation	22,715
Expenditure	24,997
Variance	(2,281)

Variance made up of:

CIP non delivery	A&EM £1,125k ; Major Trauma £60k	(1,185)	
Vacancy factor	A&EM £99k ; Major Trauma (£49k)	(50)	
		(1,235)	54%
Medical Staff	Unfunded IA strike costs	(336)	
	Unfunded Towerblock on call rota changes	(80)	
	ED : unfunded deanery +6wte	(268)	
	ED : additional wte worked	(197)	
	Acute : vacancy premium	(169)	
Major Trauma	Pay : excludes IA & CIP & VF	(18)	
Nursing Pay	Emergency Dept	(199)	
	AMU & wards	(1)	
Drugs		141	
NonPay / Income		81	
		(1,047)	46%
		(2,281)	

A&EM : £261k CIP delivered YTD - £1,125k adverse ; VF variance - £99k adverse = Total £1,224k deficit

MT : £21k CIP delivered YTD - £60k adverse ; VF variance - £49k favourable = Total £11k deficit

£336k unfunded IA medical staff strike costs

Medical Pay cost pressures continue covering gaps with locums & agency. Acute pressures are due to weekend vacancy cover premium.

ED medics continue to staff above budgeted levels & includes 6wte unfunded deanery posts.

ED Nursing is now working at the uplifted SNCT levels. Agency & overtime has reduced but is still used to cover vacancies (13 RN) & sickness (7%). New recruitment is key to mitigate this use.

There are still no plans to mitigate the external changes made to the Tower block oncall rotas. The expected annual pressure to cover Acute TG staff with locums is £160k.

Digestive Diseases – M6 Financial Position

Reason	Current Month Variance £k	Year to Date £k	Forecast £k
CIP including mitigating actions - risk adjusted forecast	-192	-1,328	-2,400
Consultant Additional Sessions before mitigations	-58	-556	-1,112
Endoscopy CHH & HRI Clinical Supplies Expense Category overspends	-21	-563	-1,126
Upper GI Clinical Supplies Expense Category overspends	-27	-125	-249
Exec historically approved Allam Build Recruitment (CHH Endoscopy Unit cost centre pay)	-29	-188	-375
Bowel screening consumables	1	-24	-48
Resident Doctors - over established (rota expansion)	-92	-459	-917
JAG Accreditation nurse	-6	-36	-72
Agency GIM rota costs consultant and CT3 level - exact WTE/amount TBC, before mitigations	-9	-86	-86
Nursing - maternity leave, redeploymnets due, long-term sickness, historically agreed spec nurses requiring business case due to saving consultant spend	-33	-231	-461
Nursing OT Pressure - Premium element estimate	-10	-70	-140
Industrial Action Cover	1	-167	-167
Technical issues/adjustments - insourcing/outsourcing	2	-223	
NLAG underspends across several nursing wards & Endoscopy	84	550	1,100
Business cases requiring approval			2,476
Other	-164	-151	
TOTAL	**554**	**3,655**	**3,577**

The Care Group was forecasting a deficit of £3.6m at the end of month 6. This includes mitigating actions totalling £3.9m, subject to further work and calculations.

36% of the year to date overspend is driven by the CIP position, which at the point of reporting had a risk-adjusted forecast variance of £2.4m under target.

Other significant cost pressures are mainly connected with waiting lists, the staffing for the new Allam building and historical resident doctor allocations, all of which require business cases to agree the run-rate expenditure and budget going forward.

Specialist Cancer and Support Services – M6 Financial Position

	(£,000s)		
	Current Month	Year To Date	Forecast
CIP Delivery	(720)	(3,654)	(5,898)
IRT consumables overtrade/Excluded devices	(78)	(380)	(621)
Medical Equipment Repair Costs	(11)	(9)	(18)
Medical Gasses Usage	22	(16)	(54)
Radiopharmacy isotopes	(50)	(182)	(387)
CT Contrast	(14)	(109)	(147)
Passthrough drugs block (over)/under trade	(404)	(1,028)	(2,164)
Trust Wide Maintenance Contracts	(36)	(132)	(228)
EMIS Contract	(69)	(69)	(138)
RT Maintenance	(38)	(174)	(354)
Dr Doctor	(32)	(116)	(231)
Haematology Agency Premium	(20)	(20)	(140)
Industrial Action	-	(44)	(44)
Drug Wastage	-	(253)	(253)
Radiology Reporting	(105)	(105)	(24)
Prior Year costs @ hihger than planned levels	-	-	-
Vacancies above NR VF (incl CDC)	379	1,914	3,699
Lung Cancer Screening Programme undertrade	19	123	245
MT expansion	-	-	(400)
ED CT OOH	-	-	(90)
Seasonal flu vaccine programme	-	-	(54)
Assumed Funding MT, OOH CT and flu vaccine program	-	-	544
Other non-pay	108	150	370
	(1,081)	(4,220)	(6,618)

At the end of M6, the Care Group is forecasting a year-end deficit of £6.6m. This assumes £0.4m of technical adjustments for NHSE MT funding and £0.15m of reserves for approved schemes are released.

The main driver of the overspend is unidentified CIP (£5.9m). This number builds in scheme risk ratings.

Other key issues include consumable overtrade on IRT (£0.6m) linked to increased IRT activity albeit with a circa £0.3m gap in devices income recovery currently being investigated.

Pass-through drugs are currently forecasting a block overtrade of £2.2m with growth above funded levels. Of this, £1.1m relates to unfunded 25/26 OT.

One-off events (£0.5m) are included in the YTD overspend related to industrial action, drug waste and Neuroradiology sickness.

Community, Frailty & Therapies – M6 Financial Position

	Current Month Variance £'k	Year to Date £'k	Forecast £'k
CIP non delivery	- 221	- 1,817	- 2,941
Ward Staffing pressures in Frailty	- 69	- 427	- 588
H1 and FSDEC	2	- 151	- 181
CHH C20 and Medical Cover	- 60	- 360	- 720
Industrial action	-	- 80	- 80
Medical staffing pressures incl Sickness & Goole	6	- 45	- 94
District Nursing Sickness Cover	- 3	- 17	- 34
Wheelchair Services	- 2	96	179
Non Pay/income	21	192	362
Additional Vacancies	59	310	322
Recovery Action Plan			88
TOTAL	267	2299	3687

As at month 6, the Care Group is forecasting a deficit of £3.8m. 78% of this is driven by the CIP position, which at the point of reporting had a risk adjusted forecast variance of £2.9m.

Other significant cost pressures are connected with Medical staff cover both at CHH and Goole as well high levels of sickness. The Nursing position is equally challenged with staffing pressures on the Frailty wards and high levels of sickness within District Nursing, however over the last few months the latter has improved significantly.

The Care Group is continuing to actively manage the sickness and reduce cover wherever safe to do so. Further CIP schemes are being developed to close the efficiency gap and a recovery action plan has been put in place.

Care Group Escalations: Family Services – M5 Financial Position

Reason	M06 Current Month Variance £k	M06 Year to Date £k	M06 Forecast £k
CIP including mitigating actions	-166	-1,879	-3,430
VF	221	1,546	2,520
Med staff	-130	-917	-2,400
Nursing	-277	-624	-1,350
Other pay	-14	-12	-24
Drugs	-67	-99	-600
Clinical supplies	-44	143	296
Other Non Pay	43	153	159
Income	48	233	460
Industrial Action Cover	0	-363	-363
TOTAL	**386**	**1,819**	**4,732**

At this stage of the financial year, the Care Group was forecasting a deficit of £4.7m at the end of month 06. This excludes some mitigating plans, subject to further work and calculations.

103% of the year to date overspend is driven by the CIP position, which at the point of reporting had a forecast variance of £3.4m.

Other significant cost pressures are mainly connected with Medical staffing Extra Contractual Payments, Nursing staff bank and OT costs.

Drug costs forecast a cost pressure across Paediatrics (£450k); maternity (£80k); Neonates (£24k) & Gynae (£46k).

Care Group Escalations: Neurosciences – M6 Financial Position

Reason	M06 Current Month Variance £k	M06 Year to Date £k	M06 Forecast £k
CIP including mitigating actions	13	-541	-1,017
VF	34	214	420
Med staff	-78	-182	-460
Nursing	-53	-129	-225
Other pay	-10	-57	-70
Drugs	-30	-152	-230
Clinical supplies	-228	-404	-594
Other Non Pay	-22	-42	0
Income	42	244	481
Industrial Action Cover	0	-32	-32
TOTAL	**332**	**1,081**	**1,727**

At this stage of the financial year, the Care Group was forecasting a deficit of £1.7m at the end of month 06. This excludes some mitigating plans, subject to further work and focus which the Care Group is now significantly focussed upon

49% of the year to date overspend is driven by the CIP position, which at the point of reporting had a forecast variance of £1.0m.

Other significant cost pressures are mainly connected with Medical staffing Agency costs; ECPs, Nursing staff bank (NLaG) and OT costs (HUTH).

Drug costs forecast a cost pressure totalling £230k for Neurology/Stroke services. Clinical supplies are forecast to be £594k overspent but 80% of this relates to excluded devices which are recharged and reflected in the positive income position. The remaining clinical supplies pressure is in Neurosurgery.

Care Group Escalations: Specialist Medicine M6 Financial Position

Specialist Medicine (Financial Position £000)	YTD (M6)
Budget Allocation	37,833
Expenditure	39,371
Variance	(1,538)

Variance made up of:

CIP non delivery		(1,137)	
Vacancy Factor		160	
		(977)	64%
Medical Staff	Unfunded IA strike costs	(73)	
	HUTH Rheumatology	(78)	
	HHP Respiratory + IS	(115)	
Activity Pressures	Renal : CAPD Fluids / LTH tests	(106)	
	Renal : Fresenius Contract	(172)	
	Respiratory : Home Ventilation	(6)	
	Respiratory : CPAP consumables	(485)	
Lung Cancer Screening	IS : actual < plan	109	
Nursing Wards	Pay	(106)	
	NonPay (includes Drugs)	55	
Drugs	non ward	343	
Income		31	
Misc Other		43	
		(560)	36%
		(1,538)	

- CIP non-delivery = 74% of YTD variance
  YTD = £372k delivered against a target of £1,509k
- Unfunded £73k IA strike medical staff costs
- HUTH Rheumatology medical staff
  M1-5 worked WTE > funded WTE ; M6 balanced
- Respiratory medical staff
  NLG 4.0 wte consultant vacancy premium
  HUTH ECPs (weekend ward & cancer clinics)
- Non-pay pressures
  CPAP (£485k) ; Renal fluids/LTH tests (£106k)
  Renal Fresenius contract (£172k) +3.5% activity
  Rheum drugs £273k underspent YTD
- Ward Pay pressures
  (H70 £79k ; H50 £16k ; Wd25 £11k)
- NLG Lung Cancer Screening £109k IS underspent based on activity phasing. A forecast balanced variance is expected.

Financial Performance – Forecast Outturn (FOT)

The Group is forecasting a deficit of (£121.2m) 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

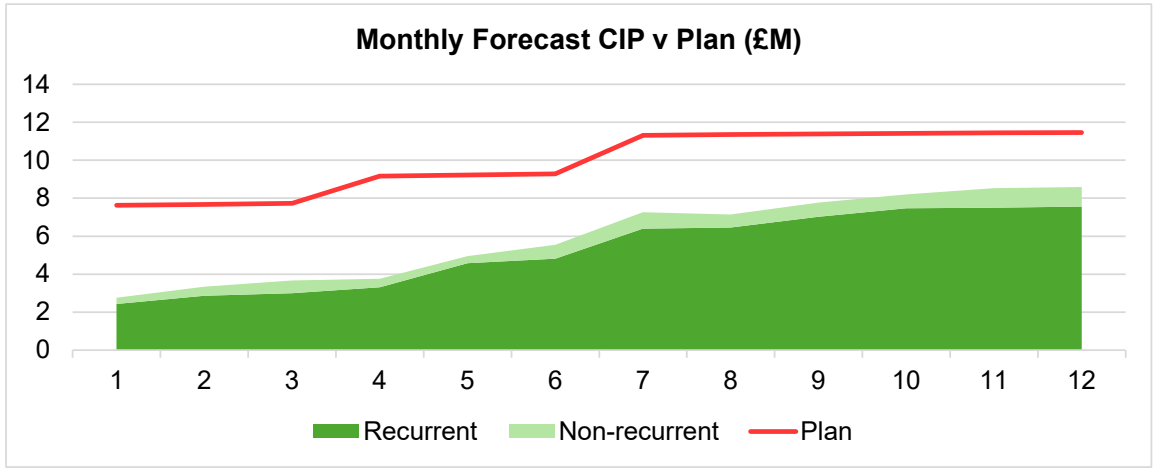
The Group has delivered £24.0m CIP year-to-date against a target of £50.7m, (£26.7m) adverse. The Group is forecasting CIP delivery of £71.5m (£47.7m) adverse to plan.

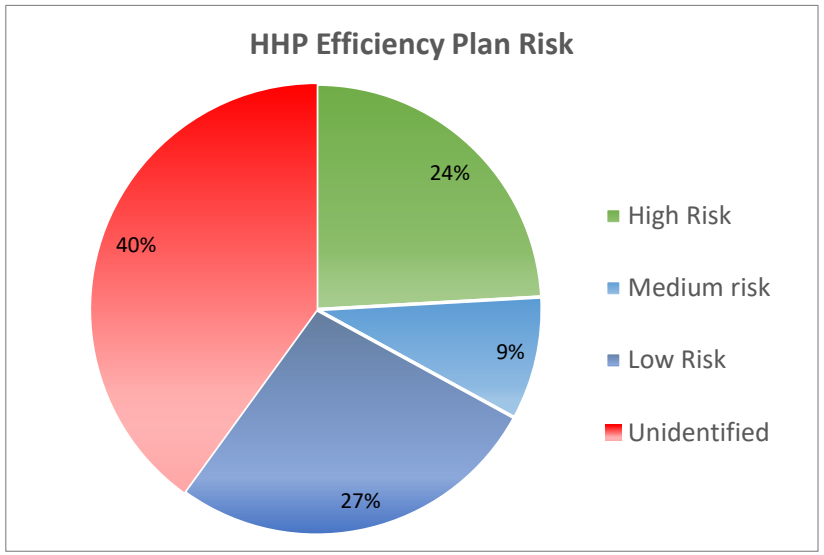
		HUTH						NLAG						HHP					
		Year to Date			Forecast Year end			Year to Date			Forecast Year end			Year to Date			Forecast Year end		
£000		Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Operations	Acute and 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)**

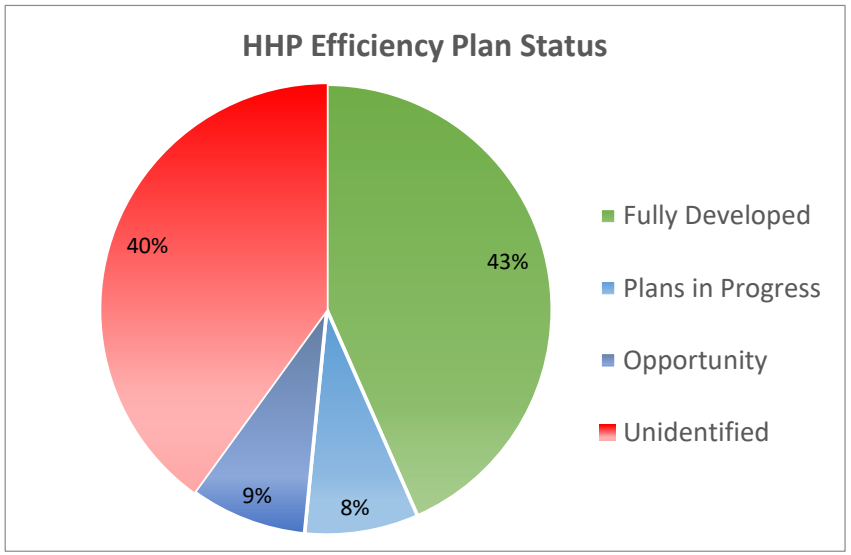
Financial Performance – CIP

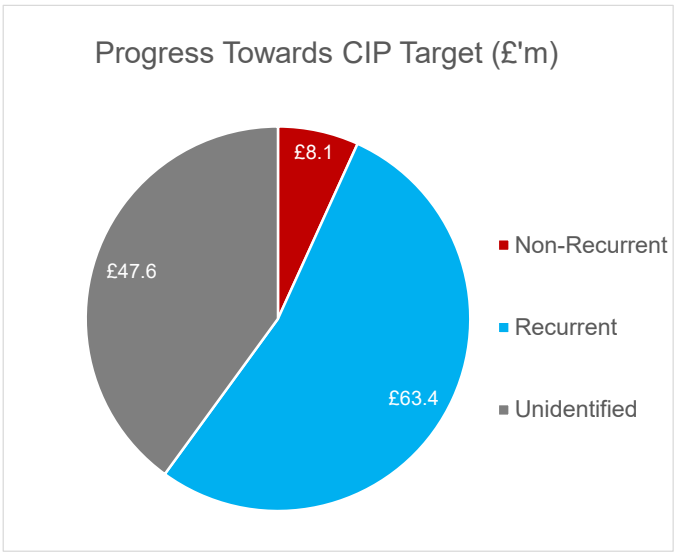
Efficiency Forecast Risk	HUTH	NLAG	HHP
High Risk	10,218	18,494	28,711
Medium risk	4,452	6,097	10,549
Low Risk	27,741	4,450	32,191
Unidentified	30,470	17,182	47,652
TOTAL	**72,881**	**46,223**	**119,103**

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.

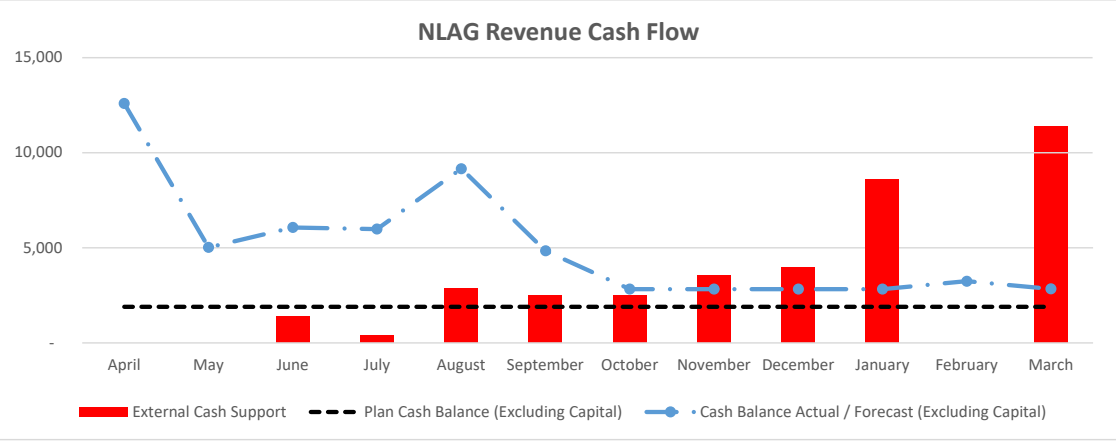
Ward C6 at DPoW is expected to be completed at the end of October.

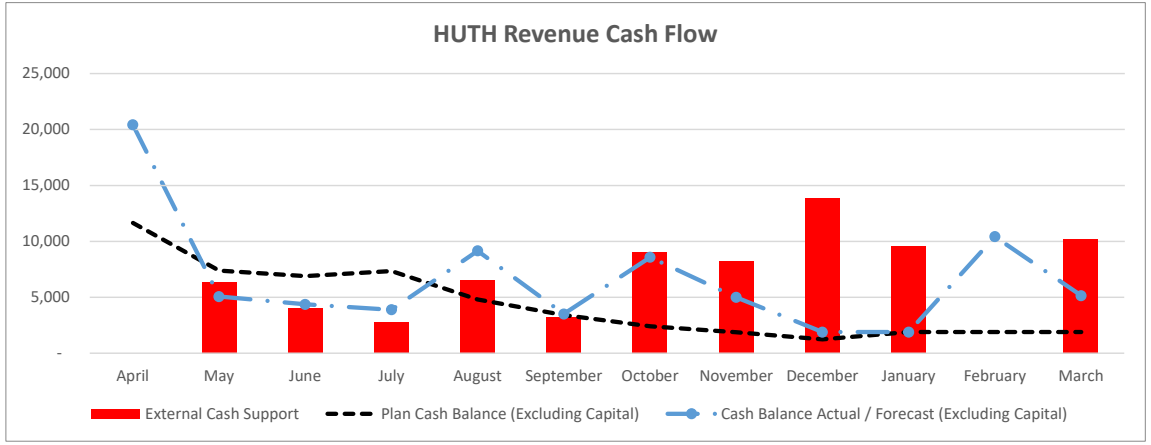
Balance Sheet

£ million	NLAG			HUTH			HHP		
	Actual 31-Aug-26	Actual 30-Sep-26	In month movement	Actual 31-Aug-26	Actual 30-Sep-26	In month movement	Actual 31-Aug-26	Actual 30-Sep-26	In month 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

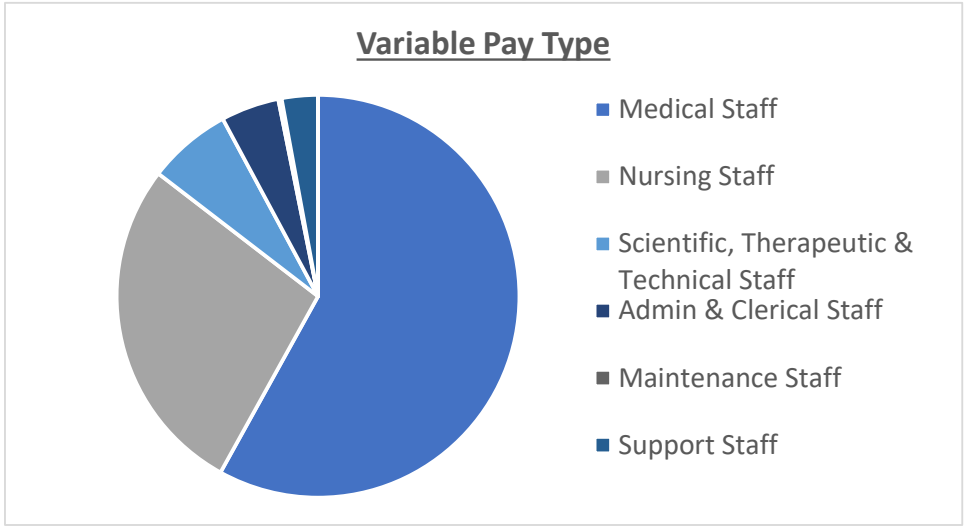
			YTD					
			Percentage of bills paid within target			Percentage of bills paid within target		
			Current YTD by Number			Current YTD by Value £000s		
Code	Name	Provider Type	Non NHS %	NHS %	Total %	Non NHS %	NHS %	Total %
Humber and North Yorkshire								
RCD	Harrogate and District NHS Foundation Trust	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%

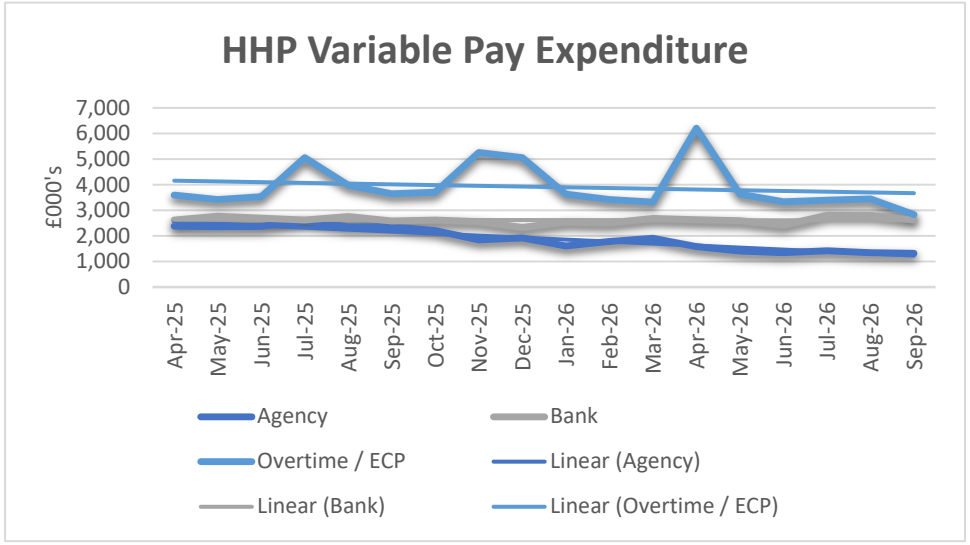
Variable Pay Summary

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**





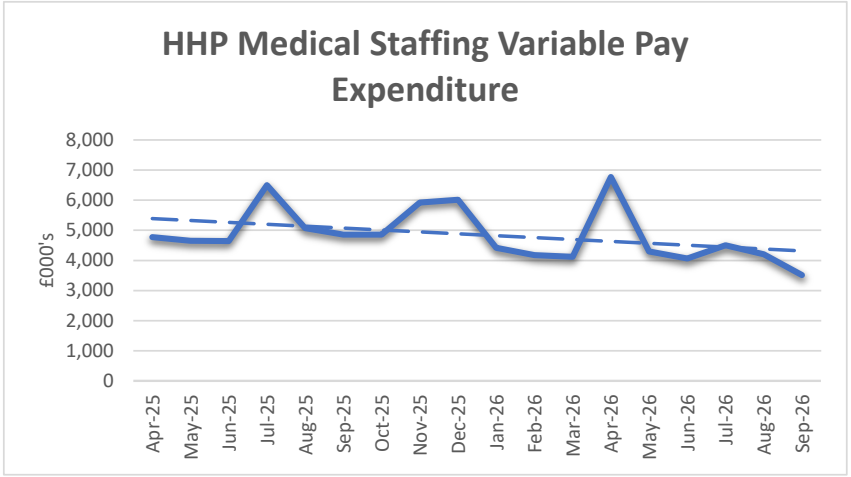
Variable Pay Summary – Directorate / Care Group

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	4,374	4,519	(145)	0	20	(20)	4,374	4,539	(165)
	Acute and Emergency Medicine (South)	0	0	0	7,690	7,009	681	7,690	7,009	681
	Cancer Network	75	18	57	47	18	29	122	36	86
	Cardiovascular	1,409	1,439	(30)	291	351	(60)	1,700	1,789	(90)
	Chief Delivery Officer	7	0	6	18	25	(7)	25	25	(0)
	Community, Frailty & Therapy	2,213	1,896	317	1,764	1,756	8	3,977	3,652	325
	Digestive Diseases	1,289	1,408	(120)	1,657	1,862	(205)	2,946	3,270	(324)
	Family Services	2,417	2,945	(528)	3,306	3,047	258	5,723	5,993	(270)
	Head & Neck	1,680	924	756	1,882	1,167	715	3,562	2,091	1,471
	Neuroscience	885	674	211	812	670	142	1,697	1,344	353
	Pathology Network Group	112	70	41	661	395	266	773	465	308
	Patient Services	721	706	15	612	603	9	1,332	1,309	24
	Site Management & Discharge teams	313	102	211	147	182	(35)	460	284	176
	Specialist Cancer and Support Services	2,700	2,544	157	2,457	1,863	594	5,157	4,407	751
	Specialist Medicine	839	701	138	1,815	1,360	455	2,654	2,061	593
	Specialist Surgery	1,495	1,236	259	1,492	951	541	2,987	2,187	800
	Theatres, Anaesthetics and Critical Care	3,137	2,368	768	2,800	2,365	436	5,937	4,733	1,204
Total Operations		**23,664**	**21,552**	**2,113**	**27,451**	**23,642**	**3,809**	**51,116**	**45,194**	**5,922**
Corporate	Corporate Directorates	756	678	78	1,849	1,254	595	2,604	1,932	673
Total Corporate		**756**	**678**	**78**	**1,849**	**1,254**	**595**	**2,604**	**1,932**	**673**
Grand Total		**24,420**	**22,230**	**2,190**	**29,300**	**24,896**	**4,404**	**53,720**	**47,126**	**6,594**

Variable Pay Summary – Medical Staffing

The Group has spent £27.4m on Medical Staffing variable pay YTD. This is £3.2m less than the same period in 2025/26 but does include £1.9m of Industrial Action Cover.

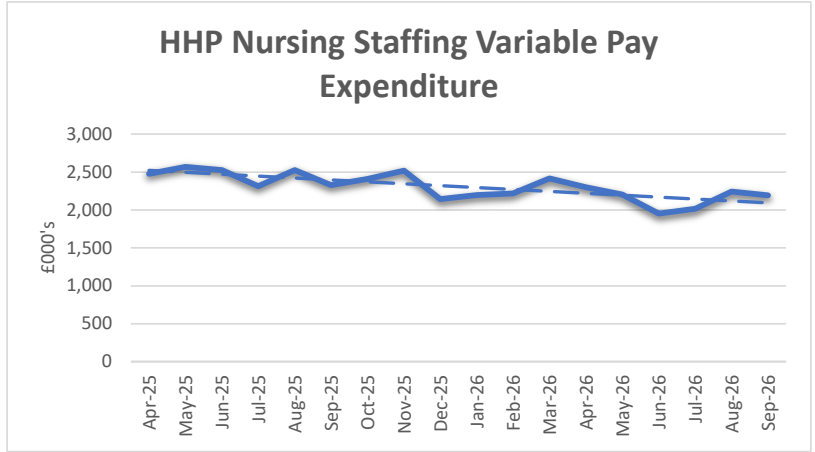
		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	3,206	3,316	(109)	0	0	0	3,206	3,316	(109)
	Acute and Emergency Medicine (South)	0	0	0	4,797	4,413	384	4,797	4,413	384
	Cancer Network	0	0	0	0	0	0	0	0	0
	Cardiovascular	1,022	991	31	80	95	(15)	1,102	1,086	16
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	1,153	969	185	702	711	(9)	1,855	1,679	176
	Digestive Diseases	738	909	(171)	966	1,176	(211)	1,704	2,085	(381)
	Family Services	1,614	1,997	(383)	1,376	1,718	(342)	2,990	3,715	(725)
	Head & Neck	1,545	824	721	1,569	911	657	3,114	1,736	1,378
	Neuroscience	552	409	142	379	318	61	930	727	204
	Pathology Network Group	96	48	48	195	126	69	292	174	117
	Patient Services	0	0	0	0	0	0	0	0	0
	Site Management & Discharge teams	0	0	0	0	0	0	0	0	0
	Specialist Cancer and Support Services	1,235	1,208	27	963	564	399	2,198	1,771	427
	Specialist Medicine	554	374	179	1,094	749	345	1,647	1,123	524
	Specialist Surgery	1,222	1,039	183	1,204	700	504	2,427	1,739	687
	Theatres, Anaesthetics and Critical Care	2,390	2,042	349	1,851	1,711	141	4,241	3,752	489
Total Operations		**15,327**	**14,124**	**1,203**	**15,177**	**13,193**	**1,984**	**30,504**	**27,317**	**3,187**
Corporate	Corporate Directorates	1	38	(37)	3	1	2	5	39	(34)
Total Corporate		**1**	**38**	**(37)**	**3**	**1**	**2**	**5**	**39**	**(34)**
Grand Total		**15,329**	**14,163**	**1,166**	**15,180**	**13,194**	**1,986**	**30,509**	**27,357**	**3,152**



Variable Pay Summary - Nursing

The Group has spent £13.0m on Nursing variable pay YTD. This is £1.8m less than the same period in 2025/26.

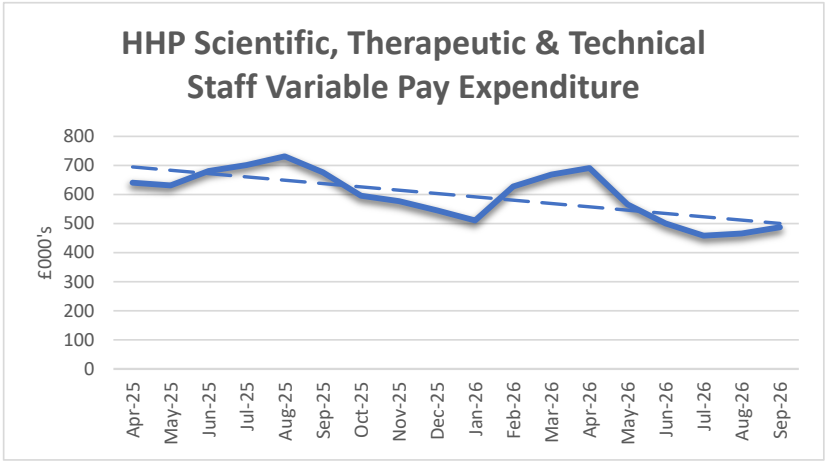
		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	1,140	1,180	(40)	0	0	0	1,140	1,180	(40)
	Acute and Emergency Medicine (South)	0	0	0	2,793	2,511	282	2,793	2,511	282
	Cancer Network	2	3	(2)	4	1	3	6	4	2
	Cardiovascular	277	350	(73)	173	199	(26)	451	549	(98)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	846	783	63	805	832	(27)	1,652	1,615	37
	Digestive Diseases	519	480	40	691	685	7	1,211	1,165	46
	Family Services	798	946	(148)	1,928	1,314	615	2,726	2,260	467
	Head & Neck	71	63	8	36	55	(19)	107	118	(11)
	Neuroscience	318	263	55	385	324	62	704	586	117
	Pathology Network Group	2	2	0	0	0	(0)	2	2	(0)
	Patient Services	11	8	3	61	4	57	72	13	59
	Site Management & Discharge teams	295	91	204	142	175	(32)	438	266	172
	Specialist Cancer and Support Services	440	327	113	110	149	(38)	550	476	74
	Specialist Medicine	279	318	(39)	694	587	106	972	905	67
	Specialist Surgery	260	185	74	287	250	37	547	436	111
	Theatres, Anaesthetics and Critical Care	534	263	270	729	507	222	1,263	771	492
Total Operations		**5,792**	**5,263**	**529**	**8,841**	**7,592**	**1,249**	**14,633**	**12,855**	**1,778**
Corporate	Corporate Directorates	58	19	40	42	28	14	100	47	54
Total Corporate		**58**	**19**	**40**	**42**	**28**	**14**	**100**	**47**	**54**
Grand Total		**5,850**	**5,281**	**569**	**8,883**	**7,620**	**1,263**	**14,734**	**12,902**	**1,832**



Variable Pay Summary – Scientific, Therapeutic & Technical Staff

The Group has spent £3.2m on AHP variable pay YTD. This is £0.9m less than the same period in 2025/26.

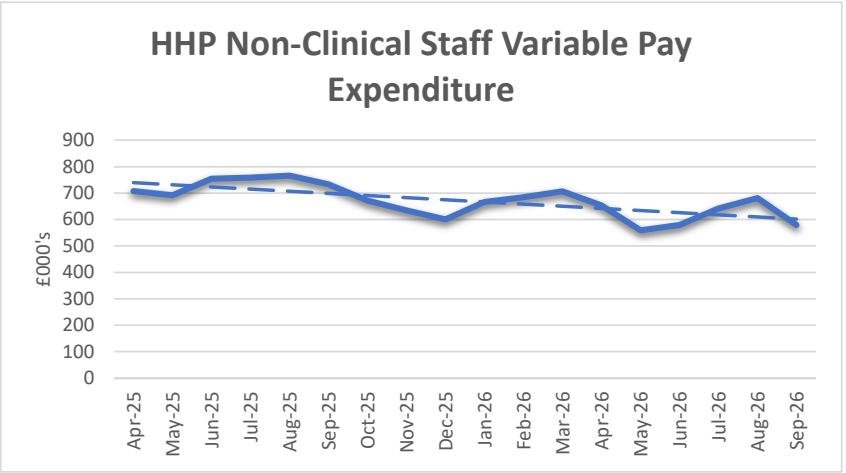
		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
	Acute and Emergency Medicine (North)	0	0	0	0	0	0	0	0	0
	Acute and Emergency Medicine (South)	0	0	0	1	0	1	1	0	1
	Cancer Network	44	0	44	0	0	0	44	0	44
	Cardiovascular	107	90	17	35	55	(20)	142	145	(3)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	198	127	70	158	89	69	355	216	139
	Digestive Diseases	0	4	(4)	0	0	(0)	1	4	(4)
	Family Services	1	1	0	0	0	0	1	1	0
Operations	Head & Neck	57	32	26	229	176	53	286	208	79
	Neuroscience	9	1	8	44	18	26	52	18	34
	Pathology Network Group	13	21	(7)	441	261	180	454	282	172
	Patient Services	0	0	(0)	0	0	0	0	0	(0)
	Site Management & Discharge teams	0	0	0	0	0	0	0	0	0
	Specialist Cancer and Support Services	929	954	(25)	1,309	1,013	296	2,238	1,967	271
	Specialist Medicine	6	4	1	9	6	3	15	10	5
	Specialist Surgery	10	12	(2)	0	0	0	10	12	(2)
	Theatres, Anaesthetics and Critical Care	213	63	150	182	132	51	395	195	200
Total Operations		**1,586**	**1,309**	**277**	**2,408**	**1,749**	**660**	**3,995**	**3,058**	**937**
Corporate	Corporate Directorates	50	92	(42)	19	21	(2)	69	113	(44)
Total Corporate		**50**	**92**	**(42)**	**19**	**21**	**(2)**	**69**	**113**	**(44)**
Grand Total		**1,636**	**1,401**	**235**	**2,427**	**1,770**	**657**	**4,064**	**3,171**	**892**



Variable Pay Summary – Non-Clinical Staff

The Group has spent £3.7m on Non-Clinical variable pay YTD. This is £0.7m less than the same period in 2025/26.

		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
	Acute and Emergency Medicine (North)	28	23	4	0	20	(20)	28	43	(15)
	Acute and Emergency Medicine (South)	0	0	0	99	85	14	99	85	14
	Cancer Network	29	15	14	43	18	26	72	32	40
	Cardiovascular	3	8	(6)	1	1	0	4	9	(5)
	Chief Delivery Officer	7	0	6	18	25	(7)	25	25	(0)
	Community, Frailty & Therapy	16	17	(1)	99	125	(26)	115	142	(27)
	Digestive Diseases	31	16	15	0	0	(0)	31	16	15
	Family Services	5	1	3	1	16	(15)	6	18	(12)
Operations	Head & Neck	6	5	1	48	25	24	55	29	25
	Neuroscience	6	1	5	4	11	(7)	10	12	(1)
	Pathology Network Group	0	0	0	25	7	18	25	7	18
	Patient Services	710	697	13	551	598	(48)	1,261	1,296	(35)
	Site Management & Discharge teams	18	11	7	5	7	(3)	23	19	4
	Specialist Cancer and Support Services	97	55	41	74	137	(63)	171	193	(22)
	Specialist Medicine	1	5	(4)	18	17	1	20	22	(2)
	Specialist Surgery	3	0	3	0	0	0	3	0	3
	Theatres, Anaesthetics and Critical Care	0	0	0	37	15	22	38	15	22
Total Operations		**959**	**855**	**104**	**1,025**	**1,108**	**(83)**	**1,984**	**1,963**	**20**
Corporate	Corporate Directorates	646	529	116	1,784	1,203	581	2,430	1,733	698
Total Corporate		**646**	**529**	**116**	**1,784**	**1,203**	**581**	**2,430**	**1,733**	**698**
Grand Total		**1,605**	**1,385**	**220**	**2,809**	**2,311**	**498**	**4,414**	**3,696**	**718**



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)**

Recovery Action Plan

Care Group:	HUTH Acute & Emerg Med & Major Trauma	£'000
Forecast Variance as at:	M6 (September-26)	(3,636)

Recovery Schemes	**Details of actions / decisions required**	**Expected Forecast Improvement - Current Year (£'000)**	**Progress status**	**Recurrent / Non-Recurrent**
Reduce additional support into ECA = overtime (work towards safe dept. numbers c40)	wef November (£20k a month)	100	Plans In Development	Rec
re-align Wd5 resources following closure	nonpay wef Sept. Review w/c 6th July to confirm	20	Plans In Development	Rec
rebanding of MT co-ordinators	to review in December	TBC	Plans In Development	Rec
Adjusted Forecast / Recovery Gap		**(3,516)**		

Recovery Action Plan

Care Group:	Digestive Diseases	£'000
Forecast Variance as at:	End of May 2026	(7,538)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
£250k Nurse Endoscopy workforce model	Consultation, agree new workforce model.	63	250	01-Jan-27	Scoping	Med	Sarah Clarke	Recovery action - to reduce current expenditure	Rec
Workforce redesign. Run rate reduction	Consultation, agree new workforce model.	(128)	130	01-Jan-27	Scoping	Med	Sarah Clarke	Recovery action - to reduce current expenditure	Rec
WLI controls further details needed for £k calculation. RR reduction	Additional internal care group controls and process changes. Then a potentially material savings amount can be forecasted. Locum cons interview july 14th gastro north. Flexible job plan for first year to fill more vacant lists and reduce WLIs. Two endoscopy fellows north intervew 18th with flexible job plann HRI and CHH. Forecast 30pc reduction in forecast from recruitment dates. Consultant start end of August. Two registrars starting end of Sept. INcrease in number of people able to do fixed lists by funding the 6th room - this will reduce the number of vacant lists that are published i.e. fewer WLIs.	400	TBC	01-Sep-26	Scoping	Med	George Abouda, Peter Grant	Recovery action - to reduce current expenditure	Rec
£34k Reduce budget WTE on wards on the south bank	Rotas and budgets permanently changed.	34	34	01-Sep-26	Plans in development	Low	Sarah Clarke	Recovery action - to reduce current expenditure	Rec
£18k PEG service income from CHCP.	Process for capturing and rechargning costs set up.	11	18	01-Sep-26	Plans in development	Low	Tracey Davies	Recovery action - to reduce current expenditure	Rec
£40k endoscopy – switch from pre-made to loaded syringes.	Switch date confirmation. Chase lisa gadd. Emailed Lisa again June 30th	23	40	01-Aug-26	Plans in development	Med	Procurement	Recovery action - to reduce current expenditure	Rec
£9k Endoscopy on-call nursing requirements GI bleed rota.	linked to Humber GI job planning review	5	9	01-Sep-26	Scoping	Med	Sarah Clarke	Recovery action - to reduce current expenditure	Rec
Technical / budget improvements - mainly outstanding business cases requiring submission and budget award	Outstanding business cases requiring submission and budget award - mainly - consultant additional sessions, Endoscopy Allam building, resident doctor rotas.	2,476	2,476	01-Oct-26	Plans in development	Med	Several Care Group Staff	Budget transfer	Rec
UNPALATABLE - stop GIM rota agency cover. THIS HAS STOPPED.	Needs trust-wide agreement. Consultant stopped but consultant review costs 2.5 PAs per week (2 hours per day mon to fri £80 per hour). CT3 end of Aug onwards replaced by substantive.	150	300	Sep-26	Scoping	High	George Abouda, Peter Grant	Recovery action - to reduce current expenditure	Rec
Back to basics exercise – review of all job plans and long-term vacancies underway	Review of all job plans and long-term vacancies underway	TBC	TBC	01-Sep-26	Scoping	Med	Tri	Recovery action - to reduce current expenditure	Rec
Other	minor adjustments across several areas to reflect YTD run-rate / balancing figure to forecast	622	622						
NEW Sep 2026 - COW model to reduce ECPs	Details to be gathered to allow quantification	TBC	TBC	01-Oct-26	Scoping	Med	George Abouda, Peter Grant	Recovery action - to deliver CIP	Rec
NEW Sep 2026 - Monofer referrals / iron infusion costs	Details to be gathered to allow quantification. Email sent to Pharmacy 14.9.26	24	50	01-Oct-26	Plans in development	Med	George Abouda	Recovery action - to deliver CIP	Rec
NEW Oct 2026 Castle Hill Ward Review	Details to be gathered to allow quantification, including start date TBC. At least £0.3m.	TBC	300	01-Dec-26	Scoping	Med	Sarah Clarke	Recovery action - to deliver CIP	Rec
NEW Oct 2026 Hold a HUTH and NLAG vacancies until next financial year - delay recruitment		230	230	01-Oct-26	Agreed / Approved	Low	George Abouda	Recovery action - to deliver CIP	NR
NEW Oct 2026 GI Physiology pay CIP		43	43	01-Oct-26	Agreed / Approved	Low	Warren Jackson	Recovery action - to deliver CIP	Rec
NEW Oct 2026 IBD contract termination	Non-rec trial to start off with	8	16	01-Dec-26	Agreed / Appr	Med	Peter Grant	Recovery action - to deliver CIP	NR
Adjusted Forecast / Recovery Gap		**(3,577)**	**(3,020)**						

Recovery Action Plan

Care Group:	Specialist Cancer & Support Services	£'000
Forecast Variance as at:	M6	(6,618)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
Clinical Engineering Repairs	Ceasing repairs and support on equipment over 10 years in age - eQIA completed and supported	11	85		Agreed / Approved	Low		Recovery action - to deliver CIP	Rec
Onc & Haem External Testing Review	Challenge the breadth of external specialist testing and review what isn't necessary and what can be downgraded to local labs instead	TBC	TBC		Scoping	Med		Recovery action - to deliver CIP	Rec
HCD Income Recovery	Embed group-wide income recovery process to align NLAG recovery with HUTH	129	388		Scoping	High		Recovery action - to deliver CIP	Rec
Biosimilar Gains Share/Further opportunity	Negotiate gains share arrangements with ICB/NHSE. Identify and progress further biosimilar switches	1,045	1,045		Plans in development	High		Additional Income allocation	NR
Manufacturer review in IR	Looking to standardise/rationalise product options	20	40		Plans in development	Low		Recovery action - to reduce forecast expenditure	Rec
IRT Stock Management	Ensuring stock processes, including regular stock takes, Scan4Safety, and consignment are actively supporting the financial position	100	100		Plans in development	Med		Recovery action - to reduce current expenditure	Rec
Breast Tissue Consumables	Product switch to be reviewed for cost effectiveness and clinical appropriateness	17	50		Plans in development	Low		Recovery action - to deliver CIP	Rec
Ultrasound Probe Maintenance	Review scope of maintenance contracts and risk appetite for probe cover	18	72		Plans in development	Low		Recovery action - to deliver CIP	Rec
Shadow On-Call Review		7	28		Scoping	Med		Recovery action - to deliver CIP	Rec
Implement Reporting Productivity Model	National tool now available, reviewing to identify opportunity to implement	150	360		Scoping	High		Recovery action - to deliver CIP	Rec
OPAT Drugs	Support transition to 7 day model to reduce premium drugs expenditure	25	50		Plans in development	Med		Recovery action - to reduce current expenditure	Rec
Variable pay reduction (Pharmacy)	Enforce cut off times for IDL	25	75		Scoping	High		Recovery action - to deliver CIP	Rec
Vacancy Hold	Support Group-wide vacancy freeze by holding non-essential vacancies which don't adversely impact variable pay - estimated at 10wte being held	300	0		Plans in development	High		Recovery action - to reduce forecast expenditure	NR
Removal of Hospital funded welfare rights officer (service commissioned from ERYC).	EQIA supported by care group, work progressing to understand contractual implications/exit arrangements	0	60		Plans in development	Med		Recovery action - to reduce forecast expenditure	Rec
CT ED Business case	Delays in recruiting additional staffing requirement	90	0		In delivery	Med		Recovery action - to reduce forecast expenditure	NR
Management of CIP schemes to ensure progression/delivery	Remove risk rating from forecast	969	969		Plans in development	Med		Recovery action - to remove forecast risk	Rec
Adjusted Forecast / Recovery Gap		(3,713)	(3,296)						

Recovery Action Plan

Care Group:	TACC	£'000
Forecast Variance as at:	Month 5	-3,046

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve						
CRES Unidentified- HUTH	Improved delivery of CIP	2,500		ASAP	Plans in Development		TACC Tri		Recurrent
Acute Latent Sessions Cease	Cease unfunded sessions	310	460	Oct-27	Plans in Development		TACC Tri		Recurrent
F2 MT Transfer - HUTH	Agree Transfer Between MT & TACC. Discussed at TACC Exec M3	260	260	Oct-26	Scoping		Hayley Briggs, Caroline Hibbert, Lorraine Laws		Recurrent
HUTH Drugs	Understand reasons for and seek control of Drugs position	250	400	Jan-27	Scoping		Rob Bourne		Recurrent
CRES Unidentified - NLAG	Improved delivery of CIP	1,000		ASAP	Plans in Development		TACC Tri		Recurrent
F2 Pressure NLAG	Do not renew	33	67	Apr-27	Plans in Development		Sophie Fisher		Recurrent
Adjusted Forecast / Recovery Gap		**1,307**	**0**						

Recovery Action Plan

Care Group:	Community, Frailty & Therapies	£'000
Forecast Variance as at:	Month 6	(3,774)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
NCTR Capacity	Exec decision on option paper submitted				Plans in development	High	Exec	Recovery action - to reduce forecast expenditure	Rec
Review of CHCP/HUTH Palliative care medical staff	Approval of Business model by CHCP	17	50	30-Nov-26	Plans in development	Med	Care Group Board	Recovery action - to deliver CIP	Rec
CHH Overnight Hospital at Night	Revert to previous model on CHH Med cover - requires Exec Approval	71	170	31-Oct-26	Plans in development	High	Exec	Recovery action - to reduce current expenditure	Rec
Active Sickness Management	Targetted actions to reduce high levels of sickness - IN FORECAST				In delivery	Low			Rec
Ward Staffing - review of levels and funding	remove additional nurse staff on rotas until funding starts in October - ACTIONED - IN FORECAST			30-Jun-26	In delivery	Low	Care Group Board	Recovery action - to reduce current expenditure	NR
Secure deanery funding	Funding request to be approved - ACTIONED - IN FORECAST				In delivery	Low			
Increased Variable pay reductions	Further stretch challenge re variable pay reductions - IN FORECAST				In delivery	Low			
Adjusted Forecast / Recovery Gap		**(3,687)**	**(3,554)**						

Recovery Action Plan

Care Group:	Family Services Care Group	£'000
Forecast Variance as at:	Month 06	(4,741)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
Uncosted CIP Schemes	A&G templates being rolled out to reduce acceptance of non commissioned pathways. EG Sleep. This will reduce the melatonin medication spend	100	200	01-Oct-26	Agreed / Approved	Low	Lisa Pearce	Recovery action - to reduce forecast expenditure	Rec
Cease use of Agency staff	Phase out usage of agency medical staff as we recruit to med staff expansion bus case	180	480	31-Mar-27	Plans in development	Med	Lisa Pearce	Recovery action - to deliver CIP	Rec
Paediatric Surgery Consultant Costs	Removal of cost pressure - end of Cons locum contract	50	0	01-Oct-26	Agreed / Approved	Low	Lisa Pearce	Recovery action - to reduce current expenditure	NR
Hospital at Home - NLAG	Decommission Hospital at Home service model - NLAG	230	350	01-Sep-26	Plans in development	Med	Debbie Bray	Non Recurrent benefit	Rec
Reduction of ECP	Workforce expansion will support additional ECP reduction via flexi job planning with consultant expansion across gynaecology and paed/neonates	100	360	01-Mar-26	Plans in development	Med	Clinical Leads and Clinical Director	Recovery action - to deliver CIP	Rec
Neonatal Critical Care Review	Outcome of the regional NCCR to be implemented. It is anticipated that this will reduce the status of the SGH service from LNU to a SCU leading to an HHP neonatal configuration of NICU HUTH L3, LNU DPoW L2, SCU SGH L1. At present efficiences are unknown given the large scale transformation and likely formal public consultation that will be required to deliver the change. NB The fallout of the NCCR will require reconfiguration of the matenrity pathways which may have financial efficiences, however these are unknown at this time	0	tbc	Unknown NHSE / Spec Comm / ODN led exercise	Plans in development	Med	NHSE	Recovery action - to reduce current expenditure	Rec
Site consolidation of Gynaecology services NLAG	Undertake a scoping exercise to review the options regarding gynaecolgoy elective and non elective pathways, IP and OP across NLAG	0	tbc		Scoping	High	QUAD	Recovery action - to reduce current expenditure	Rec
Paediatric Critical Care Service HUTH	Undertake a review of the service model and commissioning of critical care service model at HUTH - Income v's cost.	0	tbc	2027	Scoping	High	Debbie Bray	Recovery action - to reduce current expenditure	Rec
Paediatric Neonatal Surgery Senate	Outcome of the Neonatal Surgery Senate to be implemented. This may deliver some savings, however this will be unknown until the recommendations are received	0	tbc		Plans in development	Med		Recovery action - to reduce current expenditure	Rec
Drug Review	Undertake a further deep dive with pharmacy colleagues to explore any medication / prescribing efficiencies or standardisation of practice	20	60	01-Oct-26	Scoping	Med	QUAD	Recovery action - to reduce forecast expenditure	Rec
Reusable Bottles	Replace disposable bottles with reusable bottles - North bank (already in place south bank)	5	10	01-Oct-26	Agreed / Approved	Low	Yvonne McGrath	Recovery action - to reduce forecast expenditure	Rec
Conversion of community clinic Gynae NLAG	Convert the community based clinic on site to DPOW, this is due to the lack of efficiency and use of the community clinic. Currently pay rent and taxi fare to transport staff. Bi weekly clinic - Louth and Mablethorpe - 2 rooms, travel in work time so clinic capacity is compromised.	5	10	01-Oct-26	Scoping	High	Clinical Lead DPOW	Recovery action - to deliver CIP	Rec
Adjusted Forecast / Recovery Gap		(4,051)	(3,271)						

Recovery Action Plan

Care Group:	neueosciences Care Group	£'000
Forecast Variance as at:	Month 06	(1,725)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
Reduction in Nurse OT HUTH	Reduce OT to min	60	120	31-Mar-27		Low	L.Chollerton	Recovery action - to reduce forecast expenditure	Rec
Cease use of Agency staff	Phase out usage of agency medical staff as we restricted duties reduce	86	312	31-Mar-27	Plans in development	Med	Ben Davison	Recovery action - to deliver CIP	Rec
Drug Review	Undertake a further deep dive with pharmacy colleagues to explore any medication / prescribing efficiencies or standardisation of practice	20	60	01-Oct-26	Scoping	Med	Tri	Recovery action - to reduce forecast expenditure	Rec
Adjusted Forecast / Recovery Gap		**(1,559)**	**(1,233)**						

Recovery Action Plan

Care Group:	Specialist Medicine	£'000
Forecast Variance as at:	Month 6 (September-26)	**(3,105)**

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Progress status	RAG Rating	Recurrent / Non-Recurrent
vacancy pause	to review vacanct posts & impact on activity / waiting lists	16	Agreed / Approved	Low	NR
reduce NLG Respiratory Agency (from 3 to 2 posts	impact on activity/WL - (Oct-Dec)	0	Agreed - in M6 forecast		Rec
Insulin Rebates (£15k assumed in CIP plan)	to confirm any additional rebates above forecast	0	confirmed no further rebates		NR
CPAP consumables - increase in unfunded activity (£914k forecast pressure)	escalated at exec review as funded on block.activity impact of increased sleep studies. Options? cease activity & also pursue additional block funding?	400	Escalated at Exec Review & ICB contract discussions	Very High	Rec
Review of non-commissioned (unpaid) work/activity (CNS staff) - efficiency not cost out? Divert to			support by GT (TBC)		
Ward Reviews - bed reduction			support by GT (TBC)		
Lung Cancer Screening - review of staffing resource & pathways across HHP		20	Scoping	Low	Rec
Adjusted Forecast / Recovery Gap		**(2,669)**			

NHS
Humber Health Partnership

Update on Cash Requirements for 2026/27: Revenue Support Public Dividend Capital (PDC)

1. Purpose

The purpose of this paper is to provide an update on the Group's cash position, the mechanisms in place for cash support and the key drivers of the Group's reliance on this cash support in 2026/27 via Revenue Support PDC.

2. Background

The Group submitted a deficit financial plan of £63m for 2026/27 and at the time of writing this plan has still not yet been formally approved by NHS England (NHSE). Published NHSE business rules for 2026/27 require each NHS trust to deliver breakeven in its revenue position unless agreed otherwise and only in exceptional circumstances. Where a deficit plan has been approved by the national team, the usual mechanism for ensuring Trusts in deficit have sufficient cash to pay staff and suppliers would be access to Deficit Support Funding that would bring Trust plans back to breakeven, although access to that funding would remain contingent on delivery of that approved plan.

Without an approved plan or access to Deficit Support Funding the Group does not have sufficient revenue cash through income sources to meet all of its liabilities and is therefore reliant on requesting cash support from NHSE on a monthly basis.

3. Provider Revenue Support PDC – Overview

- Revenue Support PDC is available to support revenue expenditure only and is available to Providers for necessary and essential expenditure to protect continuity of patient services.
- Providers need to demonstrate their revenue cash requirements to NHSE, after exploration of local system solutions.
- Revenue support takes the form of Public Dividend Capital (PDC), with no set repayment date, but attracts a dividend payable at the current rate (3.5%).
- PDC support for capital expenditure follows a separate process and needs to be submitted to the NHSE Capital and Cash Team.
- Capital PDC should not be used for revenue expenditure. If there is a revenue requirement, Revenue PDC should be requested. As such, boards will be required to set out how they will spend their CDEL allocation so that capital projects are not slowed to prop up the cash position.
- Providers receiving revenue support may be set conditions which NHSE expects they implement or adhere to, and evidence if requested.
- All requests are subject to NHSE/DHSC scrutiny and governance, and there is no guarantee that submitted requests are approved.

4. NHSE Guidance.

- A Trust requiring cash support should first discuss requirements with the system to test whether neighbours can provide cash via intra ICS cash transfer. This is not currently an option due to the financial challenges of other Providers within the HNY ICB.

- If a solution can't be agreed with the ICB, the system should escalate to the regional team for review. Once the regional team is satisfied that the trust is doing all it can and a system solution is not available, it is escalated to the national team and to DHSC to request cash support
- The cash request must be supported by the CEO and Chair and set out agreed recovery actions including grip and control measures (first establishing and then demonstrating compliance), delivery of efficiency plans, headcount reductions, and the lead and lag metrics that will be monitored to ensure actions are being followed through.

5. Cash support requirements for 2026/27

Final financial plans submitted on the 30th of April 2026 assumed the Group would require Revenue Support PDC totalling £63m to support the planned deficit, split as shown below:

	HUTH	NLAG	HHP
	£'m	£'m	£'m
Revenue Support PDC planned	41.15	22.13	63.28m

The year-to-date financial position is driving an even larger cash requirement. Whilst the Group continues to forecast delivery of the planned deficit, 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 £58.6m, a gap of £60.5m,

The variance from plan year-to-date and the Quarter 3 forecast is adding further pressure to the cash position for the Group and this is reflected in the higher than planned cash request.

Based on the mid-case forecast, the deficit at the end of November will be:

	Plan (M1-8) £'m	**Forecast (M1-8) £m**	**Variance (M1-8) £m**
HUTH	(29.6)	(57.9)	(28.3)
NLAG	(17.8)	(23.3)	(5.5)
Total	**(47.4)**	**(81.2)**	**(33.8)**

The forecast cash requirements for the Group up to the end of December is £68.5m and the details for both Trusts are shown in the tables below:

NLAG Revenue Support PDC:

£m	AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09	Total
Planned Drawdown	-	-	1.40	0.39	1.84	5.12	-	1.89	3.56	14.19
Requested Drawdown	-	-	1.40	3.11	2.85	5.98	3.48	3.55	3.99	24.37
Confirmed Drawdown	-	-	1.40	0.39	2.85	2.50	2.50			9.64
Forecast up to the end of Q3	-	-	1.40	0.39	2.85	2.50	2.50	3.55	3.99	17.18

HUTH Revenue Support PDC:

£m	AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09	Total
Planned Drawdown	-	6.89	5.07	-	7.14	3.03	-	2.15	4.59	28.87
Requested Drawdown	-	6.35	6.68	6.80	9.01	15.61	9.03	8.26	13.83	75.56
Confirmed Drawdown	-	6.35	4.00	2.78	6.56	3.20	7.50			30.39
Forecast up to the end of Q3	-	6.35	4.00	2.78	6.56	3.20	6.34	8.26	13.83	51.31

The finance team monitors the cash forecast daily to minimise the cash support requirement and will request on a monthly basis the minimum required to maintain recommended cash balances of c.£2m.

The PDC application process requires evidence that the cash position and the Revenue Support PDC values being requested have been discussed and approved at Board level. The application deadlines are extremely tight, with only a few days between receiving confirmation of the previous month's applications and the national submission deadline for the current month. Therefore the cash requirement for Month 9 will be confirmed verbally at the Board meeting and may vary from the forecasts shown above depending on both Month 8 financial performance and whether the Month 8 cash applications are approved in full.

6. Revenue Implications of Revenue Support PDC

Revenue Support PDC is not repayable but does attract an additional dividend charge which is higher in the year of draw down. Based on the forecast PDC requirement up to the end of Month 9, there will be an additional revenue cost of £1.8m for HUTH and £0.6m for NLAG. The additional cost pressure included in the 2026/27 plan reflected planned PDC requirements for the year, so failure to deliver the planned deficit position would drive an additional revenue pressure.

7. Cash management controls in place

A cash committee for the Group has been in place since January 2026. This committee is responsible for overseeing, monitoring and reviewing the Group's cash management performance and processes and developing cash recovery plans where required.

Both Trusts have been actively managing their cash positions for a number of months due to underlying cost pressures and this has impacted the Better Payment Practice Code performance. In recent months we have seen a huge increase in the number of suppliers threatening to apply late payment fees or stop provision of goods or services. The majority have been averted through our payment prioritisation process, but the number of prioritised payments has continued to grow putting pressure on payment runs reduced due to cash restrictions.

The Trust outsources it's accounts receivable services to a shared service, East Lancashire Financial Services, (ELFs), who actively pursue any outstanding debt on the Group's behalf.

8. Conclusion and Recommendation

The Board is asked to note the above update and to approve the Month 9 Revenue Support PDC cash application for both Trusts, the value of which will be confirmed verbally at the meeting.

Date: 23rd October 2026
Author: Philippa Russell, Deputy Group Chief Finance Officer

NHS
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Partnership

Cash Committee TO Performance, Estates & Finance Committees-in-Common: ADVISE, ALERT and ASSURE	
Cash Committee:	
Meeting Date:	12th October 2026
Chair:	Philippa Russell, Deputy Group Chief Finance Officer

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Board to areas of non-compliance or matters that need addressing urgently)

Issue	Update	Assurance received	Action	Timescale
Impact on cash forecast due to limited progress in progressing CIP plans / Cash Releasing savings	At Month 6 the Group was £20.8m overspent with a risk adjusted CIP forecast that is £60.5m short of delivering the target. The financial plan for the year has still not been accepted by NHS England.		The impact on cash requirements due to slippage on CIP to be highlighted to PEF and Board as a continuing significant risk.	Oct 26
Forecast Revenue Support PDC required for Q3 for the Group is £68.49m, £25.43m higher than the planned value, but £7.01m lower than the value approved at PEF / Board in September.	An application for cash support has been submitted to NHS England as follows: Nov: 8.26m for HUTH, £3.55m for NLAG Year to date cash requirements (M1-8): HUTH £37.49m	Cash allocations confirmed for October - £2.50m for NLAG and £7.50m for HUTH. NHSE Regional team have supported the November applications. Cash forecast reviewed daily to confirm future	Awaiting confirmation from NHSE on November PDC applications. December requirements to be confirmed once confirmation of allocation has been received and applications completed in line with national deadlines. NHSE will require evidence of	Confirmation of outcome / Memorandum of Understanding due 6th November 26 National deadline for Nov submission is 11th November 26

	NLAG £13.19m Both Trusts remain within the envelope approved at the PEF meeting on the 1st of September	requirements. 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 Prioritisation process in place to ensure critical suppliers are paid promptly. Capital cash remains higher than planned.	explicit approval of monthly cash requirement at both PEF and Board. Cash support applications have been explicit about short term likely requirement to utilise capital cash to manage payroll and priority suppliers if there is a further shortfall in cash allocated.	

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
Outstanding accrued income and delays in raising invoices.	All teams have been asked to review income accruals and ensure all invoices have been raised		All requisitions for H1 to be raised by the end of October.	Oct 26
Progress in reducing aged debt	Aged debt remains broadly unchanged and York continues to be highlighted as a significant issue. Overseas visitor debt is becoming more prominent within the largest debtor balances and presents a recovery risk.	Working closely with York & Scarborough to reduce level of debt on both sides and have seen some progress during August.	Old invoices relating to CAP (York & Scarborough) have been escalated, but not yet resolved (to chase).	Oct 26

There is a material emerging exposure to historic late-payment charges. A claim of approximately £325k from is being validated, with further exposure possible given historic delays in paying invoices.		Issue that has been flagged by National team is effecting many NHS organisations. Instructed Capsticks to support.	Update following receipt of legal advice.	Nov 26
GT and Procurement working together to review stock management with potential savings linked to the use of inventory management. Need to review min and max stock levels with local teams.	Stock presents both a cash opportunity and a control risk. Work elsewhere was reported to have achieved a 31% reduction in stockholding, demonstrating potential scope for improvement locally. Specific concerns include bulk purchasing, the accuracy and frequency of stock counts, expired/write-off stock and the robustness of cardiology stock information.	Edd James has shared stock write off data with his team and are reviewing significant values and consignment values where they are high. Some unusual write offs items including gloves that Edd will pick up with Mat Man teams.	A more structured Finance/Procurement approach with budget-holder ownership is required. Edd James to ask Mat Man teams to review unusual write offs including gloves and highlight areas that require a deep dive.	Dec 26
ASSURE (Provide any areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
The Committee agreed that balance-sheet governance should be strengthened, with greater monthly scrutiny by Finance Managers and senior Heads of Finance across debtors, creditors and accruals.		Review of year end balances completed.	Centrally held reconciliation links will be shared to facilitate review and sign-off on a monthly basis by Heads of Finance.	Dec 26

Delays in approval and payment of intergroup recharges.	Progress continues on reducing inter-trust balances, with around £800k moved between Hull and NLAG in the previous week.			
Impact of much lower than requested PDC Revenue Support in September (HUTH)	Approved cash application for October was much closer to the value requested. Increased October payment runs should enable some recovery from the restrictions experienced in August and September.	Continuing to successfully manage cash balances through supplier prioritisation.		

NHS
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Partnership

Group Capital Committee TO Performance, Estates & Finance Committees-in-Common: ADVISE, ALERT and ASSURE	
Group Capital Committee:	
Meeting Date:	23rd September 2026
Chair:	Alison Drury, Assistant Director of Finance

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

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
Significant areas of slippage against the national allocations for "Return to Constitutional Standards"	For HUTH the scale of this slippage is £8.3m, with over 5.7m of this relating to the UEC SDEC/discharge schemes and slippage being due to the BSR process and planning permission delays. Other slippage relates to	Planning permission received for Landsdown block. Proposals to bring forward schemes from next year have been proposed, including b/f BLM, LINAC replacement and theatres refurbishment and agreed at	Awaiting confirmation of acceptance of the proposals from the regional/national team following submission of the month 6 finance returns.	30-11-26

	the replacement Gamma Camera due to the scheme requiring further planning and the BSR process being required given its location – a bring forward scheme of the Linac replacement has been proposed. For NLaG the scale of the slippage is £3.2m and mainly relates to the Gamma Camera Scheme and £1m funding for an MRI in the CDC	Execs. For NLaG, the delays in the Gamma Camera scheme cannot be mitigated by any other bring forward scheme and therefore national brokerage is requested. It is also proposed to return the £1m funding for the MRI in the CDC in Scunthorpe due to lack of demand in this area.		
Significant slippage relating to EPR implementation.	Brokerage arrangements agreed last year to defer the funding to this year will need to be moved on a further year. The value of this slippage is £5.7m HUTH and £3.6m NLaG	Requests have been made for postponing the brokerage with other Trusts to 2027/28 have been made. However, all Trusts within HNY ICB are reporting slippage and there is a risk that this is not possible within HNY.	Awaiting outcome from regional discussions following the review of the Trusts' month 6 forecasts. May require NHSE support for brokerage out with HNY. System capital meeting to be agreed.	30-11-26
Operational representation at the Group Capital Committee is often lacking and as a result there is often a requirement to follow up decisions virtually for quoracy.	Dates have been changed this year to avoid some of the clashes reported last year but we still seem to struggle with representation from each site (current North/South site)	Planning priorities and the draft capital programme for 2027/28 to be shared and discussed at the Business Case Approvals Group	Given future meetings will start to consider firming up the capital programme for next year and beyond, as part of the operational planning process – need to consider appropriate representation from both Trusts.	

ASSURE (Provide any areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
The funding profile of the Estates Safety Funding for the HRI tower block cladding scheme.	This has been revised from £12.5m this year to £2.4m.	The revised profile has been accepted and confirmed by NHSE	Complete	

NHS
Hull University Teaching Hospitals
NHS Trust

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)295

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	12 November 2026
Director Lead	Jane Hawkard, Non-Executive Director / Chair of Audit, Risk and Governance Committees-in-Common
Contact Officer / Author	Jane Hawkard
Title of Report	**Audit, Risk and Governance Committees-in-Common Minutes – July 2026 - Public**
Executive Summary	Public minutes of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting held on 30 July 2026, approved at the ARG CiC meeting on 15 October 2026.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – 30 July 2026
Prior Approval Process	ARG CiC meeting – 15 October 2026
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 30 July 2026 at 9.00am to 12.30pm via Microsoft Teams

For the purpose of transacting the business set out below:

Present:
Core Members:

Jane Hawkard	Chair of ARG CiC (HUTH) - Non-Executive Director
Julie Beilby	Non-Executive Director (NLaG)

In Attendance:

Emma Sayner	Group Chief Financial Officer
Rebecca Crashley	Group Deputy Director of Assurance
Sally Stevenson	Assistant Director of Finance - Compliance & Counter Fraud
Keith Haynes	Interim Board Secretary
Harriet Fisher	Director, KPMG – Group Internal Audit
Makhosi Mazibia	Audit Manager, Forvis Mazars – External Audit HUTH
Brian Clerkin	Partner, Sumer NI – External Audit NLaG
Gerard Curran	Head of Legal (for items 9.10 & 9.11)
Jonathan Brown	EPRR Manager (for item 9.1)
Stacey Howard	Workstream Lead – NHS England (for items 9.2 & 9.3)
Richard Dickinson	Associate Director of Quality Governance) (for items 9.5 & 9.6)
Tony Deal	Group Chief Technology Officer (for items 13.1 to 13.5)
Sue Meakin	Group Data Protection Officer and IG Lead (for items 13.1 to 13.5)
Dr Alastair Pickering	Interim Group Chief Digital Officer (for items 13.1 to 13.5)
Mike Bateson	NLaG Governor Observer
Jo Palmer	PA to Committees-in-Common (Minutes)

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

The meeting was recorded, and the recording will be deleted once the draft minutes are approved as correct.

1. Welcome and Apologies for Absence

Jane Hawkard, Audit, Risk and Governance Committees-in-Common (ARG CiC) Chair, welcomed colleagues to the meeting. Apologies for absence were received from Murray MacDonald, Non-Executive Director / HUTH Vice Chair, Hilda Gwilliams, Group Chief Patient Safety Officer, Nicola Hallas, Engagement Lead, Forvis Mazars and Matt Overton, Group Operations Director (Emergency Preparedness, Resilience and Response (EPRR)).

2. Declarations of Interest

Jane Hawkard asked for any declarations of interest, and none were made.

3. To approve the minutes of the meetings held on 18 June 2026

3.1 Public Minutes – 18 June 2026

The public minutes were approved as a true and accurate record of the meeting.

3.2 Private Minutes – 18 June 2026

The private minutes were approved as a true and accurate record of the meeting.

4. Matters Arising and Review of ARG Action Tracker

4.1 Public Action Tracker

The following items were discussed from the public action tracker:

- January 2026 – Item 9.6 – Jane Hawkard updated the ARG CiC and advised that it needed to be agreed with the Group Chair whether there is to be one more meeting of the Charitable Funds Committee (CFC) for HUTH to receive their accounts or whether this should be delegated to the HUTH Trust Board. The Group Chair is also preparing a paper on the final governance arrangements for closing the HUTH CFC now it has transferred to WISHH. A further update to be provided at the January 2027 meeting.
- April 2026 – Item 12.4 – Emma Sayner confirmed that this had now been incorporated into the Core Financial Controls audit and Harriet Fisher advised that the Internal Audit report would be brought to the October 2026 meeting. Action closed.
- April 2026 – Item 12.5(a) – on the agenda. Action closed.
- April 2026 – Item 12.5(b) – Emma Sayner advised she had spoken with Myles Howell and Keith Pringle in terms of the comms for highlighting the cost of wastage, including pharmacy waste. To remain on the tracker until comms issued.
- April 2026 – Item 12.6 – Following discussion of the action (exploring whether such declarations could be incorporated into the mandatory training system) it was agreed to close the specific action. Jane Hawkard stated that there needed to be a process that actually got employees to make the necessary declarations in line with the Standards of Business Conduct Policy. It was noted that the next routine report of such declarations was due at the October 2026 meeting. Julie Beilby agreed it was not the highest priority but it was a clear example of the need for the Group, at the very least, to focus on ensuring basic requirements were in place. Keith Haynes commented that he was aware of other organisations that addressed this via the job planning and appraisal process for Consultant staff, but advised that he was aware of similar struggles at other Trusts and acknowledged that it should be built into an existing process where possible.

Gerard Curran joined the meeting at 9.08am.

- April 2026 – Item 12.8 – Rebecca Crashley clarified that at the monthly Group Executive Risk and Assurance Committee (GERAC), Hilda Gwilliams went through each of the outstanding policies, in addition to the Executive Directors receiving a

list of the status of each of their policies. Action closed.
- June 2026 – Item 7.2(a) – on the agenda. Action closed.

All other actions were either confirmed as on the agenda, closed or due at a later ARG CiC meeting. The private action tracker to be dealt with in the private section.

The running order of the agenda was amended to enable discussion of Items 9.10 and 9.11 while Gerard Curran was in attendance.

9. 9.10 Review of Legal Fees – Group

Jane Hawkard asked for any questions and commented that legal costs had increased considerably on the previous year, having referred to the paper from the previous year to undertake the comparison as this detail was not in the latest paper. Gerard Curran replied that this was the first year he had prepared the report so would investigate this further. Gerard Curran advised that the tender with Capsticks was ending in October 2026 and this was now an opportunity for the Group to assess whether to continue with a tender agreement which does bring cost savings in terms of fee agreements with a single company or whether the Group accesses a pool of firms where the Group is not tied to one firm but where the cost benefit would not be as great. Gerard Curran advised that he would prepare a paper which would highlight the positives and negatives of each option for consideration. Jane Hawkard queried where that paper would go and Emma Sayner clarified that this would be submitted through the Business Compliance Group, the Business Recommendation Group and depending on the value, the Senior Leadership Team (SLT) Execs meeting.

The ARG CiC accepted the report and were reasonably assured, noting that it was difficult to take greater assurance from it without the year on year comparative financial data included.

9.11 Annual Claims Report 2025/26 – Group

Julie Beilby advised that on seeing this report at the Quality & Safety CiC (Q&S CiC), the main discussion topic was on how learning could be embedded within the organisation from these cases and a suggestion had previously been to perform some spot checks to ascertain whether any learning had been adopted within day-to-day practice. Julie Beilby did not consider there was still any assurance that this learning was indeed happening, adding that they would be highlighting that in the escalation report to the Trust Boards-in-Common from the Q&S CiC.

Gerard Curran accepted that embedding learning was a challenge generally within the organisation and he cautioned the Committees that claims data was lagging data i.e. there was a time lapse of around four and a half years between the date of the incident (treatment) and the data presented on the settlement of claims and a lot can happen in such a timeframe (e.g. the Trust's were not operating as a Group 4.5 years ago) The ARG CiC discussed the need for more robust communications with Care Group Quality Governance teams around the requirement to embed learning from claims data, and that this should be a priority area for action. Jane Hawkard stated that an effective learning process was required and considered this to be an area for potential inclusion within the rolling internal audit plan. Julie Beilby concurred, adding that it should look at improvements, learning and cost reduction, and acknowledged that whilst not directly a top priority, it was important to learn from past incidents and this had been a theme of questioning at the recent CQC well-led interviews. The ARG

CiC asked Harriet Fisher to add this to the long list of potential audit areas for the three year cycle of audits.

ACTION: Harriet Fisher

Gerard Curran left the meeting at 9.21am. The meeting reverted to the normal running order.

5. NLaG External Audit (Sumer NI)

5.1 Verbal Update

Item 5.1 taken together with 5.2.

5.2 NLaG Auditors Annual Report 2025/26 – Final

A draft of the Auditors Annual Report has been seen at the June 2026 ARG CiC meeting, this was the final version for completeness.

Brian Clerkin advised that the final audit completion certificate could not be issued until after the departmental audit was completed by the National Audit Office.

Brian Clerkin also advised that The Health Tree Foundation accounts had been audited but not yet been approved and signed. This final stage was expected imminently.

The report was noted.

Emma Sayner left the meeting for a short duration at this point.

5.3 NLaG External Audit Recommendations – Status Update

Sally Stevenson advised the ARG CiC that this report provided an update from Nicola Parker, Assistant Director of Finance, in relation to the Finance recommendations from the Sumer NI audit report, noting that some were complete and others on-going. Another update would be brought to the ARG CiC in October 2026.

Jane Hawkard noted that there was no update in the report on the Value For Money (VFM) actions, despite there being three recommendations in the Sumer NI report. Sally Stevenson clarified that it had been agreed that Stacey Howard from NHSE would provide a verbal update (on behalf of Ben Smith who had been scheduled to attend) on this later in the meeting and a written update would be provided at the October 2026 meeting.

ACTION: Ben Smith, NHSE

6. HUTH External Audit (Forvis Mazars)

6.1 Verbal Update

Makhosi Mazibia confirmed that the audit was complete and the audit completion certificate would be issued once the National Audit Office had confirmed there was no further work required in terms of the whole government accounts.

6.2 HUTH Auditors Annual Report 2025/26 – Final

Makhosi Mazibia clarified that although the full report was not shared with the ARG CiC at its June 2026 meeting, the commentary from the report was included in the Audit Completion Report in June 2026, except for the recommendation on page 36 which had subsequently been finalised.

Jane Hawkard commented on the reference to setting out clear recommendations and requirements for escalation to enable timely decision making and asked whether the current AAA (Alert, Assure, Advise) style of reporting within the Group was to be reviewed for its effectiveness by Keith Haynes. Keith Haynes confirmed this would be picked up either as part of the Board Governance Manual or in some other form, adding that the CiCs' terms of reference would be reviewed although noting that they were fairly recently updated. Keith Haynes also commented that after attending his first Trust Boards-in-Common meeting and seen AAA reporting starting to be used, he considered that it would add value. Jane Hawkard stated that it was not being used consistently yet, with reports not looking the same, etc.

6.3 HUTH EA Recommendations – Status Update

Sally Stevenson advised that Nicola Parker had also provided updates on these and that further updates would be brought to the October 2026 meeting.

Emma Sayner returned to the meeting at this point.

6.4 HUTH Additional Audit Fees 2025/26

Jane Hawkard commented that it was surprising to see additional fees for what sounded like normal audit work that would be included in the contract fee. Emma Sayner advised that she had had a robust discussion with Nicola Hallas around the initial proposed additional fee which had been higher than that in the paper, but had managed to bring the additional fee down through a process of negotiation. Emma Sayner commented this was the second year that an additional fee had been levied and would relay the ARG CiC comments to Nicola Hallas.

ACTION: Emma Sayner

The running order of the agenda was again amended at this point to enable discussion of Items 9.9, 9.12 and 9.13 while Emma Sayner was in attendance.

9. Management Reports for Assurance

9.9 Review of External Consultancy Fees – Group

Emma Sayner advised the ARG CiC that the numbers and costs are reflected in the accounts, but there was an exercise to look back and ensure that the appropriate approvals were in place and in line with NHSE business case approval levels. The report demonstrated a breakdown of each area of expenditure for both Trusts and what the approval levels were, etc.

Jane Hawkard questioned what Efficio was and what they do and Emma Sayner explained that it was a third-party company which supported procurement work and specific operational teams to make savings. As part of the business case prior to the organisation moving to a Group model, there was a proposal to engage with this

company, who worked on a contingent fee basis, with no upfront commitment so not deemed to require NHSE approval on an ongoing basis. However, NHSE approval was given at the time of the arrangement being set up a few years ago. Emma Sayner added that she was currently in discussion with Edd James, Director of Procurement, around what Efficio are doing, etc. to ensure maximum value was derived from the arrangement. There is a break point in August 2026 and this would provide an opportunity to link in with the financial recovery work headed up by both Keith Pringle, Financial Improvement Director and Grant Thornton.

Jane Hawkard also asked about the recognition of what would be classed as an external consultancy fee and what controls were in place to ensure proper approval was not bypassed. Emma Sayner replied that, although she was unable to provide assurance that there was a completely fail-safe process in place, a robust discretionary spend process was in place for requests above £5K, with a checklist which included the question around consultancy and whether NHSE approval was needed.

The ARG CiC received good assurance and accepted the report.

9.12 Group OSV Processes Review Findings

Emma Sayner advised that Craig Hodgson was the author of the paper and was able to join the meeting if needed. The ambition was for a Group approach to Overseas Visitor (OSV) processes and the report set out where the Trusts were and how they compared, and that it was work in progress. The ARG CiC noted that NLAG recovered more OSV income than HUTH and that the NLAG team was better resourced to do so in terms of WTE capacity. It was important to consider how it would be resourced to ensure maximum financial recovery and minimise the level of write-offs. Once initial work was complete, the business case proposal would be presented at the Business Case Compliance and Recommendation Group.

Julie Beilby queried why it sat within Estates and Facilities rather than Finance, commented on the choice of comparator organisations and also referred to the potential for additional income but with no sense of scale of that additional income, although Julie Beilby acknowledged that detail probably came in to play at the business case stage. Emma Sayner offered to look at where OSV sat within the organisation and what best practice looked like at other Trusts and whether there were benefits and barriers of it being placed within one team or another.

ACTION: Emma Sayner

Jane Hawkard appreciated that work was still in progress around this and it needed to be clear what the requirements were from a workforce point of view and whether a Group model would be the best option. It was necessary to ensure that the right processes were in place to recover income and if income was being lost it needed to be looked at, and asked for an idea on the timescale for this. Emma Sayner replied that she would estimate the end of the calendar year but that would depend on putting it into the context of other priorities (e.g. cleaning harmonisation, etc) and being realistic about where this sat in terms of priorities, so would consult with the team.

ACTION: Emma Sayner

The ARG CiC considered that there was only limited assurance from the paper.

9.13 Briefing Paper – Annual Indexation for Valuations

Emma Sayner advised that the paper was simply for information at this time, but happy to take questions. Jane Hawkard asked if there was any timescale for further information being published, and Emma Sayner advised not at this stage. It was noted the paper stated that it was expected to commence in 2027/28. The ARG CiC discussed accounting treatment with Emma Sayner, but it was not known at this early stage what the actual bottom line impact would be and whether any detriment would be neutralised through being funded.

The paper was accepted for information.

Emma Sayner left the meeting at 9.51am to attend another meeting.

7. Group Internal Audit – KPMG

7.1 Group Internal Audit Progress Report 2026/27 inc. Status of Management Actions

Harriet Fisher updated the ARG CiC that good progress was being made with the 2026/27 audit plan and reports would start being available at the October 2026 meeting. Harriet Fisher highlighted one proposed change to the plan which was related to the introduction of an Emergency Preparedness Resilience and Response (EPRR) audit which had been requested by the management, as they are due every three years and had fallen due for both Trusts. The proposal was to undertake the work over the summer period and produce a report in time for the September 2026 deadline. Management had suggested that, owing to the significant amount of external assurance work ongoing around the Cost Improvement Plan (CIP), that the CIP audit be removed from the plan this year and be included in the long list for next year.

Julie Beilby commented that she had mixed feeling about this, however was swayed in favour of the change due to the disruption of the care group review coming up and therefore content to leave scrutiny of the CIP to others at present. Julie Beilby also referred to concerns involving emergency preparedness, particularly in respect of the business continuity side things.

Jane Hawkard agreed with Julie Beilby's comments and having the external scrutiny of Grant Thornton in relation to the CIP, as well as the appointment of a Financial Improvement Director and the reviewing of the Programme Management Office (PMO), therefore was also content to approve the change. Jane Hawkard commented however that if all the external scrutiny ended then it may be something to revisit, as there was a need to improve managing its CIP plan to ensure it delivered the plan. It was agreed to alert the Trust Boards-in-Common to this decision to change the plan in relation to a high priority area.

In relation to follow-up of agreed management actions, Harriet Fisher informed the ARG CiC that nine actions had been implemented, leaving seven overdue which were detailed in the report. Harriet Fisher further advised however that detailed evidence had since been received however on two DSPT related actions which had been accepted for closure, so there were now five outstanding actions. Follow-up would be maintained by KPMG.

In relation to the Mortuary Services review, the final report was graded as 'partial

assurance with improvements required'. The key issue raised was around access controls to the mortuary across all sites, which was related to the number of individuals having access and the lack of differentiated types of access available. There were also issues raised over evidence of DBS checks and visitor records.

Julie Beilby expressed concern with the findings and asked Harriet Fisher if the report was pre or post the Fuller 2 report. Harriet Fisher advised it was post, and Julie Beilby commented that it incorporated Fuller 2 within it, and Harried Fisher confirmed it did. In relation to the DBS checks, Julie Beilby stressed it was important to identify a Human Resources lead for such an action. Regarding security staff, Julie Beilby questioned issues in relation to security staff. Julie Beilby also asked whether Goole & District Hospital was included within the report, as it had not been included within the Fuller Phase 2 review. Harriet Fisher confirmed that it had not been included in the Internal Audit report due to it being classed as a body store rather than a mortuary. Harriet Fisher accepted Julie Beilby's point about DBS checks, and explained about the need for them being required by the mortuary team for evidence but this needing to be enacted by the Human Resources team.

Keith Haynes spoke of Dr Peter Sedman's response and formation of an action plan to address the Fuller Phase 2 Review findings and it was agreed that this should also incorporate the actions arising from the Internal Audit report. Keith Haynes advised that he would contact Dr Sedman about this to ensure just one single action plan.

ACTION: Keith Haynes

Julie Beilby also referred to a concern around the maturity or otherwise of the Human Tissue Authority (HTA) governance group which had been referred to in the Internal Audit report. Jane Hawkard clarified that the Internal Audit report gave the ARG CiC low / no assurance particularly on mortuary access. Jane Hawkard asked whether there were any updates in terms of the actions, particularly the high importance ones being due 31st July 2026. Harriet Fisher replied that requests had gone out but no updates had yet been received but they were being monitored. Jane Hawkard made it clear that the Committees would not be accepting any revised implementation dates, and that message needed to be pushed back firmly but politely.

Jonathan Brown joined the meeting at 10.10am.

Jane Hawkard asked that the Q&S CiC follow this audit report up as part of the action plan for Fuller 2, and that the audit report actions were included in a consolidated action plan. This would avoid both Committee's duplicating the oversight of the actions. Julie Beilby accepted this suggestion and commented that it was also important for the Boards-in-Common to be sighted on this matter.

ACTION: Julie Beilby

It was agreed that both the Q&S CiC and the ARG CiC would be reporting this as an alert to the Boards-in-Common. Keith Haynes advised it was due at the September 2026 Boards-in-Common meeting.

The ARG CiC agreed it had received low assurance on the Mortuary Services audit report for the reasons discussed.

Jane Hawkard thanked Harriet Fisher for the good progress report, containing a lot of information in few pages.

8. Counter Fraud – Group

8.1 Group LCFS Progress Report

Sally Stevenson highlighted an error on the cover sheet of the report, under section 5.4 and confirmed it should read that seven of 21 referrals had been closed and not 23. Jane Hawkard commented that she was pleased to see that the new Group Local Counter Fraud Specialist would be commencing in October 2026. Sally Stevenson advised that the new member of staff had a lot of investigator experience and was excited to be joining the Group, and that in the meantime Mark Bishop was holding the fort in his part time role supplemented by herself where possible. Jane Hawkard was also pleased to see some of the cases being closed since the last report, and noted the successful financial recoveries.

The ARG CiC were assured that there was plenty of counter fraud work ongoing with some positive outcomes and welcomed the appointment of the new Group Local Counter Fraud Specialist.

8.2 Group Annual LCFS Report 2025/26 – *to be circulated virtually by September 2026*

This was noted.

9. Management Reports for Assurance

9.1 Group EPRR Highlight Report

Jane Hawkard welcomed Jonathan Brown to the meeting (attending on behalf of Matt Overton, Group Operations Director (EPRR)) noting that an AAA report had been provided which was very helpful. Jane Hawkard referred to page four of the report which detailed the recent events and exercises that had taken place and in respect of the HRI Evacuation Plan tabletop exercise having been well attended, asked whether it would be repeated, pointing out that there would be scaffolding erected and an increased number of contractors on site and therefore an associated increase in risk. Jonathan Brown confirmed that appropriate plans and procedures were in place with more regular exercises planned, which would keep staff engaged.

Stacey Howard joined the meeting at 10.20am.

Jane Hawkard also asked about the business continuity plans having dropped in compliance from 85% to 72% and questioned the expected minimum level of compliance being aimed for. Jonathan Brown responded that it was 90% which had been achieved previously, but had seen a reduction possibly due to summer annual leave, but it was continually monitored by the EPRR Board and EPRR Group and escalated where necessary to the Group Chief Delivery Officer.

Jonathan Brown updated that the EPRR team were seeing more business continuity incidents being declared to them, which was positive in that Care Groups had the correct structures in place and recognised they needed managing as a Group, and shared that the organisation was on a par with other Trusts across the region so not an outlier in this respect. Good assurance was taken that the activation plans were activated and Jonathan Brown advised that following this, a debrief of the business continuity plans was undertaken and learning taken from it and shared appropriately,

including to regional partners.

Jane Hawkard concluded that there was good assurance in relation to the EPRR report. Julie Beilby commented that it was a good report with lots of assurance, but remained concerned about the digital recovery response in the event of a cyber-attack and that Digital was not included within the report, however it was recognised that Digital would be discussed further on in the agenda. Jonathan Brown replied that a cyber incident business continuity exercise was planned for the following week, along with IT and NHS England Regional Head of Cyber Security support, assuring the Committees that the relevant parties were talking to each other and not operating in silos Julie Beilby thanked Jonathan Brown for this further information.

The ARG CiC agreed that, on the basis of the reduced compliance rates for business continuity plans and digital concerns, they were reasonably assured. Jane Hawkard noted that the annual EPRR regulatory report was normally received at the November 2026 ARG CiC meeting but as this meeting had been brought forward to October 2026, the paper would now be circulated virtually for assurance in advance of submission to the Trust Boards-in-Common in December 2026. Harriet Fisher added that the Internal Audit report on EPRR would be available for the October 2026 ARG CiC meeting.

Jonathan Brown left the meeting at 10.29am. The agenda running order was amended at this point to enable discussion of Item 9.3 whilst Stacey Howard was in attendance.

9.3 HHP NPIP Assessment Report

Stacey Howard reminded colleagues that the organisation had entered the National Oversight Framework (NOF) segment 4 and, along with the league tables, the organisation rated against its provider capability and given a RAG rating of red, which necessitated a move into segment 5. This instigated an automatic review from the National Provider Improvement Team (NPIP) consisting of an Improvement Director and associated team.

The NPIP team produced a mobilisation report and then moved into the assessment phase and the item 9.3 paper was the assessment outcome report. The NPIP team worked with Executives, Non-Executive Directors and senior leaders to gain insight into five conditions (Board Effectiveness and leadership; Governance; Improvement Approach; Staff Engagement; and Structural Barriers). In relation to condition 5 (Structural Barriers) because HHP agreed to be part of NHSE's pilot, PA Consulting were asked by NHSE to complete this piece of work which was close to completion and therefore not included in the paper.

Focus groups were also held with staff across all sites and Stacey Howard commented that this proved very useful in terms of providing information and intelligence and linking in with the assessment work against the key lines of enquiry to produce a final report. The findings were that there were structural barriers to improvement, leadership at that time had insufficient grip and control, there was an ineffective governance system and improvement capability to steer and deliver sustainable change that was needed at pace. Board intent and frontline commitment was apparent, but delivery was constrained by prolonged Executive instability. Governance arrangements, whilst compliant, were not working effectively. Reporting remained data rich, but insight poor. The Board Assurance Framework (BAF) was not

routinely used to drive prioritisation of risk and there was insufficient triangulation of quality performance, workforce and finance which did not enable the Trust Boards-in-Common to be able to intervene or arrive at conclusions. A significant amount of improvement activity was however evident but it was fragmented and the PMO and analytical support need to drive improvement at pace was underdeveloped.

Stacey Howard stated that the conclusion was that the organisation was in the very early stages of improvement and ten high priority recommendations were therefore made, which focused on governance and leadership. NHSE were mindful of The Value Circle (TVC) review and its 52 resultant recommendations, although noted that TVC also looked at quality and safety elements which NHSE had not. NHSE was now supporting the organisation in developing an Integrated Improvement Plan (IIP), which was now in the operating framework and a requirement for all organisations to have an IIP.

Stacey Howard advised the Committees that NOF 5 had now been disbanded, along with the NPIP team, leaving levels NOF 1 to 4. The organisation was therefore now in NOF 4, adding that it was important that the IIP got pace and rhythm behind it.

The ARG CiC acknowledged receipt of this report at this point, but asked to take item 9.2 next and then open up to questions.

The agenda returned to normal running order at this point.

9.2 The Value Circle Implementation Plan Update

Stacey Howard advised the Committees that The Value Circle (TVC) report had detailed 52 recommendations and NHSE had subsequently agreed to set up an interim process led by Hilda Gwilliams, Group Chief Patient Safety Officer, along with some PMO support to assist in tracking progress and gathering updates from various operational leaders with actions assigned. This commenced in June 2026 and they were able to obtain a reasonably good update position for each recommendation, however as time has gone it has become more difficult to obtain further information. Stacey Howard commented that they were not sure if this was due to annual leave but it had indicated a fragmented approach to obtaining updates against the recommendations and so it was decided to incorporate all the TVC recommendations into the IIP by mapping them across the domains and workstreams.

Stacey Howard referred to the example within the paper of a highlight report indicating deliverables within workstreams mapped against NPIP and TVC recommendations and it had become apparent that many of them were duplicative so were then amalgamated so that it was easier to monitor and see interdependencies. Stacey Howard stated that they were confident that all recommendations had been mapped across to the IIP. Detailed delivery plans were now being designed for each workstream with the use of Aspyre, which was an electronic PMO management tool used in many NHS organisations. Stacey Howard further added that the report evidenced the support provided by TVC and TVC colleagues were working as part of a delivery team within the workstream governance. Stacey Howard added that they were now in delivery phase and expecting to step up the oversight function in August 2026, and tweaking what that looked like given that a Financial Improvement Director had joined the organisation and the need to ensure everyone was working together to avoid duplication.

Richard Dickinson joined the meeting at 10.42am.

Julie Beilby commented that a lot of the report had been seen in various other forums and as a result a lot of questions had already been asked on the journey so far, but was of the view that it would be useful to monitor progress in this way and was pleased to hear of the rationalisation of the NPIP recommendations to those of TVC to enable effective monitoring.

Jane Hawkard summarised that the ARG CiC were assured that there was a good process in place and that TVC recommendations had been mapped into the IIP domains and work streams, but queried how it all got reported into the Trust Boards-in-Common and how quickly outcomes would be seen, commenting that it was about delivery of what was on paper and effecting change so that risks were better managed and doing so at pace.

Keith Haynes stated that this was the single most important piece of work in the organisation and therefore the organisation had to see this as an absolute priority to achieve a turning of the dial in terms of improvement. It was therefore important that the oversight delivery group reported directly into the Trust Boards-in-Common through the Group CEO.

Keith Haynes also referred to the governance work stream and advised that they were working with TVC and commencing with the BAF, to improve it by getting rid of the current risks and reformulate what the risks are in accordance with some of TVCs earlier work, keeping it simple to start with and then building it up. This work would commence the following week. Keith Haynes stated that the BAF would therefore be moving away from the current template, although with an eye on areas that needed to be transferred into the new template, to something that is more timely and more prioritised and be really focussed on what the top risks and priorities are as an organisation.

Keith Haynes also advised the ARG CiC that he was working on the Board Assurance Manual, which needed to be adopted by the organisation and embedded and understood within the organisation. In response to a question from Jane Hawkard, Keith Haynes confirmed that he had been engaged to focus on sorting out the BAF and doing the Board Assurance Manual, and welcomed the Committees support in achieving these.

Jane Hawkard reminded colleagues that it was the role of the ARG CiC to ensure that TVC recommendations were implemented but recognising that these were now aligned with the NPIP recommendations and subsequently with the IIP, it was now important that the governance work streams were prioritised and asked that this become a standing agenda item for this meeting going forward.

ACTION: Sally Stevenson

In response, Stacey Howard confirmed this was okay but would need to test out with the ARG CiC which highlight reports they would want to see, as there were 34. Jane Hawkard stated that they did not want to see 34 highlight reports, the priority for the ARG CiC were the governance one's.

The ARG CiC concluded that there was a process in place but no deliverables / outputs yet, therefore they were reasonably assured overall.

Keith Haynes left the meeting at 10.53am. There was a ten-minute break at 10.54am.

The running order of the agenda was amended on resumption of the meeting to enable discussion of Item 9.5 first whilst Richard Dickinson was in attendance.

9.5 Group Risk Register

Richard Dickinson advised colleagues that the Risk Register continued to be reported at regular intervals, with new risks identified on an ongoing basis (twelve in the last quarter), along with some closing of risks (eleven in the last quarter). Richard Dickinson was of the view that the process had generally improved following discussions over the last few months regarding working with Care Groups and corporate directorates around reviewing their risk registers, ensuring risks are identified and progressed / managed on a timely basis.

Rebecca Crashley rejoined the meeting at 11.06am.

One of the initiatives being used to improve engagement was training on risk and Richard Dickinson confirmed that this was one of a new range of KPIs for clinical governance. 45% of the senior management team were now trained on risk and Richard Dickinson stated that they wanted to achieve 100% on this but that this would be achieved through running a series of training sessions over the rest of the financial year, so not immediate.

Richard Dickinson also highlighted that there was a varying understanding about what risk appetite is in the organisation and although the Trust Boards-in-Common had set the risk appetite level and reviewed it again in March 2026, there was a view that were a significant number of high scoring risks because managers were using the Risk Register to make a case for additional resources rather than look at mitigating actions using their current resource available and doing a business case for requesting additional resources if necessary, and they were trying to flush such issues out as part of their discussions with Care Groups.

In response to a question, Richard Dickinson clarified the focus from May to August 2026 on the review process with all Care Groups, undergoing a detailed review of their individual high level risks. Once this process was complete they would revert to having monthly meetings to obtain updates on the position with existing risks, discuss new risks, etc. The Care Groups also link in with their performance reviews and raise issues through that route, so looking at triangulation between these.

Jane Hawkard observed that several risks had been open for a significant amount of time with no movement and just being tolerated. Julie Beilby agreed, questioning the detail on what action was being taken against the risk and whether something was really a high level risk if it had been on the Risk Register for 18 months if nothing catastrophic had happened and cited a particular risk on the register. Richard Dickinson explained the details on the Excel spreadsheet in terms of when risks have had a major rewrite to reflect changes, etc. and explained potential issues with them, and also explained the process at the Risk and Compliance Group meetings and how they were attempting to tackle the issues the ARG CiC was raising. Jane Hawkard commented that there had clearly been an increase in scrutiny of risks on the risk register but that there was still a relatively high number of overdue risk reviews. Jane Hawkard asked that an age profile of risks was shown on future reports i.e. how many risks over 12 months, 24 months, etc. Richard Dickinson agreed to include this

in future reports.

Action: Richard Dickinson

Jane Hawkard also spoke of the benefit of a benchmarking exercise against a couple of other organisations similar in size to HUTH and NLaG in terms of how many risks they held and whether the Group was an outlier in this aspect to obtain some assurance around this. Richard Dickinson commented that this may be a little more difficult to provide as different organisations have slightly different issues to HHP, but would discuss with his contacts to see what could be provided.

Action: Richard Dickinson

The ARG CiC recognised an improved process of risk management but as the outcomes were overdue, there was no benchmarking data and there were risks of considerable age still on the risk register, assurance was limited.

9.6 Annual Review of Risk Management Strategy

Richard Dickinson explained the three-year plan focused on insight, involvement and improvement, with a performance indicator, description and data/charts to illustrate. It was clear that there was much needed improvement around review date compliance although it was moving in the right direction, as well as risk mitigation but noted a reduction in the number of issues being reported which followed the aligning of the Risk Registers from both Trusts in October 2025.

There were still challenges around high-risk scores despite mitigating actions being put into place. The management of education and training was progressing well. The Trust Boards-in-Common had undertaken the annual review of the risk appetite in March 2026 and Richard Dickinson advised that the Risk Register does seem to have a lot of association with financial costs and business cases. There was also a minor reduction in longstanding risks but acknowledged there was still some way to go on this. In relation to the risk maturity assessment, this would be addressed shortly whilst the Strategy was in its infancy.

Jane Hawkard referred to an Internal Audit on risk management and a requested change to the Strategy on the process for adding a new risk to the Register. Richard Dickinson responded that all audit requirements had been completed and there was now Executive portfolio alignment to the high-level risks. Jane Hawkard thanked Richard Dickinson for the report but asked for RAG rating on KPIs to be included in future iterations. Richard Dickinson responded by sharing on screen an example of how the data was to be presented to Care Groups going forward, which did include the RAG rating and would provide the Care Groups with a clearer visual chart. Jane Hawkard agreed that this would be useful to see in future.

ACTION: Richard Dickinson

Jane Hawkard also referred to the aim for training compliance to reach 95% by 2028 and asked whether this date could be brought forward, as it seemed a long way off. Richard Dickinson replied that this was a fair point and that training compliance was one of the IIP objectives so would be monitored closely and the position at year end could be reported on.

Assurance was taken as limited still given the current position, but good progress was noted and the ARG CiC looked forward to seeing a really big shift once the BAF has been reviewed and training levels were as planned. Julie Beilby reflected that the

imminent work with the BAF and realignment with the Risk Register would hopefully promote an improved assurance level going forward, but that it was quite difficult to give any greater assurance currently.

Richard Dickinson left the meeting at 11.32am. The meeting agenda reverted to discussion of Item 9.4.

9.4 Group Board Assurance Framework

Rebecca Crashley advised that the Board Assurance Framework (BAF) was out of date and reminded the ARG CiC that Keith Haynes was refreshing the BAF format, as discussed earlier.

Jane Hawkard questioned that although cyber security assurance remained on the ARG CiC's Terms of Reference whether it should move to that of the Performance, Estates & Finance CiC (PEF CiC), however noted that the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook indicated that this came under the ARG CiC oversight for assurance purposes, not in terms of oversight of the risk. Rebecca Crashley responded that the new Digital risk would be overseen by the PEF CiC but the ARG CiC would receive the full BAF, and suggested once the Digital risk had been discussed at the PEF CiC, details of the cyber risks could be extracted and shared with the ARG CiC. Jane Hawkard responded to say that she would consider this further. Julie Beilby suggested that this paper be for noting purposes only, as a level of assurance was inappropriate due to the redesigning work underway on the BAF.

The report was noted by the ARG CiC rather than a level of assurance provided, and the work underway on its redesign was acknowledged.

9.7 Annual Review of Adequacy & Effectiveness of System for Devising and Monitoring the Board Assurance Framework (BAF) – Group

This item was deferred to the October 2026 meeting.

9.8 Annual Review of Adequacy & Effectiveness of System for Management and Monitoring of Risk (inc. ICS Risks) – Group

This item was deferred to the October 2026 meeting.

The meeting returned to normal running order and Rebecca Crashley left the meeting at this point

10. Policies for Review/Approval

10.1 Policy for Managing Conflicts of Interest in an Outsourced Internal Audit Service

Jane Hawkard advised that there was such a policy in place for External Audit but as Internal Auditors were now bidding for other work, it was considered pertinent that a similar policy should be in place for Internal Audit. KPMG had provided a very helpful template document which had then been used as the basis for devising a HHP policy. Jane Hawkard advised that it was at the ARG CiC for approval and asked for any comments, but none were made.

The policy was approved.

11. ARG CiC Governance Items

11.1 November 2026 meeting date change to 15.10.26

This date change was noted by the ARG CiC.

11.2 Schedule of ARG CiC Meetings 2027

This was noted by the ARG CiC.

12. Highlight Reports and Action Logs from Board Sub-Committees-in-Common

12.1 Performance, Estates & Finance CiC
12.2 Quality & Safety CiC
12.3 Workforce, Education & Culture CiC
12.4 The Health Tree Foundation Trustees' Committee – NLaG

The above highlight reports and action logs were received for information. There were no issues raised.

13. Private Agenda Items

Items 13.1-13.5 were minuted as private agenda items.

14. Any Other Urgent Business

There was no other urgent business.

15. Matters for Escalation to the Trust Boards-in-Common (Public/Private)

A number of items discussed by the ARG CiC were agreed to be notified to the Trust Boards-in-Common as either Alert, Advise or Assure items – see ARG CiC Highlight Report to the September 2026Trust Boards-in-Common.

16. Matters to Highlight to other Trust Board CiCs

There were no items to be highlighted to other CiCs.

17. ARG CiC Workplan – for information only

18. Review of the Meeting

There were no comments made.

19. DATE OF THE NEXT MEETING

The next meeting of the Audit, Risk and Governance Committees-in-Common will be held on 15 October 2026 at 1.00pm to 4.30pm via MS Teams.

The ARG CiC Chair closed the meeting at 12.34pm.

Schedule of Attendance at ARG CiC Meetings 2026/27

Member / Attendee	Apr-26	Jun26 Audited Accounts	Jul-26	Nov26	Jan-27	Total
Members - HUTH:						
Jane Hawkard – NED - ARG Chair	Y	Y	Y			3/3
Members - NLaG:						
Julie Beilby – NED	Y	Y	Y			3/3
Regular Attendees:						
Emma Sayner – Group CFO	Y	Y	Y[1]			3/3
David Sharif – Group Director of Assurance	Y	N	N			1/3
Keith Haynes – Interim Board Secretary			Y[1]			1/1
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	Y	Y	Y			3/3
Daryl Cheetham – Local Counter Fraud Specialist	Y[1]					1/1
External Audit - NLAG (Sumer NI)	Y	Y	Y			3/3
External Audit – HUTH (Forvis Mazars)	Y	Y	Y			3/3
Internal Audit – Group (KPMG)	Y	Y	Y			3/3
Sue Meakin - Group DPO / IG Lead	N	N[3]	Y[1]			1/3
Mike Bateson - NLAG Governor Observer	N[2]	Y	Y			3/3
Ad-hoc Attendees:						
HUTH Vice Chair (Murray MacDonald)	Y	Y	N			2
Asst. DoF – Planning & Control (Nicola Parker)	Y	Y	-			2
Group Chair (Alan Downey)	-	Y	-			1
Group CEO (Lyn Simpson)	-	Y[1]	-			1
Group Chief Digital Officer (Alastair Pickering)	-	Y[1]	Y[1]			2
Group Chief Patient Safety Officer (Hilda Gwilliams)	-	Y[1]	-			1
Nurse Director HUTH (Vicky Sharman)	-	Y[1]	-			1
Deputy Director of Governance (Rebecca Crashley)	-	Y	Y[1]			2
Head of Legal (Gerard Curran)	-	-	Y[1]			1
EPRR Manager (Jonathan Brown)	-	-	Y[1]			1
Associate Director of Quality Governance (Richard Dickinson)	-	-	Y[1]			1
Group Chief Technology Officer (Tony Deal)	-	-	Y[1]			1

NHS England (Stacey Howard)	-	-	Y[1]			1

Notes:
[1] Part meeting
[2] Ian Reekie attended instead
[3] Not required to attend, audited accounts meeting only

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)297

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12th November 2026
Director Lead	Sam Peate, Group Chief Delivery Officer
Contact Officer / Author	Louise Topliss, Head of Performance
Title of Report	Integrated Performance Report – September 2026
Executive Summary	Integrated Performance Report for Information
Background Information and/or Supporting Document(s) (if applicable)	Presented to Performance, Estates and Facilities CiC on 3rd November 2026.
Prior Approval Process	As per above
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Integrated Performance Report

Reporting Month:
September 2026

United by Compassion:
Driving for Excellence

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

disability confident EMPLOYER

VETERAN AWARE

CiC Oversight Dashboard

Operational Performance

Metric	Period	Actual	Plan	V	A	Status
A&E - 4 Hour Standard (All - Footprint)	Aug-26	70.9%	≥ 75.0%			Alert
A&E - 4 Hour Standard (All)	Sep-26	62.4%	≥ 71.0%			Alert
A&E - Patients Waiting > 12 hours in Department	Sep-26	15.1%	≤ 15.3%			Assure
Cancer - 28 Day Faster Diagnosis Standard	Aug-26	72.3%	≥ 70.7%			Assure
Cancer - 62 Day All Referral Sources	Aug-26	54.2%	≥ 56.3%			Alert
Diagnostics - 6 Week Standard	Sep-26	35.2%	≤ 27.7%			Alert
RTT - Incomplete 18 Week Standard	Aug-26	56.5%	≥ 58.4%			Alert
RTT - Percentage of 52+ Week Waits	Aug-26	3.9%	≤ 3.7%			Alert

Quality of Care

Metric	Period	Actual	Plan	V	A	Status
CQC Inpatient Survey Satisfaction Mean Score	Sep-26	8.2				
CQC Safe Inspection Score	Sep-26	1.5				
Falls - Serious harm or death	Sep-26	3				
Infections - C.Difficile (Cumulative)	Aug-26	70				
Infections - E.Coli (Cumulative)	Aug-26	131				
Infections - Klebsiella (Cumulative)	Aug-26	39				
Mortality - SHMI	May-26	1.0				Advise
Patient Safety Incidents - Moderate harm	Sep-26	86				
Patient Safety Incidents - Severe harm	Sep-26	6				
Pressure Ulcers - Category 3	Sep-26	15				
Pressure Ulcers - Category 4	Sep-26	0				

People

Metric	Period	Latest	Previous	Change
Staff Appraisal Rate (AfC)	Aug-26	81.8%	81.6%	0.2%
Staff e-Job Planning	Sep-26	76.1%	85.1%	-9.1%
Staff Mandatory Training - Core	Aug-26	87.1%	85.3%	1.8%
Staff Mandatory Training - Role Specific	Aug-26	82.5%	81.2%	1.2%
Staff Sickness Absence Rate	Aug-26	4.9%	4.8%	0.1%
Staff Turnover Annual FTE Rate	Aug-26	6.9%	7.4%	-0.4%

Finance and Productivity

Metric	Period	Latest	Previous	Change
Finance - CIP YTD against Plan	Sep-26	60.0%	64.6%	-4.6%
Finance - Planned Surplus/Deficit	Sep-26	(63,065)	(63,065)	
Finance - Variance YTD to Financial Plan	Sep-26	(20,839)	(16,383)	-4,456

Monthly Trend Key

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

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1. Overview

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

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

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

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

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

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

2. Regulation and Compliance

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

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

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

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

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

3. HHP Key Metric Oversight Scorecard

Oversight Framework

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

Oversight | CQC

Oversight Group	Subject Area	Metric	National Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Access to Services	Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	70.8%	65.8%	64.1%	55.9%	72.9%	73.0%	68.4%	66.2%	66.1%	69.5%	72.3%	
		Cancer - 31 Day All Stages	≥ 94.0%	79.9%	78.2%	81.1%	72.6%	80.0%	82.6%	78.7%	78.7%	80.7%	79.3%	80.7%	
		Cancer - 62 Day All Referral Sources	≥ 80.0%	59.7%	61.0%	57.4%	55.4%	55.3%	61.3%	56.9%	53.6%	57.4%	55.1%	54.2%	
	Elective Care	Outpatient - Follow-up Overdue Backlog (3+ months)		80,277	81,157	82,616	81,155	80,063	80,952	81,089	82,310	82,550	83,655	83,969	84,071
		RTT - 52+ Week Waits		4,215	4,279	3,987	4,087	3,983	3,616	3,803	4,107	4,406	4,743	5,079	
		RTT - 65+ Week Waits	≤ 0	123	163	154	157	147	97	130	191	302	375	513	
		RTT - Incomplete 18 Week Standard	≥ 92.0%	57.6%	57.1%	56.8%	56.0%	56.2%	58.0%	58.0%	58.8%	58.4%	57.3%	56.5%	
		RTT - Total Incomplete Pathways		121,435	120,086	120,937	120,981	120,762	120,651	124,408	125,756	126,198	128,361	129,877	
	Urgent & Emergency Care	A&E - 4 Hour Standard (All - Footprint)		69.9%	68.7%	69.3%	69.6%	72.4%	73.8%	73.7%	70.8%	69.6%	71.4%	70.9%	
		A&E - 4 Hour Standard (All)	≥ 82.0%	63.4%	62.5%	62.9%	62.0%	66.3%	68.2%	67.8%	65.0%	64.2%	66.0%	65.1%	62.4%
		A&E - 4 Hour Standard (Type 1)		44.4%	43.1%	44.8%	42.2%	50.6%	52.8%	52.6%	48.8%	48.8%	50.2%	49.8%	46.8%
		A&E - 4 Hour Standard (Type 3 - Footprint)		95.2%	93.9%	94.3%	95.9%	94.2%	96.1%	95.7%	94.2%	92.3%	94.0%	94.9%	
		A&E - 4 Hour Standard (Type 3)		95.7%	94.7%	96.3%	96.8%	96.4%	97.2%	96.5%	96.2%	94.1%	96.5%	95.9%	93.7%
		A&E - Ambulance Handovers within 45 minutes													
		A&E - DTA to Admission > 12 hours	≤ 0.0%	26.1%	24.6%	26.8%	37.6%	27.4%	19.9%	20.3%	24.1%	24.6%	21.8%	22.9%	29.6%
		A&E - Patients Waiting > 12 hours in Department	≤ 0.0%	17.1%	15.9%	16.0%	20.2%	14.7%	11.7%	11.4%	12.8%	12.9%	11.6%	12.4%	15.1%
Effective	Effectiveness	Inpatient - Bed occupancy classed as clinically ready for discharge		23.9%	24.4%	25.3%	26.9%	25.1%	25.8%	25.9%	24.2%	23.9%	24.9%	23.2%	23.2%	23.5%
		Inpatient - Cancelled Operations 28 Day perfomance	≤ 5.0%	29.4%			30.6%			33.5%			29.2%			22.4%
	Productivity	Theatres - Capped Theatre Utilisation	≥ 85.0%	80.0%	80.0%	81.2%	81.4%	80.2%	80.9%	82.1%	82.2%	82.5%	82.9%	82.2%	83.3%	81.6%
Responsive	Primary Prevention	Diagnostics - 6 Week Standard	≤ 1.0%	33.4%	35.3%	38.5%	43.7%	44.9%	36.6%	31.8%	35.9%	36.8%	35.2%	35.2%	36.8%	35.2%
		Diagnostics - Total Activity Levels		45,747	46,366	43,164	42,817	46,564	45,800	52,808	36,658	36,089	37,605	40,623	38,172	39,391

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

Provider displayed

Metric (right click to drill through to SPC chart)	Period	Target	Result	Var	Asr
A&E - 4 Hour Standard (All - Footprint)	Sep-26	≥ 74.6%	65.7%		
A&E - 4 Hour Standard (All)	Sep-26	≥ 65.4%	54.6%		
A&E - 4 Hour Standard (Type 1)	Sep-26	≥ 52.0%	42.4%		
A&E - 4 Hour Standard (Type 3 - Footprint)	Sep-26	≥ 95.0%	88.1%		
A&E - 4 Hour Standard (Type 3)	Sep-26	≥ 95.0%	85.5%		
A&E - Ambulance Handovers within 45 minutes	Sep-26	≥ 96.5%	98.2%		
A&E - DTA to Admission > 12 hours	Sep-26	≤ 0.0%	20.3%		
A&E - Patients Waiting > 12 hours in Department	Sep-26	≤ 15.0%	14.0%		
Cancer - 28 Day Faster Diagnosis Standard	Aug-26	≥ 71.0%	72.9%		
Cancer - 31 Day All Stages	Aug-26	≥ 76.0%	78.1%		
Cancer - 62 Day All Referral Sources	Aug-26	≥ 53.9%	51.8%		
Diagnostics - 6 Week Standard	Sep-26	≤ 29.7%	38.2%		
Diagnostics - Total Activity Levels	Sep-26	≥ 20,958	21,319		
Inpatient - Bed occupancy classed as clinically ready for disc...	Sep-26		28.9%		
Inpatient - Cancelled Operations (%)	Sep-26	≤ 0.7%	1.9%		
Inpatient - Cancelled Operations 28 Day perfomance	Sep-26	≤ 5.0%	25.7%		
Inpatient - Days between DRD and Discharge Date	Sep-26	≤ 3.7	4.6		
Outpatient - Follow-up Overdue Backlog (3+ months)	Sep-26		48,174		
RTT - 52+ Week Waits	Aug-26	≤ 3,575	3,500		
RTT - 65+ Week Waits	Aug-26	≤ 0	355		
RTT - Incomplete 18 Week Standard	Aug-26	≥ 57.6%	55.4%		
RTT - Total Incomplete Pathways	Aug-26	≤ 83,961	86,732		
Theatres - Capped Theatre Utilisation	Sep-26	≥ 85.0%	81.4%		

Northern Lincolnshire and Goole NHS Foundation Trust

Provider displayed

Metric (right click to drill through to SPC chart)	Period	Target	Result	Var	Asr
A&E - 4 Hour Standard (All - Footprint)	Sep-26	≥ 77.3%	71.7%		
A&E - 4 Hour Standard (All)	Sep-26	≥ 75.6%	68.9%		
A&E - 4 Hour Standard (Type 1)	Sep-26	≥ 57.0%	51.0%		
A&E - 4 Hour Standard (Type 3 - Footprint)	Sep-26	≥ 95.0%	98.5%		
A&E - 4 Hour Standard (Type 3)	Sep-26	≥ 99.0%	98.8%		
A&E - Ambulance Handovers within 45 minutes	Sep-26	≥ 89.0%	75.6%		
A&E - DTA to Admission > 12 hours	Sep-26	≤ 0.0%	46.9%		
A&E - Patients Waiting > 12 hours in Department	Sep-26	≤ 15.6%	16.2%		
Cancer - 28 Day Faster Diagnosis Standard	Aug-26	≥ 70.0%	71.1%		
Cancer - 31 Day All Stages	Aug-26	≥ 96.2%	92.2%		
Cancer - 62 Day All Referral Sources	Aug-26	≥ 61.7%	59.9%		
Diagnostics - 6 Week Standard	Sep-26	≤ 25.5%	31.2%		
Diagnostics - Total Activity Levels	Sep-26	≥ 27,633	18,072		
Inpatient - Bed occupancy classed as clinically ready for disc...	Sep-26		14.8%		
Inpatient - Cancelled Operations (%)	Sep-26	≤ 0.7%	7.3%		
Inpatient - Cancelled Operations 28 Day perfomance	Sep-26	≤ 5.0%	15.6%		
Inpatient - Days between DRD and Discharge Date	Sep-26	≤ 4.3	5.5		
Outpatient - Follow-up Overdue Backlog (3+ months)	Sep-26		35,897		
RTT - 52+ Week Waits	Aug-26	≤ 996	1,579		
RTT - 65+ Week Waits	Aug-26	≤ 0	158		
RTT - Incomplete 18 Week Standard	Aug-26	≥ 60.3%	58.6%		
RTT - Total Incomplete Pathways	Aug-26	≤ 38,945	43,145		
Theatres - Capped Theatre Utilisation	Sep-26	≥ 85.0%	82.7%		

4.1 Chief Delivery Officer Update – Performance Overview (September 2026)

Delivery of core access standards remains materially below the constitutional standards in both HUTH and NLAG. Whilst September RTT data is not available in this reporting period due to changes in the national reporting cycle Waiting list volume, compliance and volume of patients beyond 52 and 65 weeks remains behind plan in both HUTH and NLAG.

Cancer standards improved or maintained across all key indicators except for 62days in HUTH. Principal measures and diagnostics remain significantly off the national standard and continue to be constrained by Outpatient and treatment capacity.

Cancer performance showed positive movement in August, with 62-day compliance for HUTH remains close to plan with some deterioration in month from 54.5% to 51.7%. All other standards showed improvement with FDS in HUTH improving from 70% to 72.9% and in NLAG from 68% to 70.4%. The 31day target in HUTH improved from 76.4 to 78.1% and remained broadly the same at 92.2% in NLAG. The 62day target improved in NLAG from 56.5% to 59.9%.

Diagnostics performance continues to be a major constraint to elective and cancer recovery. Six-week performance remains static at both Trusts with some minor improvements in month for September. Significant increases in demand for MRI is leading to deterioration in compliance for this test at HUTH, whilst access times for Endoscopy at NLAG is a key constraint. All areas have developed test level improvement plans and trajectories for the second half of the financial year.

Unplanned Care performance in September remained below plan across both Trusts with higher levels of Type 1 demand evident in both organisations. Early signs of improved 12-hour performance over the summer months in HUTH has been hampered in September however this follows regional and national trends in line with in month demand. 12 hour waits at NLAG remains a materially different to HUTH with low levels of admitted compliance.

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 at HUTH remains on plan and ambulance handovers remained assured; however, Type 3 performance and whole-pathway flow remain the key gaps. Implementation of continuous flow principles in NLAG are planned to roll out in November. The planned opening of the UTC 24/7 on the HRI site has been delayed and contingency plans are being worked through with the provider.

a. Hull University Teaching Hospitals Performance AAA Summary

Count: 14	Count: 2	Count: 5
Alert	**Advise**	**Assure**
A&E - 4 Hour Standard (All - Footprint)	RTT - 52+ Week Waits	A&E - Ambulance Handovers within 45 minutes
A&E - 4 Hour Standard (All)	Theatres - Capped Theatre Utilisation	A&E - Patients Waiting > 12 hours in Department
A&E - 4 Hour Standard (Type 1)		Cancer - 28 Day Faster Diagnosis Standard
A&E - 4 Hour Standard (Type 3 - Footprint)		Cancer - 31 Day All Stages
A&E - 4 Hour Standard (Type 3)		Diagnostics - Total Activity Levels
A&E - DTA to Admission > 12 hours		
Cancer - 62 Day All Referral Sources		
Diagnostics - 6 Week Standard		
Inpatient - Cancelled Operations (%)		
Inpatient - Cancelled Operations 28 Day perfomance		
Inpatient - Days between DRD and Discharge Date		
RTT - 65+ Week Waits		
RTT - Incomplete 18 Week Standard		
RTT - Total Incomplete Pathways		

b. Northern Lincolnshire and Goole Hospitals Performance AAA Summary

Count: 17	Count: 2	Count: 2
Alert	**Advise**	**Assure**
A&E - 4 Hour Standard (All - Footprint)	A&E - 4 Hour Standard (Type 1)	A&E - 4 Hour Standard (Type 3 - Footprint)
A&E - 4 Hour Standard (All)	Theatres - Capped Theatre Utilisation	Cancer - 28 Day Faster Diagnosis Standard
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 - 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 - Incomplete 18 Week Standard		
RTT - Total Incomplete Pathways		

c. Unplanned Care

Increasing levels of Type 1 demand in both ED's has impacted UEC performance in September. Seasonal respiratory illness rates have tracked a number of weeks ahead of previous years. Four-hour performance remains below trajectory at both Trusts in September. Type 1 performance was 42.6% at HUTH and 51% at NLAG, compared with 48.6% and 50.4% respectively in September.

Admission delay remains a principal risk. Decision-to-admit waits over 12 hours with significant deterioration in this standard in month at HUTH and compliance static at NLAG. Ambulance Handovers within 45 minutes remains to consistently at HUTH and is below the standard at NLAG.

The variation between HUTH and NLAG indicates that winter readiness cannot be assessed from Group-level performance alone. At NLAG, the scale of admission delay and the weaker handover position make dependable inpatient capacity and timely discharge central to the response. At HUTH, sustained handover performance needs to be supported by stronger Type 1 and Type 3 pathway delivery. The planned extension of the HRI UTC to 24/7 opening in October has been delayed by the provider into the New Year, the effect of this delay is being assessed. The continual flow model has commenced at NLAG and is expected to support improvement of Ambulance handover times in future months.

Progress

- Front-door frailty, streaming, Same Day Emergency Care (SDEC), Urgent Treatment Centre (UTC) and Model ward round work progressed. These pathways support earlier senior assessment and care outside the inpatient pathway where clinically appropriate. Their contribution to winter resilience will depend on consistent access, timely specialty response and demonstrable reductions in avoidable admissions and time spent in ED.
- Completion of a number of planned ward moves on the HRI site has been delivered in September enabling improved access to the right speciality capacity.
- Paediatric Assessment Unit (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.

- Role out of the approved continuous flow model across NLAG building on learning from HUTH.
- Embed criteria to admit and seven-day senior decision-making across relevant specialties.
- Confirm delivery and outcomes of the GIRFT length-of-stay rounds scheduled at SGH on 14 September, DPoW on 21 September and HUTH on 27 September. The initial focus is on stays over 17 days, identifying avoidable inpatient delays and escalating NCTR barriers with named owners and agreed resolution dates.
- Completion of planning for Perfect Week and MADE events due to be delivered in November and throughout the winter.
- Continued working with partners to deliver a multi agency winter plan to support UEC flow through all sites.

Unplanned Care 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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Effective	Effectiveness	Inpatient - Corridor Care on Wards		66.7	62.3	59.0	65.5	72.5	70.2	51.5	41.9	48.4	46.2	40.4	39.6	50.0
		Inpatient - Days between DRD and Discharge Date		4.2	4.2	4.1	4.7	4.4	5.2	5.3	5.3	4.8	5.2	5.3	4.7	4.6
		Inpatient - Discharge Lounge Utilisation		14.3%	12.2%	11.6%	7.3%	11.2%	14.9%	15.5%	14.7%	14.5%	15.0%	16.3%	14.9%	15.9%
		Inpatient - Discharge to Assess (D2A) over 14 days		2.5%	1.6%	1.6%	2.3%	2.4%	3.1%	2.8%	3.0%	2.9%	2.5%	3.1%	2.4%	2.4%
		Inpatient - Discharges by 12pm (midday)		23.7%	23.8%	24.8%	23.0%	22.3%	25.8%	23.2%	22.0%	21.7%	21.3%	21.3%	22.9%	22.8%
		Inpatient - Discharges by 5pm		63.8%	62.2%	63.9%	65.2%	61.0%	64.7%	64.7%	62.2%	61.6%	63.4%	64.0%	62.8%	63.1%
		Inpatient - IDS Completed within 24 hours		84.8%	85.7%	85.3%	81.3%	83.2%	85.4%	82.9%	83.6%	84.5%	83.8%	86.4%	85.8%	84.3%
		Inpatient - Long Stay Occupancy (21+ days)		205.4	183.4	173.3	175.6	206.5	201.6	191.3	197.7	184.1	187.7	170.3	178.8	180.1
		Virtual Wards - Utilisation		35.1%	50.2%	53.1%	59.6%	53.3%	52.6%	49.7%	53.6%	35.4%	36.1%	35.0%	44.0%	39.9%
	Urgent & Emergency Care	A&E - 4 Hour Standard (All - Footprint)		68.5%	67.3%	67.4%	69.5%	69.8%	70.4%	73.2%	74.6%	70.0%	67.5%	70.6%	70.8%	
		A&E - 4 Hour Standard (Type 1 - Admitted)		21.5%	21.4%	24.9%	26.3%	23.4%	24.2%	26.5%	31.0%	26.0%	26.3%	31.0%	27.6%	24.1%
		A&E - 4 Hour Standard (Type 1 - NonAdmitted)		51.0%	49.5%	50.5%	56.7%	50.9%	56.4%	61.5%	64.4%	56.7%	55.2%	57.7%	57.4%	50.0%
		A&E - 4 Hour Standard (Type 1)		42.1%	40.9%	42.6%	47.1%	42.6%	46.3%	50.7%	54.1%	47.7%	46.9%	49.8%	48.6%	42.4%
		A&E - 4 Hour Standard (Type 3 - Footprint)		92.6%	91.8%	90.0%	90.2%	92.9%	90.3%	93.9%	93.2%	90.5%	87.7%	90.0%	91.9%	
		A&E - Ambulance Average Handover Time		23.1	23.8	23.9	23.8	26.6	20.4	19.2	18.6	19.5	20.1	19.1	20.0	19.8
		A&E - Ambulance Handovers within 45 minutes		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 - Assessed within 60 minutes		84.6%	80.4%	84.3%	88.0%	87.0%	92.5%	94.1%	93.3%	91.6%	92.1%	92.1%	92.2%	92.4%
		A&E - Corridor Care in Dept		48	41	30	33	44	26	22	17	23	29	13	22	37
		A&E - DTA to Admission > 12 hours	≤ 0.0%	19.8%	21.5%	16.3%	19.7%	28.0%	14.7%	11.7%	9.2%	15.0%	14.7%	5.6%	8.6%	20.3%
		A&E - DTA to Admission > 24 hours	≤ 0.0%	3.1%	5.2%	3.4%	4.8%	10.4%	1.0%	0.6%	0.8%	0.3%	0.8%	0.0%	0.1%	0.6%
		A&E - Patients Waiting > 12 hours in Department	≤ 0.0%	15.0%	17.4%	14.2%	14.0%	18.3%	11.8%	9.0%	6.9%	10.5%	10.2%	5.6%	7.6%	14.0%
		A&E - Specialty Referral to Departure within 30 minutes		10.8%	11.0%	11.0%	11.6%	11.1%	13.3%	13.1%	12.0%	10.6%	12.3%	12.4%	11.4%	10.5%
		A&E - Time to Initial Assessment	≤ 15	30	34	29	24	25	19	17	18	20	21	20	21	20
		A&E - Total Time in A&E (Admitted)	≤ 180	668	733	622	638	801	579	509	465	545	543	416	465	612

Unplanned Care NLAG Scorecard

Tier 1 - Foundation Scorecard

Oversight | CQC

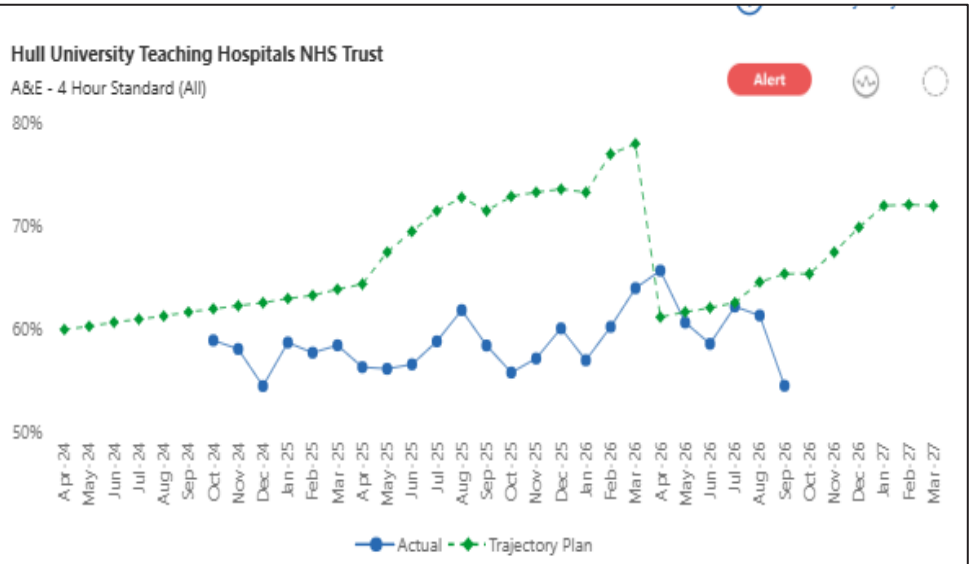
Right click metric to drill through to SPC chart or view metric breakdown

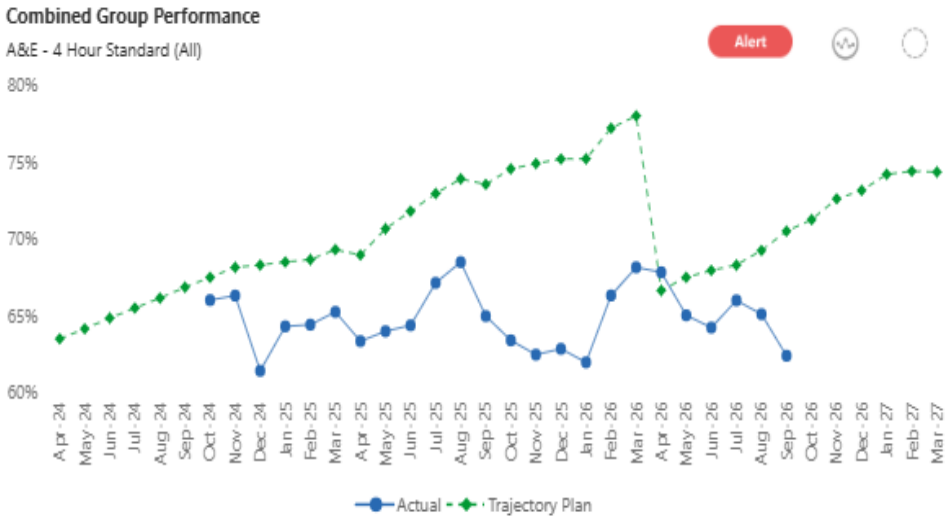
Domain	Subject Area	Metric	National Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Effective	Effectiveness	Inpatient - Corridor Care on Wards		3.1	2.5	1.9	3.7	3.9	3.9	4.1	7.1	3.5	3.6	2.0	0.5	0.0
		Inpatient - Days between DRD and Discharge Date		4.9	3.9	5.0	4.5	4.1	5.8	4.9	5.2	4.9	5.2	5.1		
		Inpatient - Discharge Lounge Utilisation		17.1%	20.9%	16.4%	17.7%	19.5%	19.4%	20.0%	21.2%	19.2%	18.1%	16.0%	15.9%	18.4%
		Inpatient - Discharge to Assess (D2A) over 14 days		2.0%	2.5%	2.2%	3.3%	3.3%	5.4%	4.2%	1.5%	4.9%	2.8%	3.6%	8.5%	3.3%
		Inpatient - Discharges by 12pm (midday)		29.8%	28.3%	30.4%	29.0%	25.4%	26.9%	26.6%	25.5%	26.8%	27.0%	25.7%	25.6%	28.3%
		Inpatient - Discharges by 5pm		74.7%	72.5%	75.5%	73.6%	71.3%	72.0%	73.1%	71.4%	71.8%	73.7%	71.3%	72.6%	72.4%
		Inpatient - IDS Completed within 24 hours		87.8%	87.8%	87.8%	86.7%	87.1%	86.8%	87.8%	87.6%	87.5%	87.5%	88.9%	86.7%	88.7%
		Inpatient - Long Stay Occupancy (21+ days)		77.0	78.0	82.9	84.9	85.5	97.3	86.9	81.8	84.8	88.1	88.0	93.4	93.3
		Virtual Wards - Utilisation		65.9%	75.0%	56.7%	63.8%	68.1%	69.3%	70.1%	67.6%	71.6%	64.0%	29.8%	53.9%	71.8%
	Urgent & Emergency Care	A&E - 4 Hour Standard (All - Footprint)		73.4%	72.7%	70.1%	68.9%	69.4%	74.6%	74.4%	72.8%	71.7%	71.7%	72.2%	71.1%	
		A&E - 4 Hour Standard (Type 1 - Admitted)		10.1%	11.1%	9.6%	11.2%	7.7%	8.8%	10.8%	8.3%	10.3%	8.7%	8.3%	8.7%	9.9%
		A&E - 4 Hour Standard (Type 1 - NonAdmitted)		57.9%	57.1%	51.9%	50.8%	50.5%	64.0%	64.7%	60.2%	58.3%	58.9%	58.4%	59.1%	58.3%
		A&E - 4 Hour Standard (Type 1)		48.9%	48.0%	43.7%	42.3%	41.8%	54.5%	54.9%	51.2%	49.9%	50.6%	50.5%	51.0%	51.0%
		A&E - 4 Hour Standard (Type 3 - Footprint)		99.1%	99.2%	98.6%	99.5%	99.3%	99.4%	98.7%	98.8%	98.8%	97.6%	98.8%	98.8%	
		A&E - Ambulance Average Handover Time		29.0	26.0	37.0	51.0	61.0	45.0	32.0	36.0	31.0	32.0	38.0	38.0	38.0
		A&E - Ambulance Handovers within 45 minutes		83.3%	86.5%	75.6%	65.6%	57.0%	71.5%	81.7%	77.2%	82.5%	80.3%	73.6%	74.4%	75.6%
		A&E - Assessed within 60 minutes		76.2%	73.7%	69.3%	66.8%	68.4%	79.0%	79.1%	80.9%	80.4%	78.2%	76.6%	79.0%	79.1%
		A&E - Corridor Care in Dept		9	9	10	11	9	11	9	11	10	11	8	12	0
		A&E - DTA to Admission > 12 hours	≤ 0.0%	33.0%	33.3%	38.0%	37.8%	52.5%	48.9%	32.9%	39.2%	38.5%	41.0%	50.3%	48.3%	46.9%
		A&E - DTA to Admission > 24 hours	≤ 0.0%	7.6%	7.9%	11.0%	11.6%	16.9%	14.7%	6.5%	9.7%	8.1%	10.3%	10.5%	13.7%	12.5%
		A&E - Patients Waiting > 12 hours in Department	≤ 0.0%	15.7%	16.8%	17.6%	18.1%	22.2%	17.5%	14.1%	15.8%	15.0%	15.6%	17.3%	17.1%	16.2%
		A&E - Specialty Referral to Departure within 30 minutes		5.2%	5.0%	4.1%	4.2%	4.5%	4.2%	5.0%	4.0%	3.7%	4.1%	5.0%	3.6%	4.4%
		A&E - Time to Initial Assessment	≤ 15	46	48	53	56	52	43	42	41	41	43	45	42	43
		A&E - Total Time in A&E (Admitted)	≤ 180	670	667	687	667	776	730	667	701	697	710	768	762	747

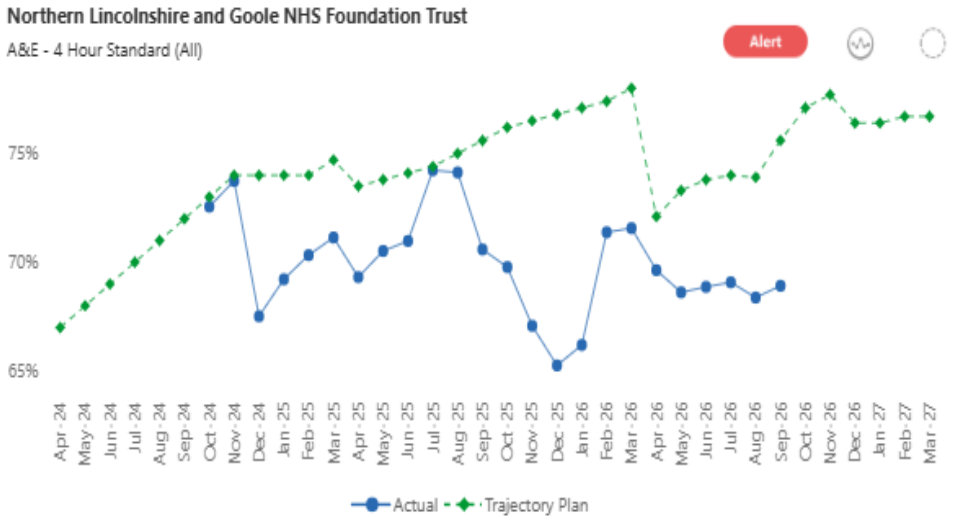
4.2 Emergency Care Standards – 4-hour Performance

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.







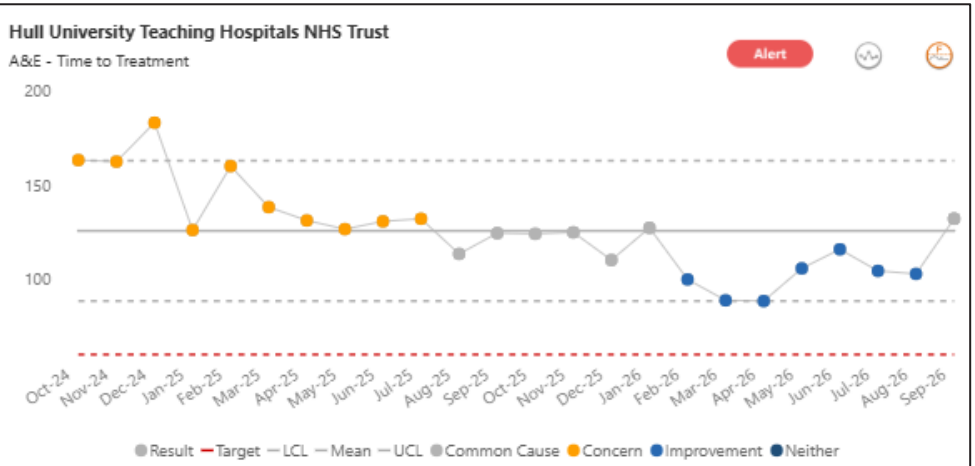
4.3 Enabler Metric 1: Mean Time to Treatment

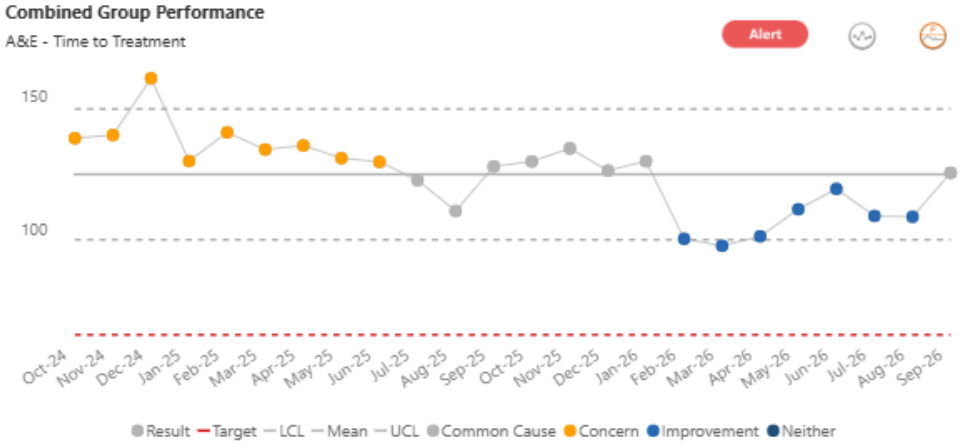
HUTH:

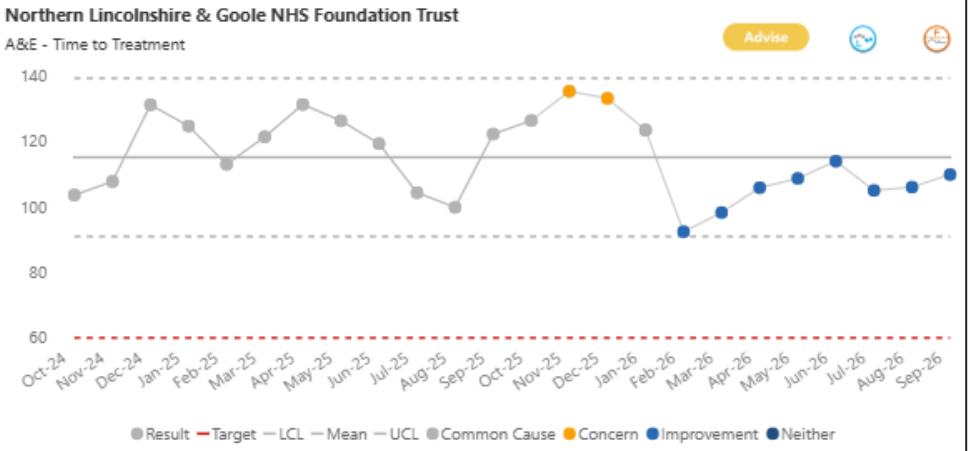
Mean time to treatment improved again in August and remained below the historical mean but was still above 100 minutes and the 60-minute operational target. Early clinical assessment, streaming and rapid decision-making must therefore be sustained at peak times.

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.







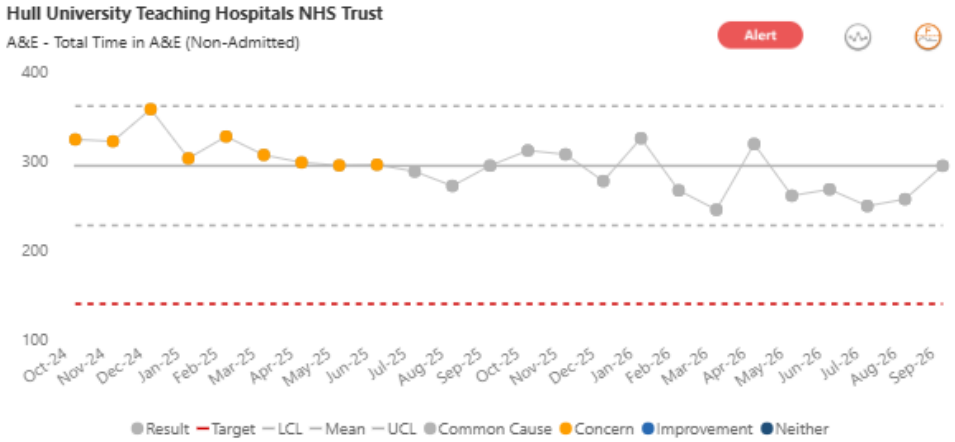
4.4 Enabler Metric 2: Non-Admitted Total Time in Department

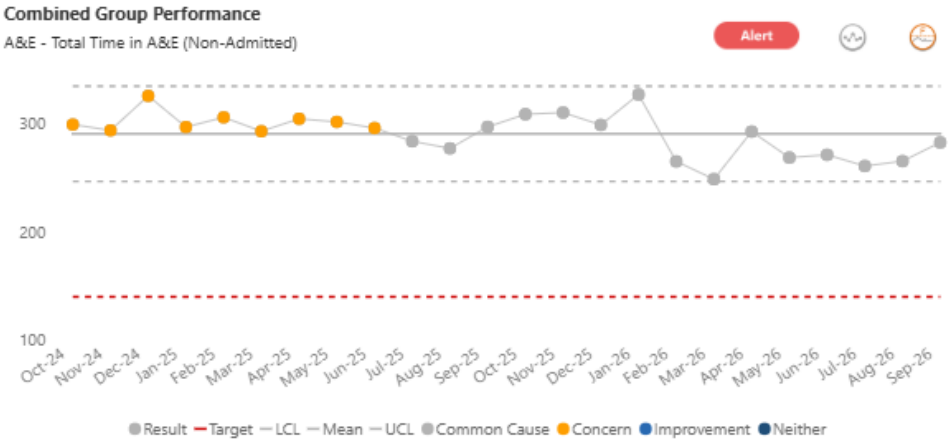
HUTH:

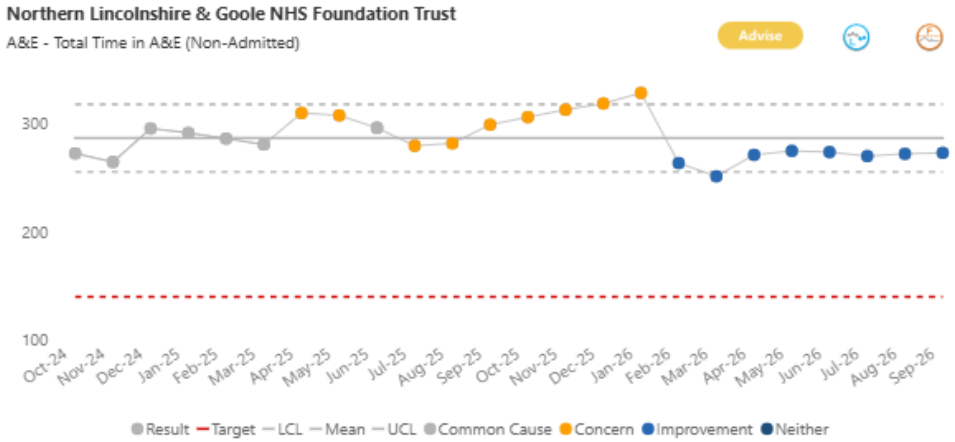
Non-admitted time improved in August but remained substantially above the 140-minute target. The response is to strengthen early streaming, rapid assessment and discharge from ED pathways, with daily review of avoidable waits for patients who do not require admission.

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.







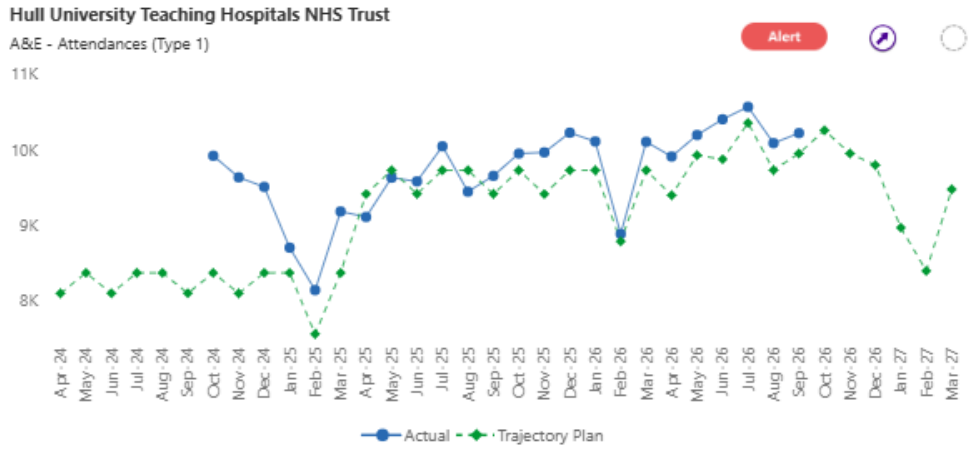
4.5 Enabler Metric 4: A&E Attendances – Type 1 Attendances

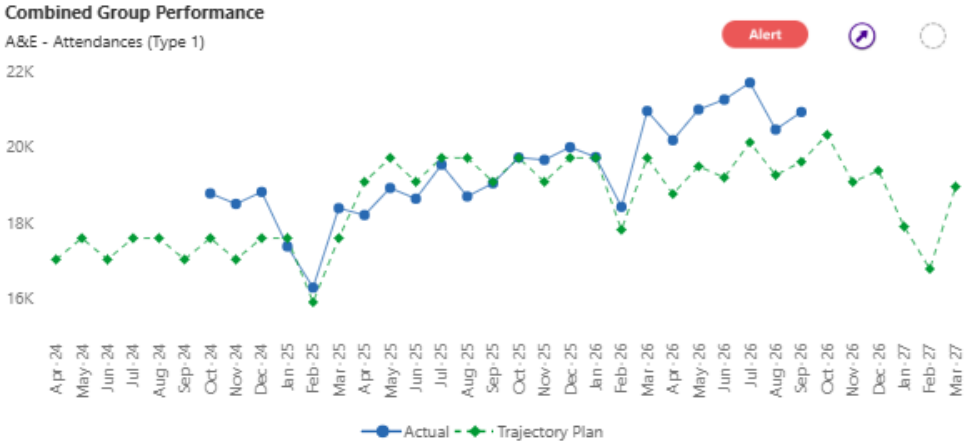
HUTH:

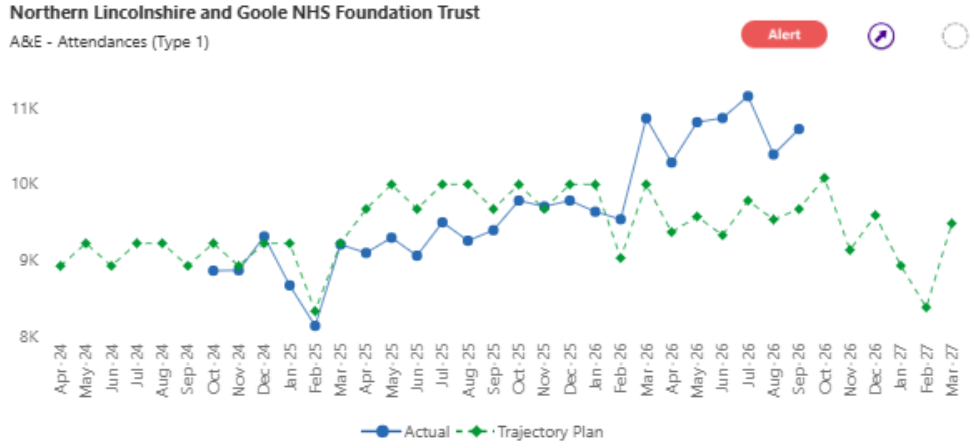
Type 1 attendances reduced from July but remained above trajectory in August, continuing the sustained upward pressure on ED. Action remains focused on streaming, alternatives to ED, SDEC and demand management with system partners.

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.







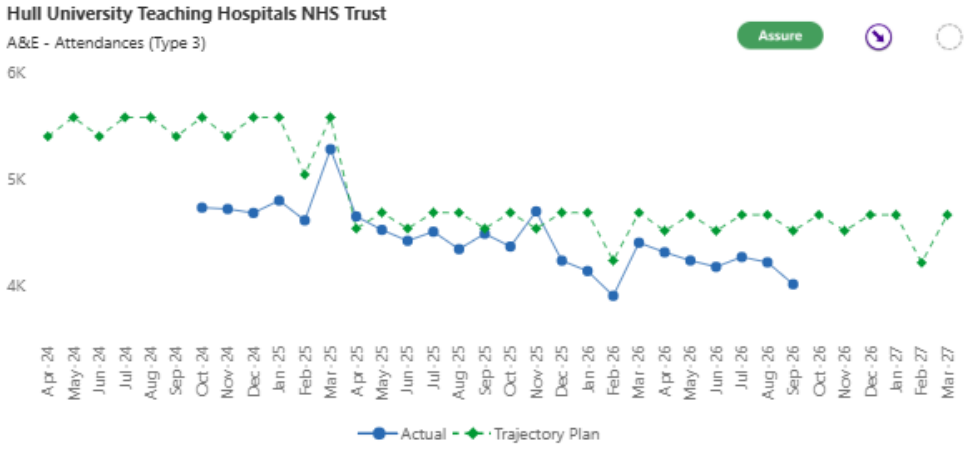
4.6 Enabler Metric 5: A&E Attendances – Type 3 Attendances

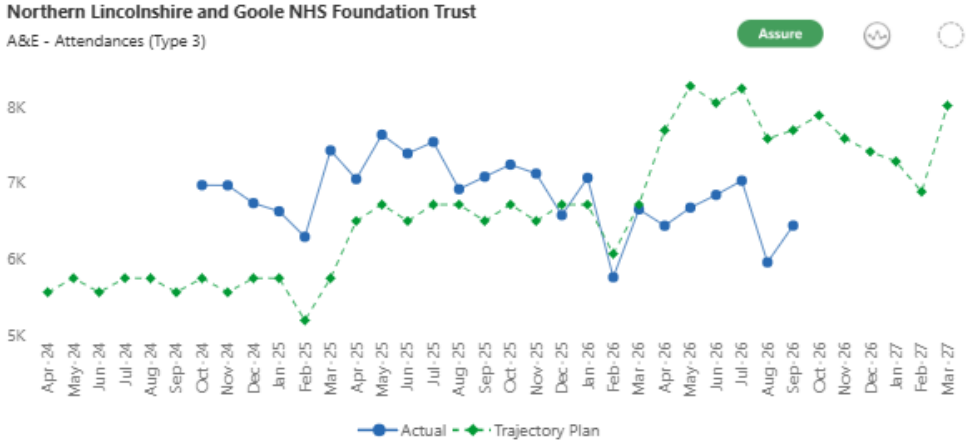
HUTH:

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.





4.7 Planned Care

September RTT data is not yet available because of recent changes to the national submission timetable of monthly RTT submissions.

Long waits remain the main risk across the Group. The latest 65-week position indicates 355 patients at HUTH and 158 at NLAG.

Progress

Cancer performance showed positive movement in August, with 62-day compliance for HUTH remains close to plan with some deterioration in month from 54.5% to 51.7%. All other standards showed improvement with FDS in HUTH improving from 70% to 72.9% and in NLAG from 68% to 70.4%. The 31day target in HUTH improved from 76.4 to 78.1% and remained broadly the same at 92.2% in NLAG. The 62day target improved in NLAG from 56.5% to 59.9%.

The August update uses the latest Time to First Appointment position of 61.0% at HUTH and 68.2% at NLAG. August RTT validation improved to 94.2% at HUTH and just below standard at 89.5% at NLAG. LUNA-ROVA deployment in August and September will strengthen patient-level tracking and exception management.

In September, the latest diagnostic six-week position deteriorated at HUTH to 38.2% and improved at NLAG to 31.2%. Both remain materially above the 1% standard.

September theatre utilisation was 81.4% at HUTH and 82.7% at NLAG. The August combined follow-up backlog increased to 84,071: HUTH increased to 48,174 but NLAG decreased to 35,897.

Action

- Elective Single Point of Access implementation in progress and expected to complete as per the national timelines for all the specialties by March 27
- Elective access governance and assurance in place reflecting the 10 GiRFT recommendations. This includes the steering group reporting to Planned Care Board incorporating RTT, Diagnostics and Non-RTT pathways.
- Weekly grip and control in place from October 26 through specialty, care group, tactical and executive meetings tracking the agreed performance.
- Weekly in year trajectories for RTT long waits, Diagnostics (DM01) and first appointments to be reset at specialty level by November 26 considering any changes to recovery plans to March 27.
- GiRFT focus on first appointment priority dating being considered for implementation in November 26 through clinical leads.
- Support care groups to implement chronological dating of patients after clinical urgency.

- Demand and capacity completed for outpatients; admitted theatre model will be completed in October 26.
- Luna Rova now live across NLaG and HUTH to strengthen data quality improvement providing areas of focus for a more prioritized approach.
- Specialty deep dives in outpatients will conclude by November 26 with specialty plans finalized for improvements in first appointments, reduction in follow up pathways and the management of non-RTT follow ups.
- The clinical harm policy and risk stratification being re-enforced to improve compliance during November 26.
- CDC activity improvement plan developed and will be implemented in November 26.
- Active engagement with GiRFT leads in place including seeking support from the national specialty leads to act as support for clinical leads in implementing best practice. Gastroenterology has had this in place through SPoA implementation**.**

Planned Care Scorecard HUTH

Tier 1 - Foundation Scorecard

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

Oversight | CQC

Domain	Subject Area	Metric	National Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Effective	Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	59.8%	70.7%	60.2%	58.7%	52.9%	74.6%	76.6%	71.2%	70.6%	67.3%	70.0%	72.9%	
		Cancer - 31 Day All Stages	≥ 94.0%	69.1%	75.5%	74.0%	76.7%	67.5%	76.2%	78.4%	73.5%	75.2%	77.2%	76.4%	78.1%	
		Cancer - 31 Day First Treatment	≥ 94.0%	73.7%	81.1%	80.3%	78.3%	72.3%	77.4%	80.0%	81.2%	79.7%	81.4%	83.8%	80.8%	
		Cancer - 62 Day All Referral Sources	≥ 80.0%	50.2%	55.5%	57.4%	53.7%	52.0%	51.6%	56.0%	52.9%	49.4%	54.4%	54.5%	51.8%	
		Cancer - 62 Day GP Referral	≥ 80.0%	44.3%	49.9%	49.7%	43.6%	39.7%	44.5%	55.8%	49.4%	41.2%	44.1%	43.9%	40.1%	
		Cancer - PTL Waits 104+ days		298	336	241	236	222	232	237	232	226	235	249	280	
	Elective Care	Outpatient - Clinic Slot Utilisation		95.4%	94.5%	94.4%	93.3%	95.1%	96.4%	95.6%	96.3%	95.9%	95.0%	95.8%	95.4%	94.5%
		Outpatient - DNA Rate	≤ 8.5%	5.8%	5.8%	5.9%	6.0%	5.9%	5.4%	5.6%	5.8%	5.8%	5.8%	5.9%	5.7%	6.0%
		Outpatient - Follow-up Overdue Backlog (3+ months)		46,343	46,284	47,461	48,561	47,880	46,880	47,001	46,354	46,905	46,821	47,753	47,359	48,174
		Outpatient - Hospital cancellations < 6 weeks	≤ 5.0%	7.0%	7.1%	7.4%	7.0%	6.8%	6.8%	7.1%	6.5%	6.9%	7.2%	7.0%	6.8%	7.4%
		RTT - 52+ Week Waits		3,216	3,221	3,291	3,072	3,157	3,110	2,796	2,888	3,069	3,188	3,331	3,500	
		RTT - 65+ Week Waits	≤ 0	85	96	134	112	131	109	65	89	141	224	277	355	
		RTT - 78+ Week Waits	≤ 0	2	0	0	0	0	2	0	1	3	5	7	7	
		RTT - Incomplete 18 Week Standard	≥ 92.0%	56.7%	56.5%	56.0%	55.6%	54.9%	54.6%	56.3%	56.3%	57.3%	56.8%	56.0%	55.4%	
		RTT - Pathways Validated within 12 weeks	≥ 90.0%	94.9%	93.5%	95.5%	95.6%	96.9%	95.5%	93.9%	92.0%	92.0%	92.5%	95.0%	95.2%	94.2%
		RTT - Patients waiting <= 18 weeks for 1st appointment		64.5%	64.3%	64.4%	62.6%	62.9%	62.9%	64.6%	65.1%	65.4%	64.3%	62.6%	61.0%	
		RTT - Total Incomplete Pathways		80,583	81,279	80,790	81,643	81,337	81,319	80,999	83,615	84,208	84,186	85,756	86,732	
	Productivity	Theatres - Capped Theatre Utilisation	≥ 85.0%	79.6%	80.0%	81.3%	81.0%	80.0%	80.7%	82.2%	81.9%	82.2%	82.6%	82.4%	82.8%	81.4%
		Theatres - Early Finishes		65.6%	66.9%	64.2%	66.0%	69.7%	67.6%	67.2%	63.4%	64.8%	62.5%	65.9%	61.2%	62.1%
		Theatres - Late Starts		68.6%	69.9%	68.7%	66.0%	69.0%	65.4%	61.8%	64.7%	65.5%	65.9%	68.2%	66.6%	67.8%
Responsive	Primary Prevention	Diagnostics - 6 Week Standard	≤ 1.0%	30.0%	31.3%	34.5%	40.2%	42.8%	35.9%	33.8%	38.1%	38.6%	37.2%	36.6%	39.1%	38.2%
		Diagnostics - Total Activity Levels		20,488	20,788	19,009	18,875	20,662	20,542	21,934	18,996	19,337	20,386	21,652	20,841	21,319
		Diagnostics - Total Waits		17,424	18,458	19,247	20,037	21,431	21,518	23,025	22,796	22,456	23,901	23,885	23,044	22,730

Planned Care Scorecard NLAG

Tier 1 - Foundation Scorecard

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

Oversight | CQC

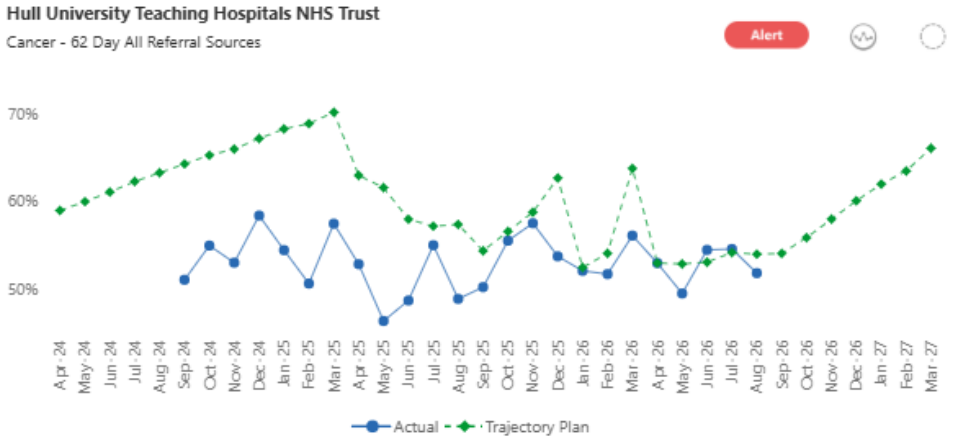
Domain	Subject Area	Metric	National Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Effective	Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	66.7%	70.8%	75.6%	73.8%	62.2%	69.9%	66.4%	63.0%	58.5%	64.0%	68.7%	71.1%	
		Cancer - 31 Day All Stages	≥ 94.0%	94.9%	95.5%	97.3%	98.7%	90.8%	96.0%	98.1%	97.1%	92.2%	94.1%	92.8%	92.2%	
		Cancer - 31 Day First Treatment	≥ 94.0%	96.5%	94.8%	97.3%	98.0%	92.1%	95.8%	98.1%	98.0%	93.8%	93.6%	93.9%	93.1%	
		Cancer - 62 Day All Referral Sources	≥ 80.0%	59.1%	67.2%	70.4%	66.1%	62.1%	63.3%	74.2%	65.0%	64.0%	64.1%	56.7%	59.9%	
		Cancer - 62 Day GP Referral	≥ 80.0%	45.1%	54.8%	58.5%	61.1%	57.1%	58.5%	66.8%	60.1%	61.0%	54.9%	43.2%	45.4%	
		Cancer - PTL Waits 104+ days		42	41	39	34	42	32	40	40	46	35	36	33	
	Elective Care	Outpatient - Clinic Slot Utilisation		95.7%	92.9%	91.9%	92.0%	92.8%	92.3%	92.9%	92.1%	92.3%	93.1%	79.0%	91.9%	92.9%
		Outpatient - DNA Rate	≤ 8.5%	7.6%	7.4%	7.3%	7.6%	7.2%	6.8%	7.0%	7.1%	6.7%	6.7%	6.8%	6.9%	6.6%
		Outpatient - Follow-up Overdue Backlog (3+ months)		33,862	33,993	33,696	34,055	33,275	33,183	33,951	34,735	35,405	35,729	35,902	36,610	35,897
		Outpatient - Hospital cancellations < 6 weeks	≤ 5.0%	8.2%	8.0%	9.1%	8.0%	7.6%	7.5%	8.4%	8.3%	8.8%	7.8%	8.0%	8.6%	7.9%
		RTT - 52+ Week Waits		1,045	994	988	915	930	873	820	915	1,038	1,218	1,412	1,579	
		RTT - 65+ Week Waits	≤ 0	64	27	29	42	26	38	32	41	50	78	98	158	
		RTT - 78+ Week Waits	≤ 0	3	1	0	0	1	2	2	0	1	2	2	3	
		RTT - Incomplete 18 Week Standard	≥ 92.0%	59.3%	59.7%	59.5%	59.2%	58.3%	59.5%	61.4%	61.4%	62.0%	61.6%	59.8%	58.6%	
		RTT - Pathways Validated within 12 weeks	≥ 90.0%	90.2%	89.1%	87.8%	90.0%	85.0%	91.2%	93.0%	86.1%	89.5%	90.4%	87.5%	89.1%	89.5%
		RTT - Patients waiting <= 18 weeks for 1st appointment		67.6%	67.3%	68.0%	67.2%	66.5%	69.7%	71.3%	72.2%	72.4%	71.6%	69.6%	68.2%	
		RTT - Total Incomplete Pathways		40,146	40,156	39,296	39,294	39,644	39,443	39,652	40,793	41,548	42,012	42,605	43,145	
	Productivity	Theatres - Capped Theatre Utilisation	≥ 85.0%	81.9%	79.9%	81.1%	82.9%	81.2%	81.5%	81.8%	83.7%	83.9%	84.0%	81.5%	85.6%	82.7%
		Theatres - Early Finishes		50.3%	61.4%	57.1%	52.4%	53.9%	57.4%	53.2%	58.4%	52.7%	47.4%	58.5%	43.2%	50.6%
		Theatres - Late Starts		100.0%	98.4%	99.0%	99.4%	98.5%	98.2%	98.3%	100.0%	98.7%	98.8%	98.8%	98.7%	99.4%
Responsive	Primary Prevention	Diagnostics - 6 Week Standard	≤ 1.0%	35.9%	38.4%	41.6%	46.5%	46.5%	37.2%	29.9%	33.0%	34.4%	32.6%	33.5%	33.6%	31.2%
		Diagnostics - Total Activity Levels		25,259	25,578	24,155	23,942	25,902	25,258	30,874	17,662	16,752	17,219	18,971	17,331	18,072
		Diagnostics - Total Waits		23,942	24,162	25,675	26,004	26,804	27,270	24,997	17,062	16,998	18,789	18,447	17,343	17,543

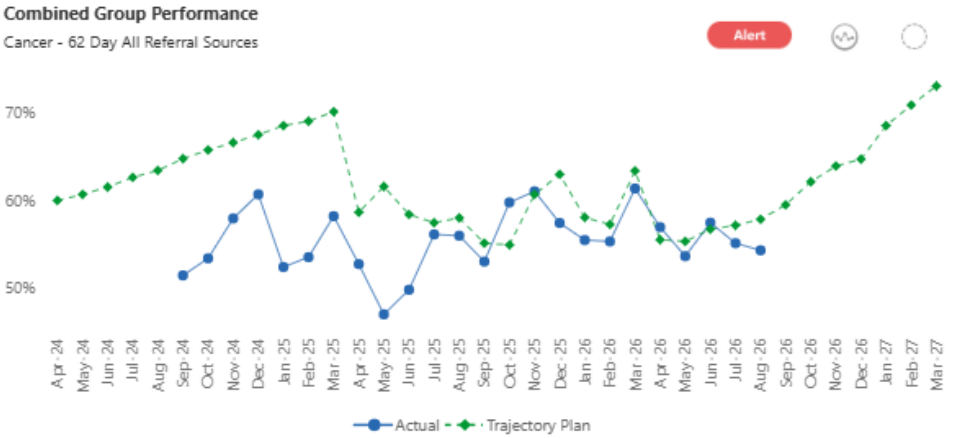
4.8 Cancer 62 Day First Definitive Treatment

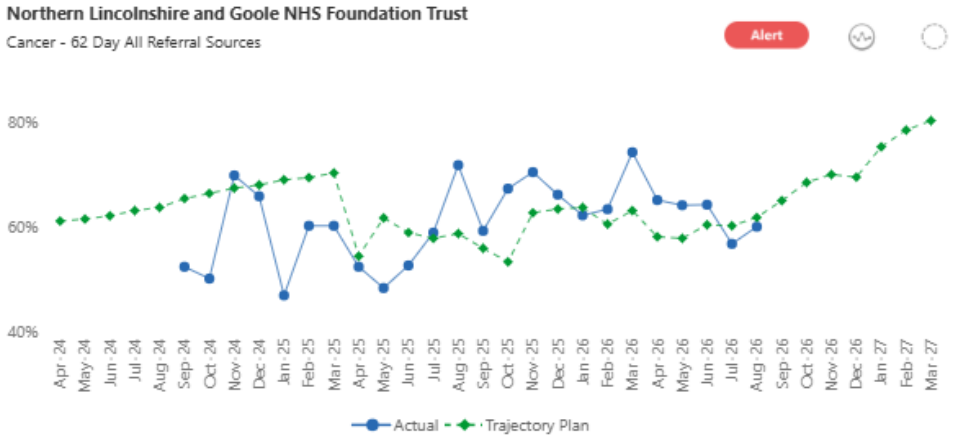
Summary:
August update: the latest available national cancer data remains August. Both Trusts remain below the national standard of 80%.62-day compliance for HUTH remains close to plan with some deterioration in month from 54.5% to 51.7% in July. The 62day target improved in NLAG from 56.5% in August to 59.9% in July.

Progress:
Radiotherapy, histopathology, gynaecology and lower GI 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.





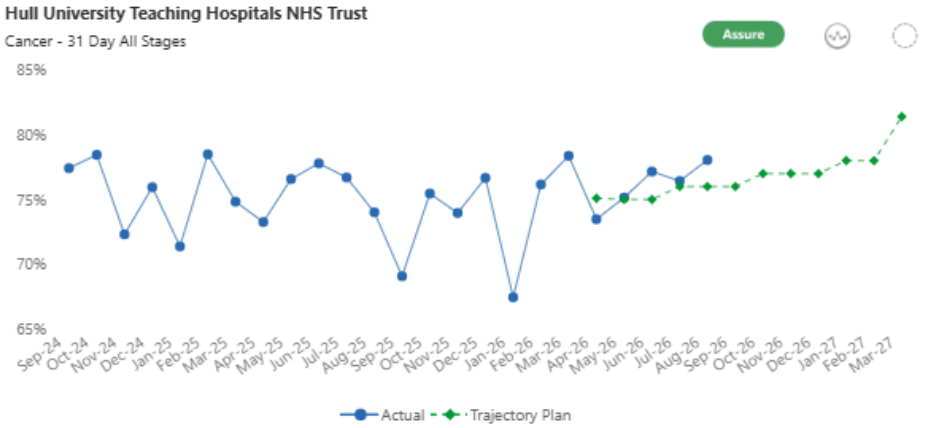


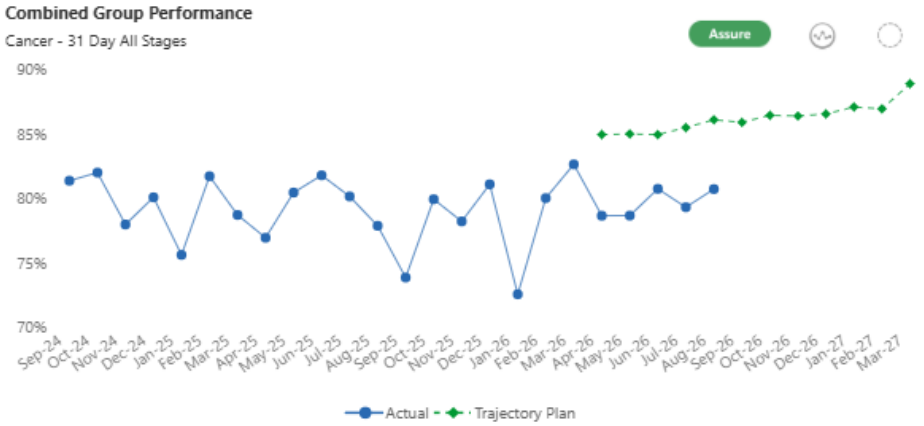
4.9 Cancer 31-day First Treatment

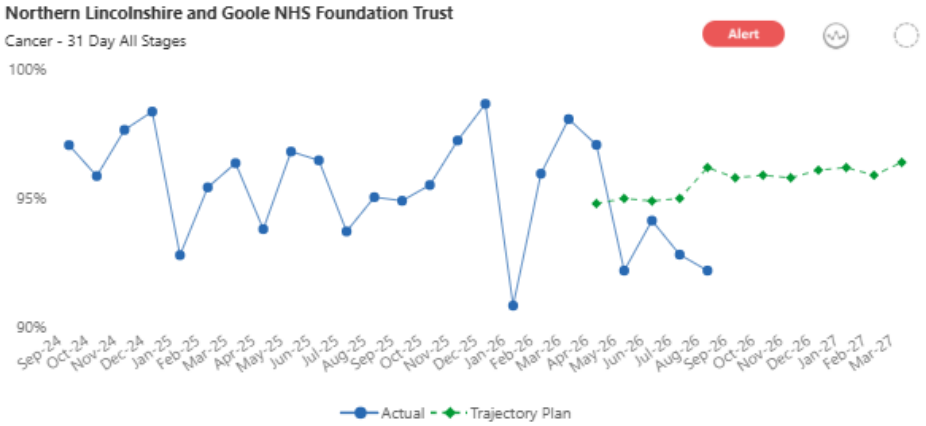
Summary:
August update: the latest available national cancer data remains July. Both Trusts remain below the 94% standard.

Progress:
The 31day target in HUTH improved from 76.4 to 78.1% and remained broadly the same at 92.2% in NLAG. Radiotherapy, Skin and Gynaecology improvement plans are in place to increase capacity and improve pathways.

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





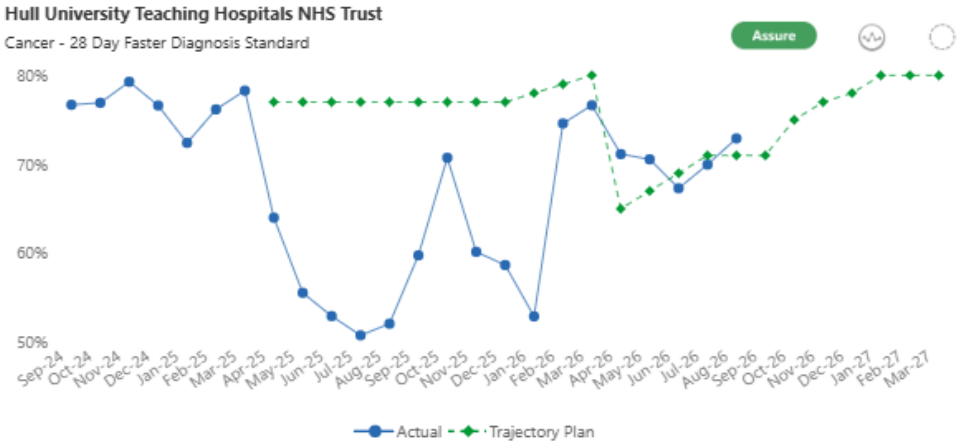


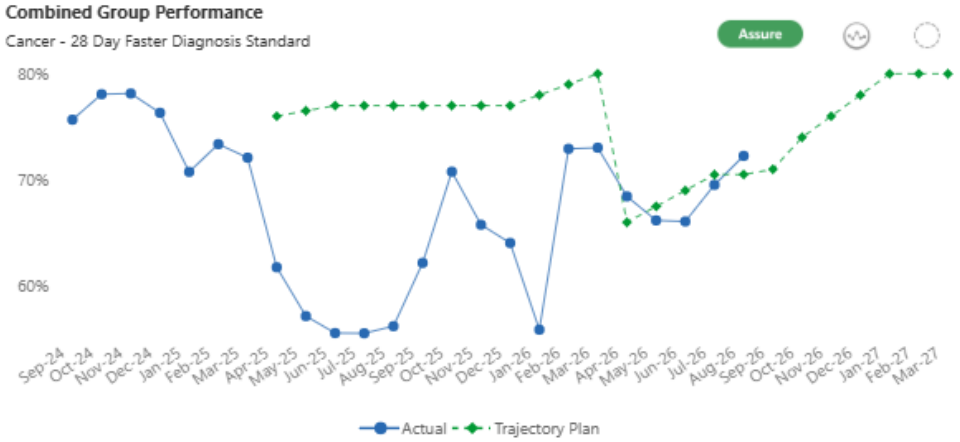
4.10 Cancer 28-day Faster Diagnosis Performance

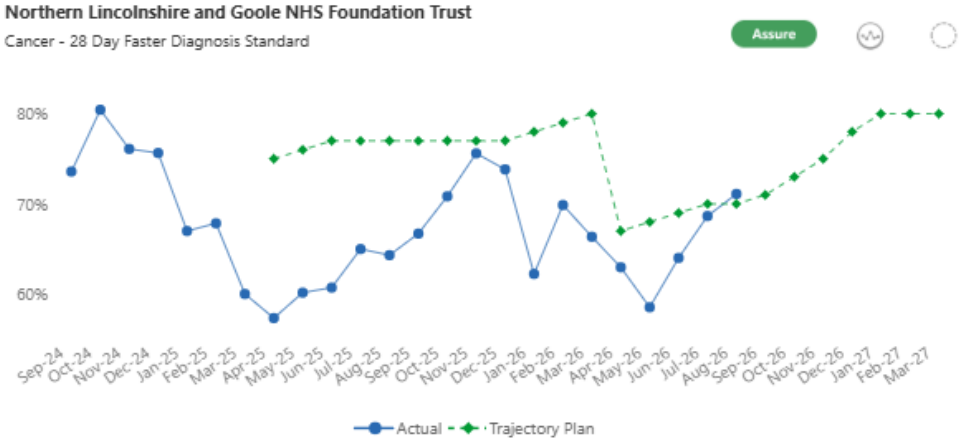
Summary:
August update: the latest available national cancer data remains July. Both Trusts remain below trajectory and the 80% standard. FDS in HUTH has improved from 70% to 72.9% and in NLAG from 68% to 70.4%.

Progress:
The latest data improved at both Trusts, but delivery remains below the required level across tumour pathways. Recent improvements are supported by additional capacity sourced through non-recurrent funding.

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







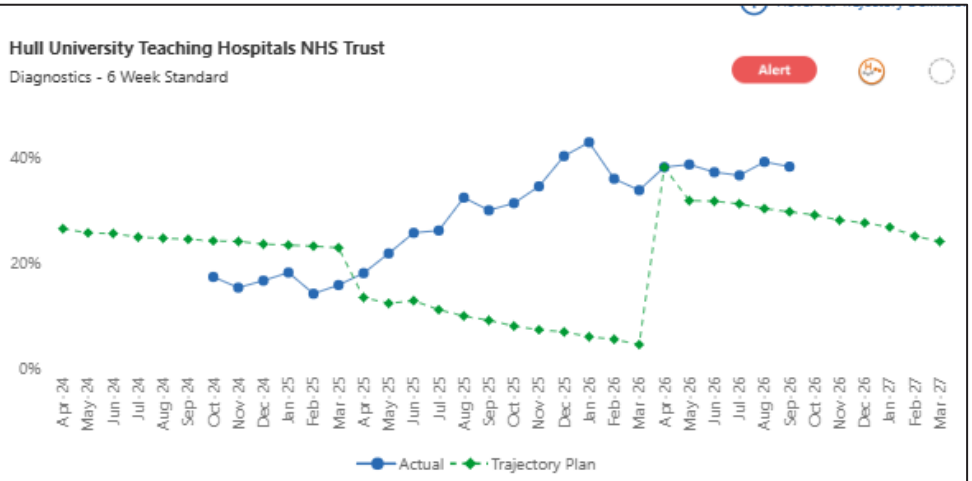
4.11 Diagnostic 6-Week Standard

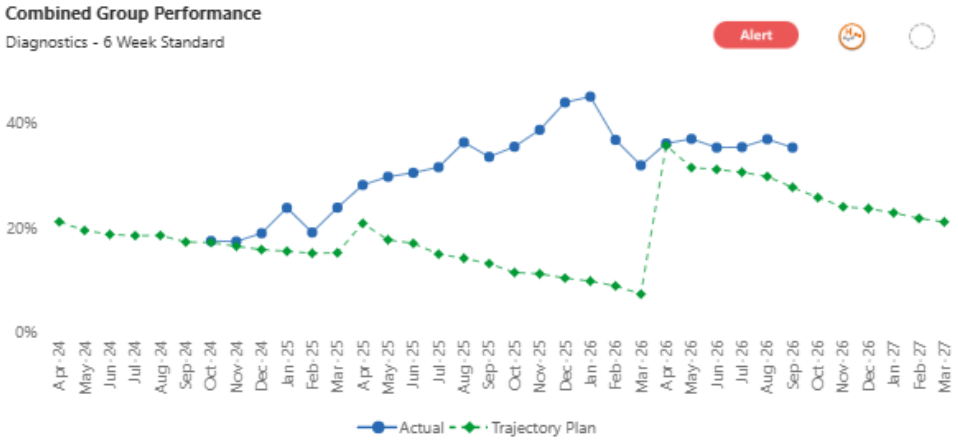
Diagnostics - 6 Week Standard

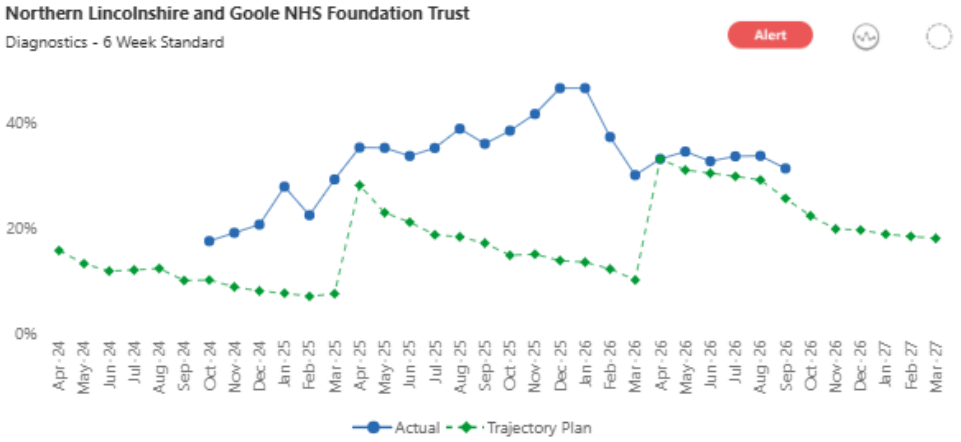
Summary:
September update: the latest graph position is 38.2% at HUTH and 31.2% at NLAG. Both Trusts remain materially above the 1% six-week standard.

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.





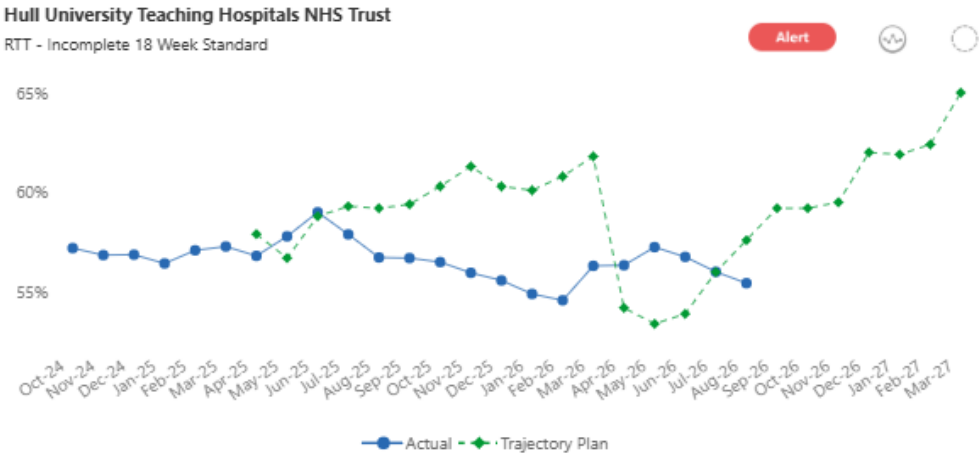


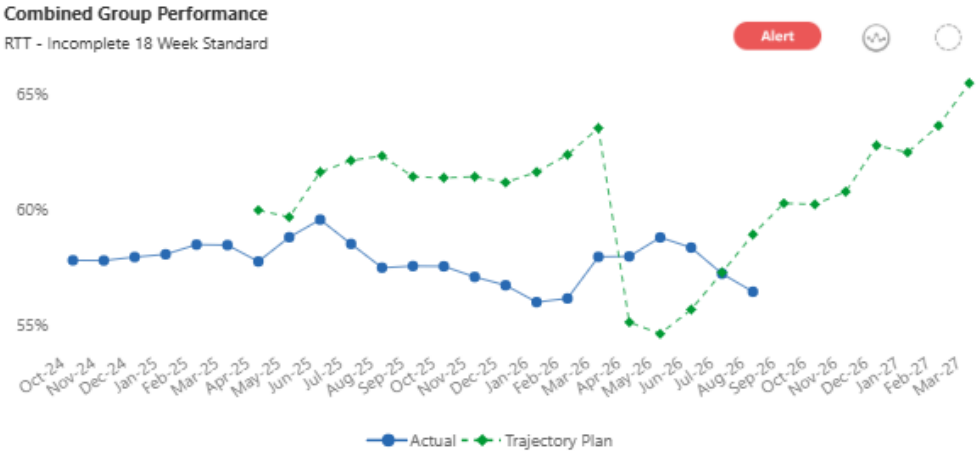
4.12 RTT Incomplete Performance

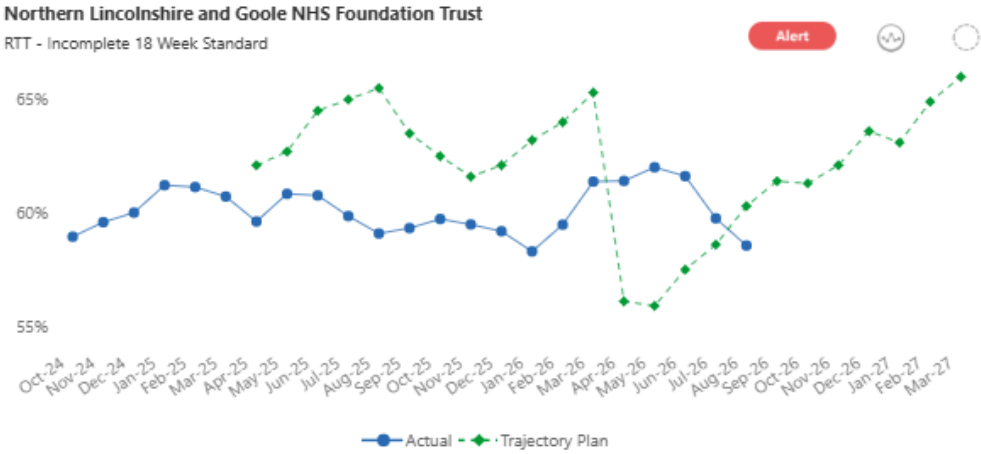
Summary:
August RTT performance reduced by 0.6 percentage points at HUTH to 55.4% and by 1.2 points at NLAG to 58.6%. Both Trusts remain well below the 92% standard and below their August trajectory.

Progress:
Outpatient transformation programme refreshed in July 26. Demand and capacity model completed. Specialty level position reviewed to inform in year recovery and annual planning 2027/28.

Action:
Specialty level weekly tracking in place and a focus on the reduction of long waits through ensuring chronological dating of patients after clinical urgent cases. This includes weekly oversight meetings for performance including CDO chaired reviews for assurance and support.





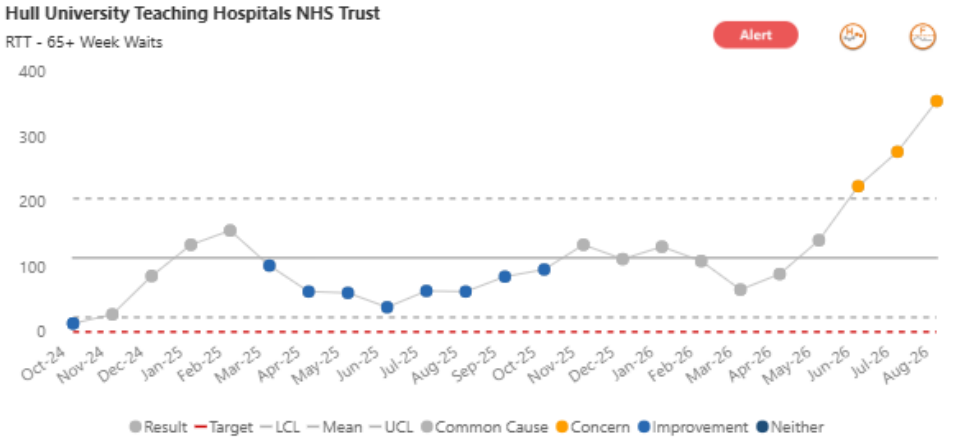


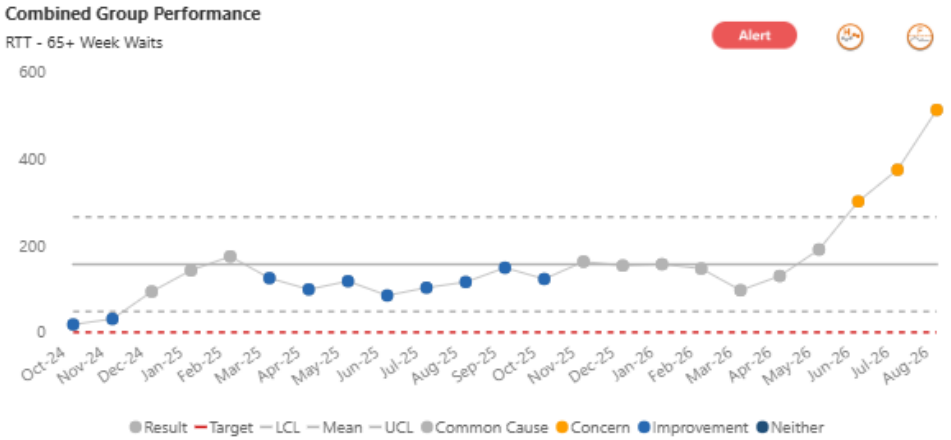
4.13 RTT 65 week waits

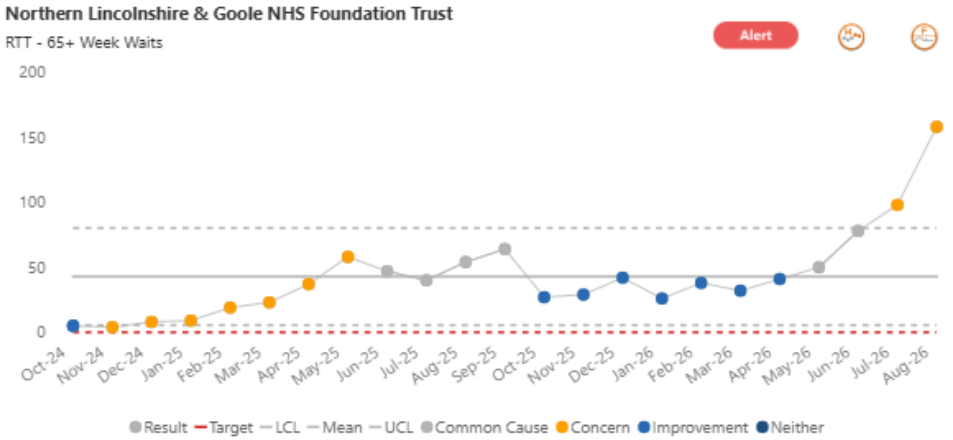
Summary:
65-week waits increased to 355 at HUTH and 158 at NLAG. This sharp deterioration reflects the underlying long wait volumes and capacity restraints.

Progress:
Validation and specialty oversight are established. A key area of focus is limiting progression to over 65 week waits preventing additions and clearing the existing backlog as part of the over 52 week wait reduction through the weekly oversight meetings

Action:
Maintain weekly dated-patient plans and protect capacity. Support required: executive escalation of unresolved outpatient, diagnostic, theatre, workforce and mutual-aid gaps





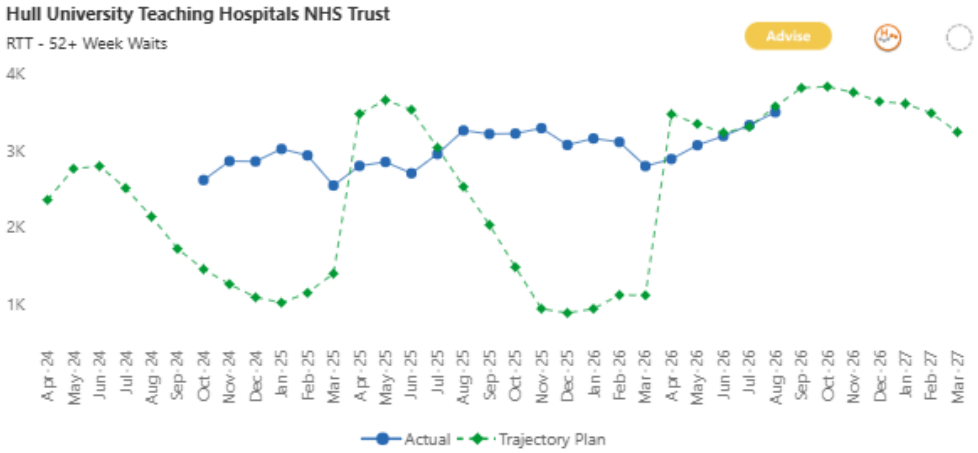


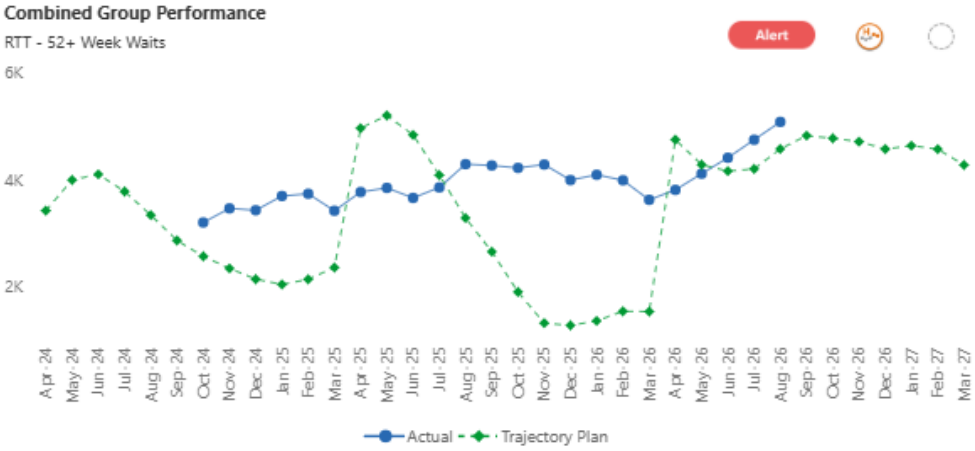
4.14 RTT 52 week waits

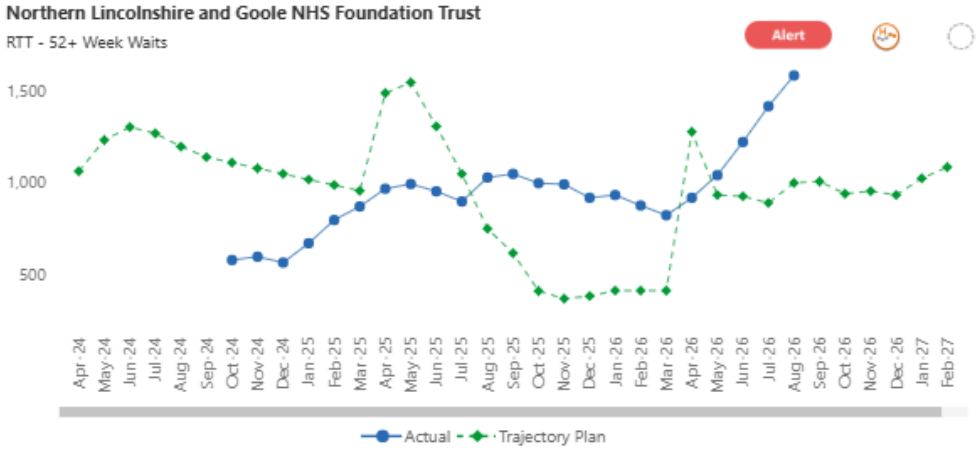
Summary:
52-week waits increased at HUTH to 3,500 and NLAG to 1,579. Growth was not expected; HUTH remains on its plan line, while NLAG is above trajectory.

Progress:
Validation and specialty oversight are in place. A key area of focus is limiting progression to over 65 week waits preventing additions and clearing the existing backlog as part of the over 52 week wait reduction through the weekly oversight meetings

Action:
Set weekly specialty trajectories and date highest-risk patients. Support Care Group ownership and resolution of outpatient, diagnostic and treatment capacity gaps.





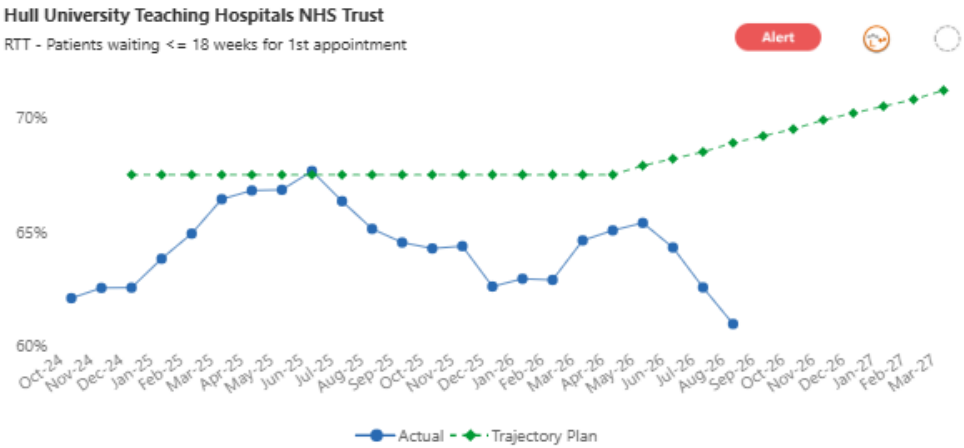


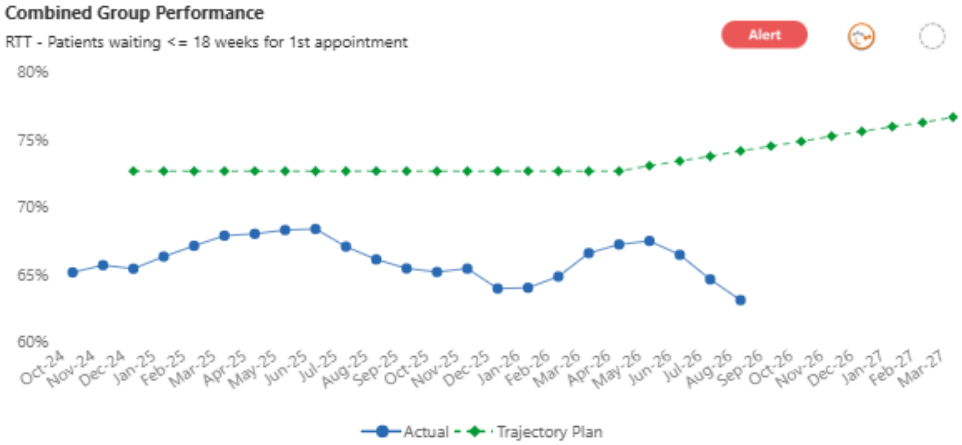
4.15 Enabler Metric 1: Time to First Appointment (%)

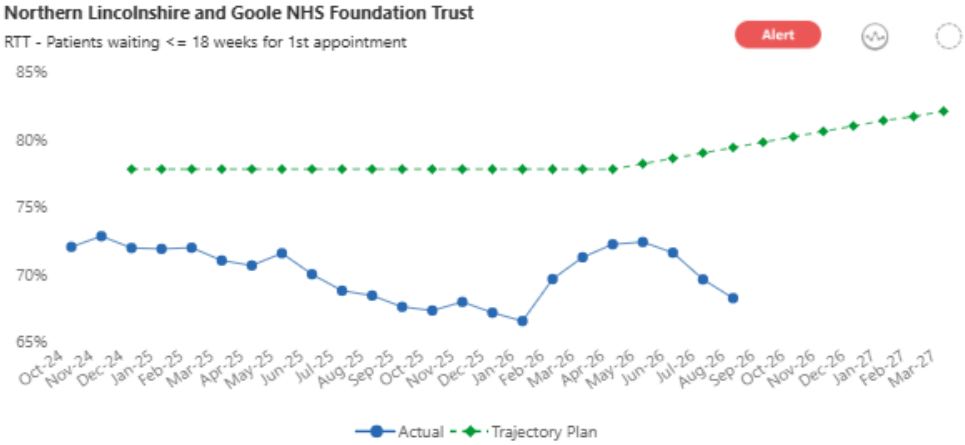
Summary:
August update: the latest graph position is 62.6% at HUTH and 69.6% at NLAG. Both Trusts remain below trajectory for patients waiting no more than 18 weeks for a first appointment.

Progress:
GiRFT supported focus in dating first outpatient waits during November by repurposing capacity being considered through clinical leads for specialties.

Action:
Improve slot fill, booking controls and continue to implement SPOA pathways. Confirm specialty capacity plans, referral-demand controls and resolution of workforce gaps.





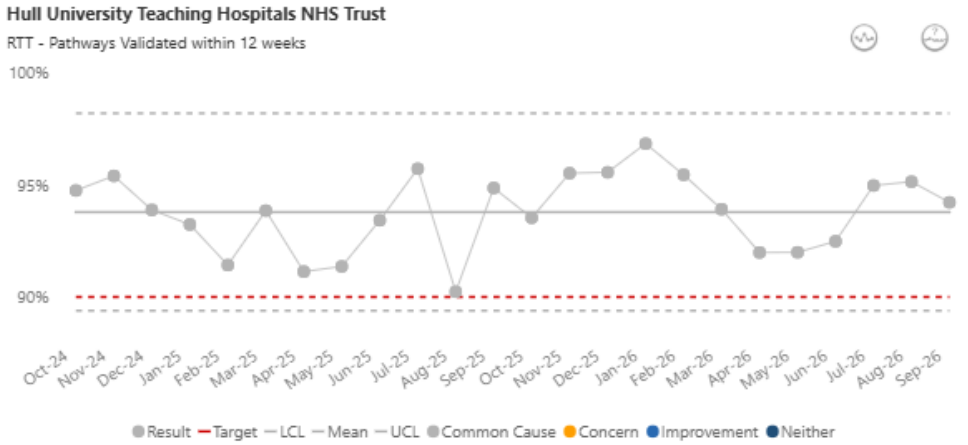


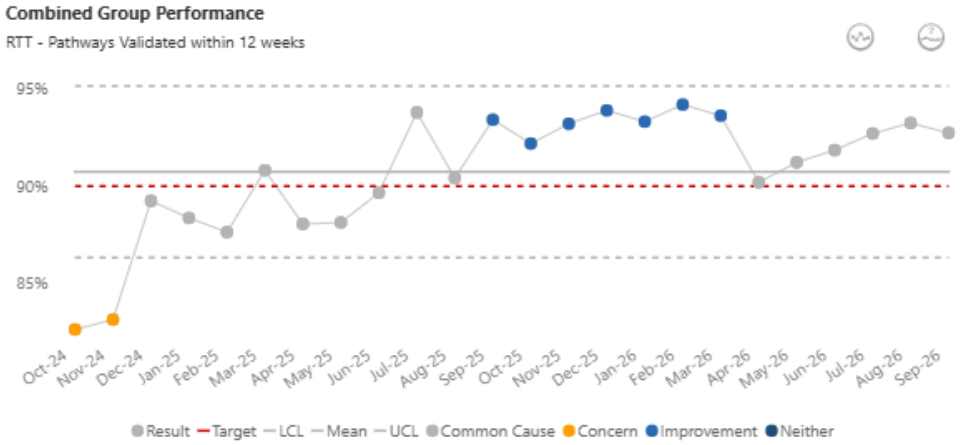
4.16 Enabler Metric 2: RTT Data Quality

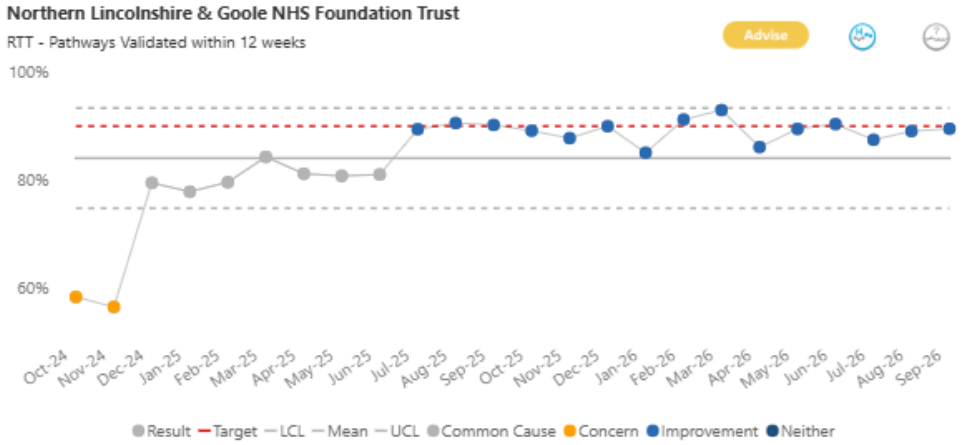
Summary:
September validation improved to 94.2% at HUTH and 89.5% at NLAG.

Progress:
Weekly validation, completeness work and pathway oversight have improved the position. LUNA-ROVA deployment should strengthen patient-level tracking and exception management. This will be fed through to specialties and care groups to address at source and will be overseen by the new elective access governance and assurance steering group reporting to the planned care board.

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.





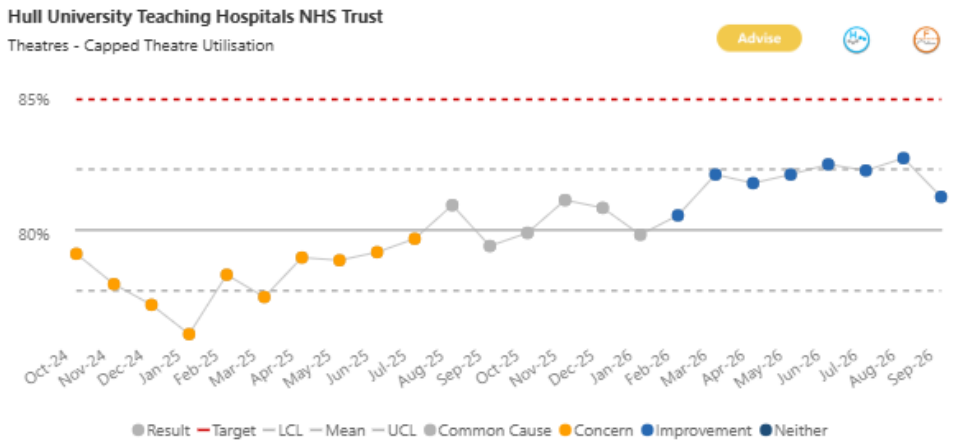


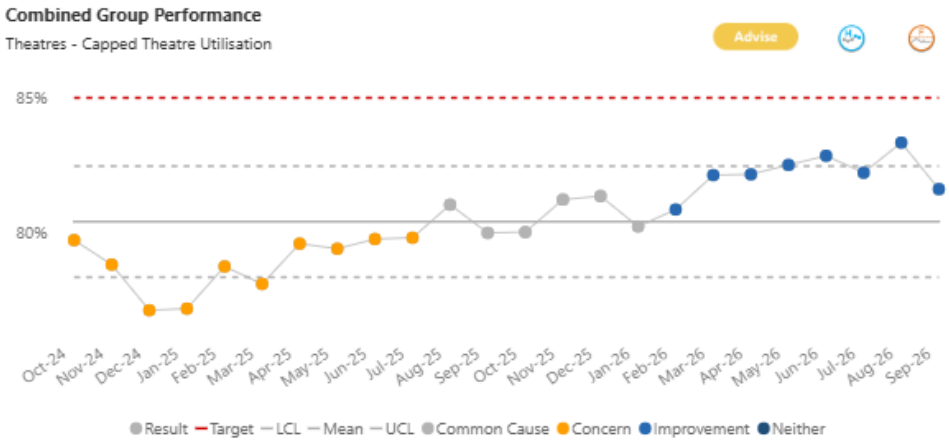
4.17 Enabler Metric 3: Capped Theatre Utilisation

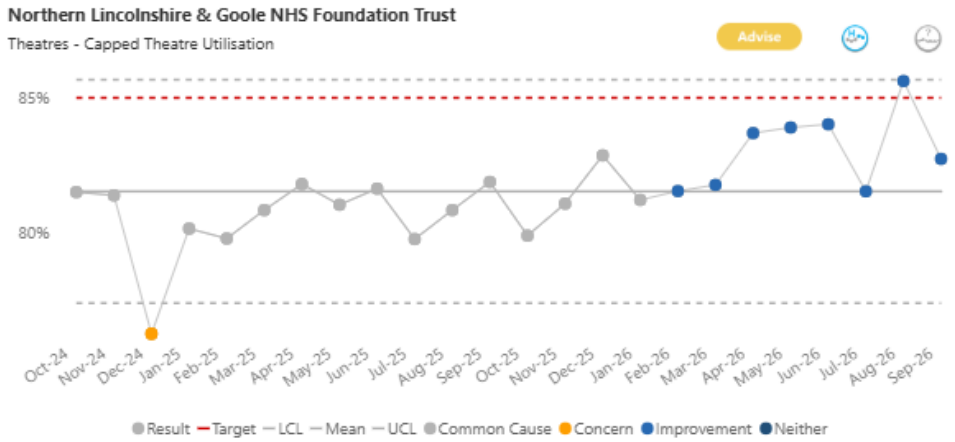
Summary:
September theatre utilisation reduced by 1.4 percentage points at HUTH to 81.4% and NLAG reduced by 2.9 points to 82.7%.

Progress:
NLAG has converted improved session delivery into target achievement in August. HUTH remains off target despite scheduler access and productivity oversight.

Action:
Recover both HUTH and NLAG above 85%. Track session fill, starts, finishes and cancellations weekly, with Care Group action on workforce and long-wait capacity.





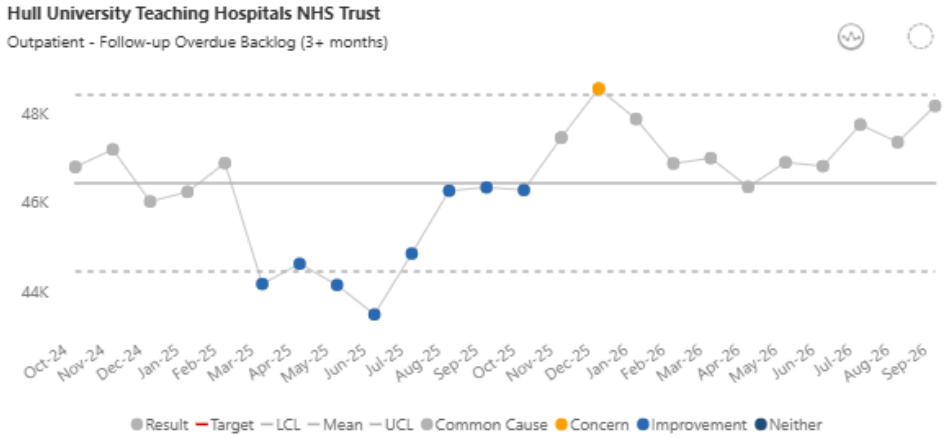


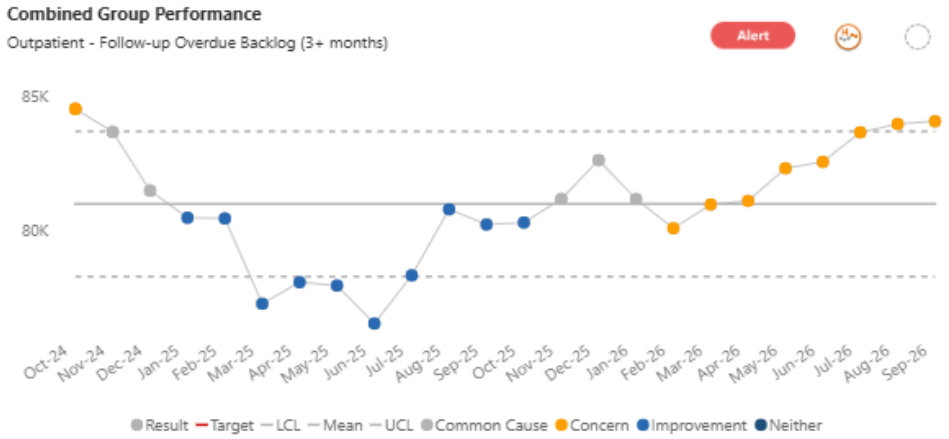
4.18 Enabler Metric 4: Outpatient Follow Up Backlog

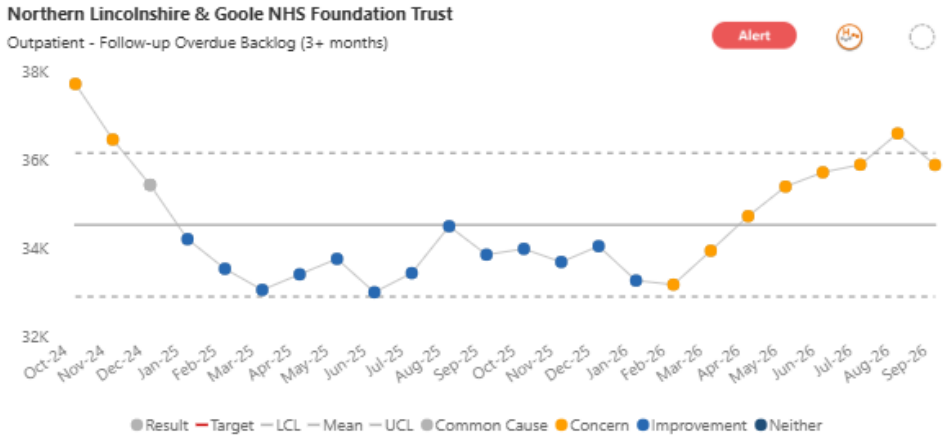
Summary:
HUTH increased to 48,174 while NLAG increased to 35,897.

Progress:
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. Consider validation tool for in year management to support prioritised dating and extend Luna ROVA for follow ups in 2027/28.







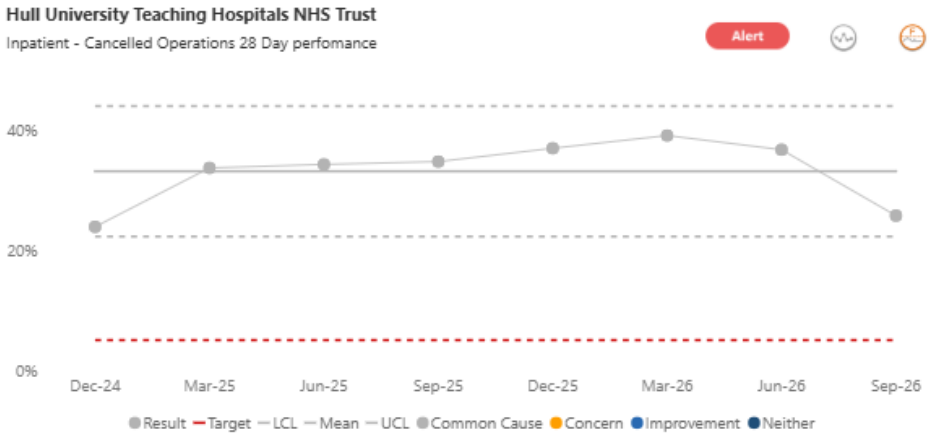
4.19 Enabler Metric 5: Cancelled Operations – 28-day Breaches

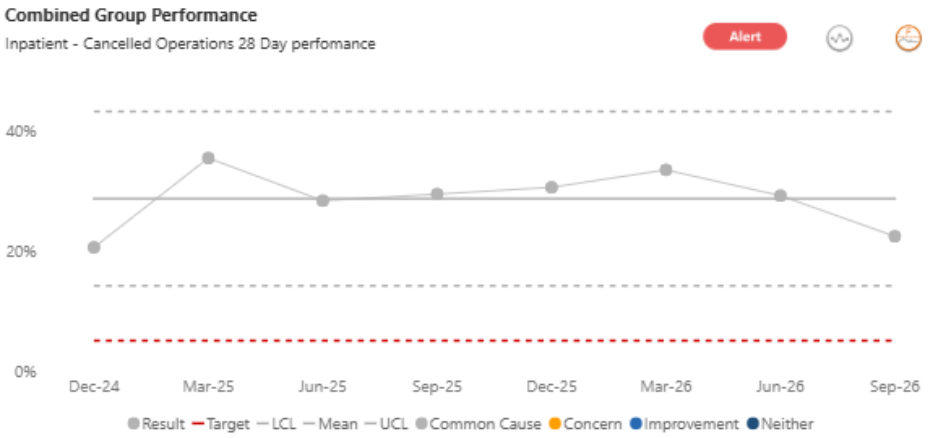
Inpatient - Cancelled Operations 28 Day perfomance

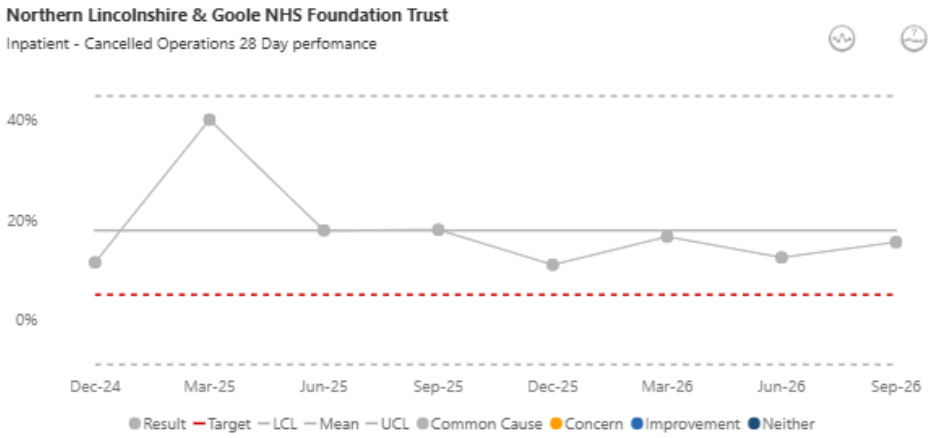
Summary:
September update: the quarter 2 performance shows an improved position at HUTH to 25.7%. NLAG remains static at 15.6%. Both Trusts remain significantly above the 5% standard.

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

Provider displayed

Metric (right click to drill through to SPC chart)	Period	Target	Result	Var	Asr
Care Hours per Patient Day - Overall	Jul-26	≥ 9.0	7.4		
Complaints - 60 day compliance	Sep-26	≥ 85.0%	42.1%		
Falls - per 1,000 bed days	Sep-26		6.4		
Falls - Serious harm or death	Sep-26		1		
Friends & Family - A&E Score	Aug-26	≥ 85.0%	66.7%		
Friends & Family - Antenatal Score	Aug-26	≥ 95.0%	91.3%		
Friends & Family - Inpatient Score	Aug-26	≥ 95.0%	96.7%		
Friends & Family - Outpatient Score	Aug-26	≥ 95.0%	96.9%		
Infections - C.Difficile (Cumulative)	Aug-26	≤ 61	48		
Infections - E.Coli (Cumulative)	Aug-26	≤ 216	90		
Infections - Klebsiella (Cumulative)	Aug-26	≤ 88	30		
Infections - MRSA (per 1,000 bed days)	Aug-26		0.0		
Inpatient - Corridor Care on Wards	Sep-26		50.0		
Mortality - SHMI	May-26	≤ 1.0	1.1		
Never Events	Sep-25		1		
Patient Safety Incidents - Moderate and above (per 1,000 be...	Sep-26		1.2		
Pressure Ulcers - Category 3	Sep-26		3		
Pressure Ulcers - Category 4	Sep-26		0		
Pressure Ulcers - Hospital acquired	Sep-26		135		
VTE Risk Assessment 14 Hour Standard	Aug-26	≥ 95.0%	91.5%		

Northern Lincolnshire and Goole NHS Foundation Trust

Provider displayed

Metric (right click to drill through to SPC chart)	Period	Target	Result	Var	Asr
Care Hours per Patient Day - Overall	Jul-26	≥ 9.0	8.5		
Complaints - 60 day compliance	Sep-26	≥ 85.0%	59.0%		
Falls - per 1,000 bed days	Sep-26		6.5		
Falls - Serious harm or death	Sep-26		2		
Friends & Family - A&E Score	Aug-26	≥ 85.0%	52.5%		
Friends & Family - Antenatal Score	Aug-26	≥ 95.0%	0.0%		
Friends & Family - Inpatient Score	Aug-26	≥ 95.0%	97.4%		
Friends & Family - Outpatient Score	Aug-26	≥ 95.0%	92.1%		
Infections - C.Difficile (Cumulative)	Aug-26		22		
Infections - E.Coli (Cumulative)	Aug-26	≤ 57	41		
Infections - Klebsiella (Cumulative)	Aug-26	≤ 34	9		
Infections - MRSA (per 1,000 bed days)	Aug-26		0.0		
Inpatient - Corridor Care on Wards	Sep-26		0.0		
Mortality - SHMI	May-26	≤ 1.0	1.0		
Never Events (per 1,000 bed days)	Aug-26		0.0		
Patient Safety Incidents - Moderate and above (per 1,000 be...	Sep-26		2.7		
Pressure Ulcers - Category 3	Sep-26		12		
Pressure Ulcers - Category 4	Sep-26		0		
Pressure Ulcers - Hospital acquired	Sep-26		228		
VTE Risk Assessment 14 Hour Standard	Aug-26	≥ 95.0%	93.3%		

5.1 Group Chief Patient Safety Officer Update – Quality Overview (September 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.

NHS outcomes Framework for Quarter 1 shows a quartile 4 performance in Patient Safety, Effectiveness and Experience of care for HUTH. NLAG also has quartile 4 performance in Patient Safety and Experience of care and quartile 3 for Effectiveness.

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: 16

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
Inpatient - Discharges by 12pm (midday)
PALS - Complaints compliance within 10 working days
Pressure Ulcers - Category 2
Pressure Ulcers - Category 3
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: 6

Assure

Inpatient - Corridor Care on Wards
Inpatient - Discharge Lounge Utilisation
PALS - Complaints
Patient Safety Incidents - Low harm
Patient Safety Incidents - No harm
Patient Safety Incidents - Severe harm

b. Northern Lincolnshire & Goole Hospitals Quality AAA Summary

Count: 11

Alert

Care Hours per Patient Day - Overall
Care Hours per Patient Day - Registered
Care Hours per Patient Day - Unregistered
Complaints - 40 day compliance
Duty of Candour - Written apology
Friends & Family - A&E Score
Infections - C.Difficile
Infections - C.Difficile (per 1,000 bed days)
Inpatient - Annual Growth Under 18s Elective Activity
Inpatient - Discharges by 12pm (midday)
Inpatient - Long Stay Occupancy (21+ days)

Count: 2

Advise

Friends & Family - Postnatal Community Score
VTE Risk Assessment 14 Hour Standard

Count: 5

Assure

Friends & Family - Community Score
Friends & Family - Inpatient Score
Inpatient - Corridor Care on Wards
Mortality - HSMR
Patient safety alerts actioned by specified deadline

5.2 Experience

Summary

complaints received and PALS concerns are the core measures of responsiveness to patient concerns. The complaint rate has reduced for HUTH, with an increase for NLAG, the timeliness in responding to complaints remains below the target, although has shown improvement on the 40-day target across HPP. There has been a reduction in the number of PALS contacts at HUTH. The scorecards scope complaints 60-day compliance has reduced for HUTH; however the 40-day target shows improvement as new measures outlined below are enabling earlier resolution of new complaints. Improvement in learning from complaints and patient feedback sources is part of a group wide quality improvement plan, this includes support external providers.

Progress

PALs at HUTH PALs recovery work access to the PALs service for the public has improved
PALS contacts have reduced recently, however the complaint rate does not yet correlate with this, as it will take a quality review to show improvement. It may be there is an increased PALS contact rate with reduced complaint rates, as HPP moves to a more proactive approaches to engage with patients and their families. 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. The pattern suggests earlier resolution and thematic learning are not yet consistently reducing formal complaint or PALS activity. Reduction in second complaints being opened, has reduced over the last 6 months.

Action

- HUTH PALS service is relocating to enable a face-to-face service to be available, NLAG already provides this service.
- Across HPP Care Groups now manage PALs concerns directly. PALs concerns are managed by care group leads directly with telephone contact or in person conversation, reducing escalation to formal complaints
- Early resolution meetings are offered for formal complaints, to ensure timely responses and actions for families, patients.
- Quality Improvement in place across nine care groups to change behaviours, based on learning identified by care groups.

Friends and Family Test (FFT) current contracts have ended. Current in-house solution is not sustainable. A procurement exercise has been completed. Discussions in place to improvement a provided under the contracts for both HUTH and NLAG.

Experience 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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Caring	Experience	Friends & Family - A&E Score	≥ 85.0%	0.0%	0.0%	0.0%	100.0%	72.4%	70.8%	90.0%	71.4%	66.7%	100.0%	83.3%	66.7%	
		Friends & Family - Antenatal Score	≥ 95.0%	0.0%	100.0%	0.0%	100.0%	0.0%	81.8%	50.0%	93.8%	100.0%	82.4%	78.8%	91.3%	
		Friends & Family - Birth Score	≥ 95.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.4%	
		Friends & Family - Inpatient Score	≥ 95.0%	97.8%	98.8%	97.2%	96.2%	96.5%	97.1%	96.1%	96.9%	89.0%	96.9%	97.8%	96.7%	
		Friends & Family - Outpatient Score	≥ 95.0%	96.7%	97.8%	96.7%	94.1%	98.6%	97.1%	96.1%	96.2%	96.2%	97.9%	97.0%	96.9%	
		Friends & Family - Postnatal Score	≥ 95.0%	0.0%	100.0%	0.0%	0.0%	100.0%	66.7%	85.7%	100.0%	100.0%	75.0%	100.0%	100.0%	
Responsive	Experience	Complaints - 60 day compliance	≥ 85.0%	71.0%	24.6%	35.4%	51.9%	40.0%	53.5%	50.0%	64.5%	48.8%	57.6%	64.4%	56.1%	42.1%
		Complaints - Average response time	≤ 40.0	122.8	116.6	112.1	76.6	77.5	65.2	69.9	47.5	65.8	60.6	48.7	51.2	61.3
		Complaints - Received		47	51	56	36	31	35	26	18	49	29	28	29	
		Complaints - Received (per 1,000 bed days)		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	2	1	4	2	2	4	3	2	0	1	0	
		PALS - Complaints		250	397	272	241	254	216	140	64	219	159	130	122	
		PALS - Complaints compliance within 10		46.9%	52.5%	42.9%	42.0%	38.3%	47.4%	41.1%	46.6%	55.3%	33.0%	36.4%	27.3%	20.2%

Experience NLAG Scorecard

Tier 1 - Foundation Scorecard

Oversight | CQC

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

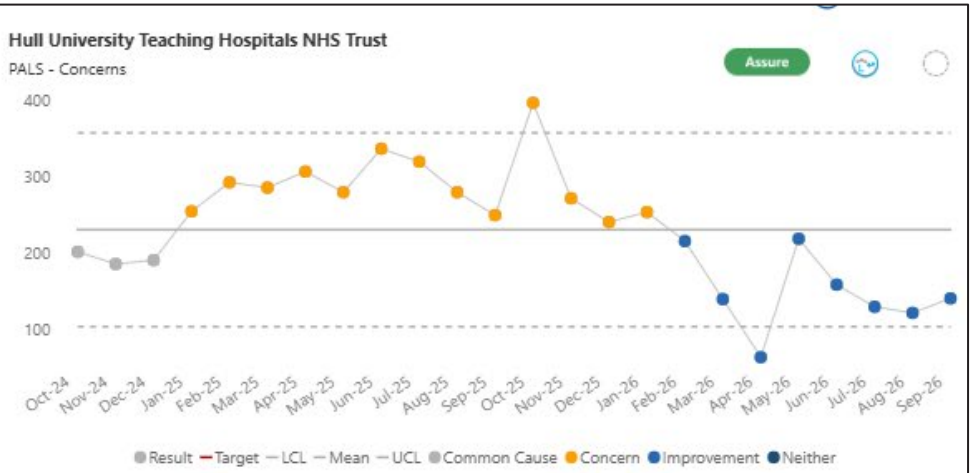
Domain	Subject Area	Metric	National Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Caring	Experience	Friends & Family - A&E Score	≥ 85.0%	75.6%	75.6%	75.6%	75.0%	76.8%	76.8%	76.4%	79.4%	74.3%	76.0%	60.0%	52.5%	
		Friends & Family - Antenatal Score	≥ 95.0%	65.6%	65.6%	76.2%	75.8%	68.0%	96.3%	87.0%	100.0%	66.7%	66.7%	50.0%	0.0%	
		Friends & Family - Birth Score	≥ 95.0%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
		Friends & Family - Inpatient Score	≥ 95.0%	97.4%	97.4%	97.5%	97.2%	97.5%	98.2%	98.7%	98.5%	98.4%	98.6%	98.0%	97.4%	
		Friends & Family - Outpatient Score	≥ 95.0%	96.9%	96.9%	95.9%	97.7%	95.1%	96.9%	95.5%	97.9%	96.3%	97.9%	98.3%	92.1%	
		Friends & Family - Postnatal Score	≥ 95.0%	100.0%	100.0%	92.9%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	
Responsive	Experience	Complaints - 60 day compliance	≥ 85.0%	50.0%	37.1%	53.1%	67.9%	48.3%	63.9%	71.8%	78.6%	59.2%	72.2%	62.1%	68.6%	59.0%
		Complaints - Average response time	≤ 40.0	59.5	74.2	67.2	43.8	63.3	55.3	40.8	45.8	48.6	42.4	48.8	40.6	50.5
		Complaints - Received		27	20	26	19	47	45	43	46	34	26	45	34	
		Complaints - Received (per 1,000 bed days)		1.39	0.97	1.29	0.91	2.22	2.33	2.12	2.30	1.63	1.29	2.22	1.67	0.00
		Complaints - Reopened		1	1	7	0	5	4	2	6	2	4	1	0	0
		PALS - Complaints		247	278	228	240	262	208	233	253	226	248	263	149	
		PALS - Complaints compliance within 10 working days		60.9%	59.0%	56.1%	57.3%	61.4%	63.4%	64.8%	66.9%	63.3%	54.0%	59.9%	54.7%	58.9%

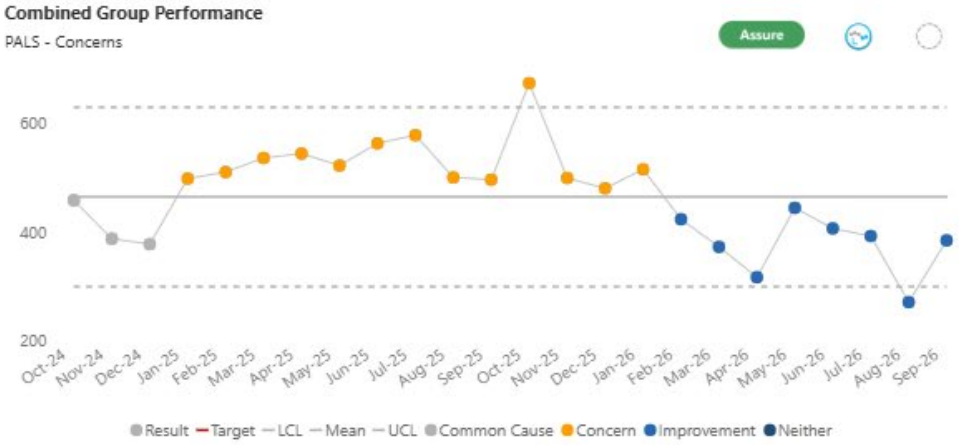
5.3 PALS Concerns

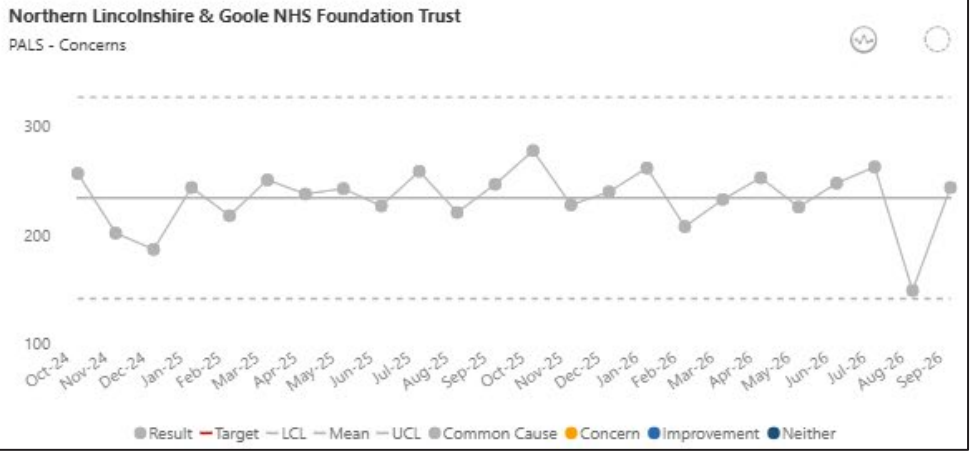
HUTH:
PALS concerns contact rates shows improvement across the period. Following extensive PALs recovery work and a Perfect week 17/08/26, access to the PALs service for the public has improved.

NLAG:
NLAG shows common cause variation in PALS contacts, with no clear sustained change evident from.

HHP:
Further data is required to see if a consistent change is maintained. The aim is complaints prevention and learning from complaints. Continued focus is required on early PALs resolution, responsiveness to patient concerns and thematic learning, with repeat issues are identified across services. 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.







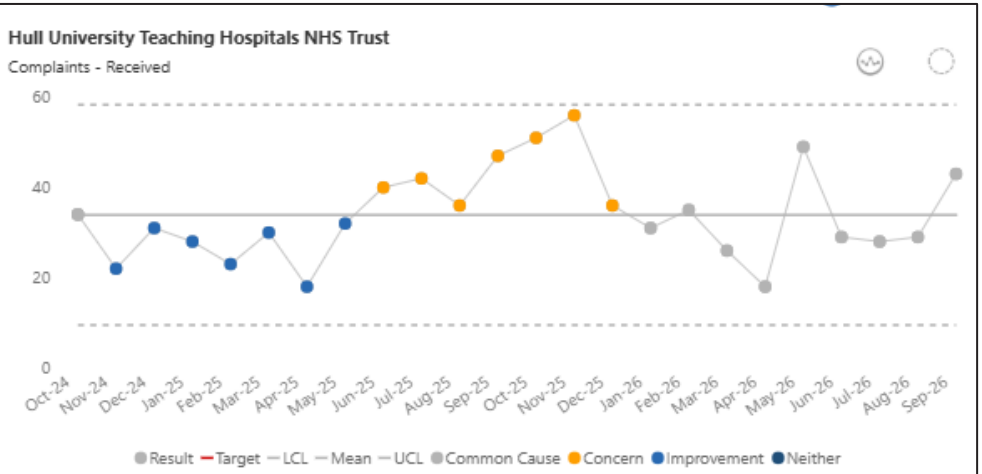
5.4 Complaints Received

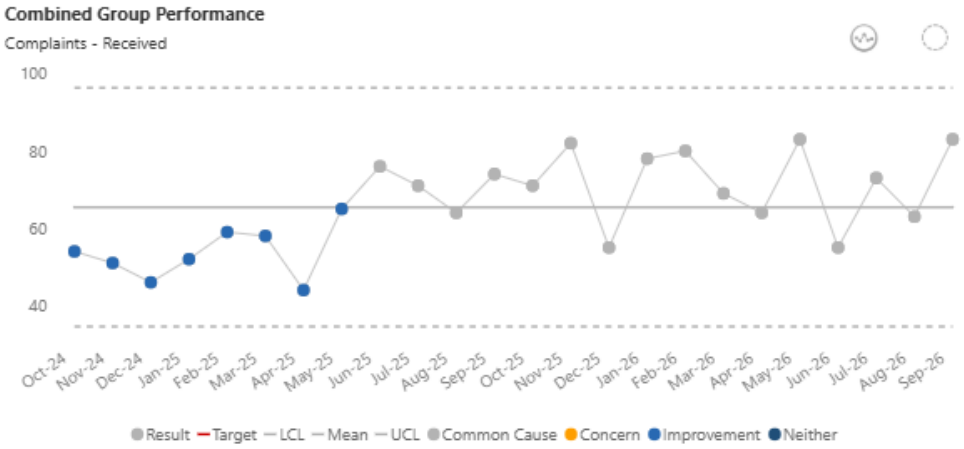
Complaints - Received

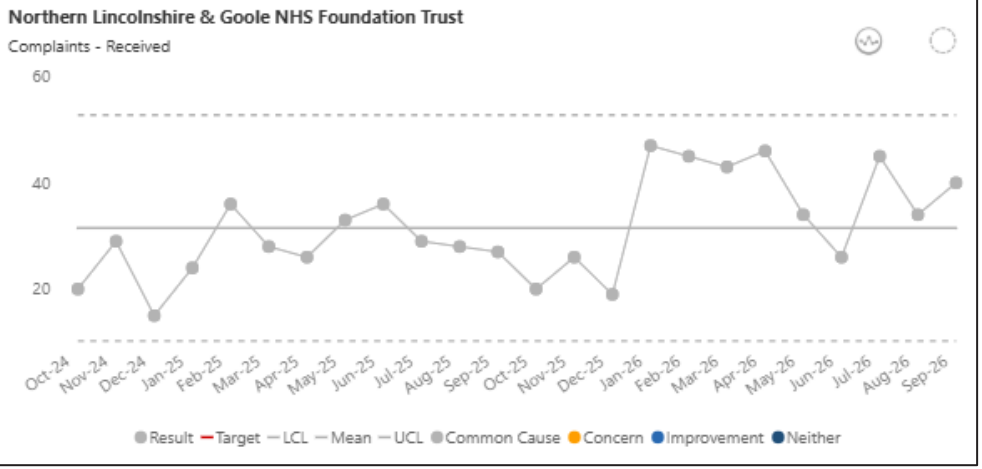
HUTH:
Complaints received rate shows common cause variation over the recent period, with significant variation historically. Recent changes in PALs process should show complaint improvements over the next quarter.

NLAG:
Complaints received rate shows common cause variation over the recent period, with an increased rate during the period from January to April 2026. This is due to increase in complaints

HHP:
Continued focus is required on themes, early resolution in PALs should support a reduction in complaints. Learning from complaints and making improvements for patient experiences will demonstrate the required improvement.





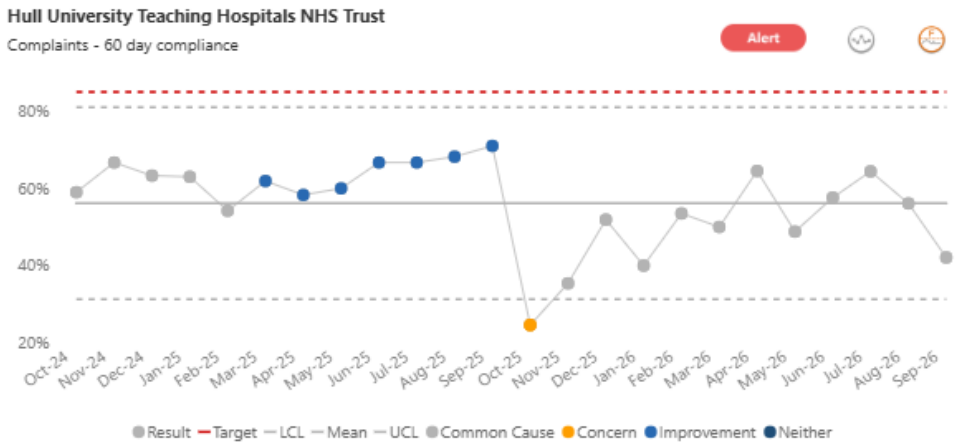


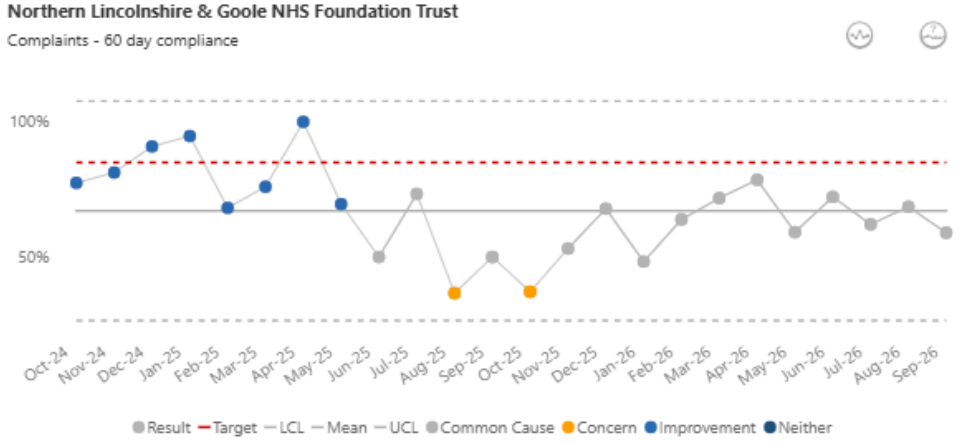
5.5 Complaints 60 Day Compliance

HUTH:
There is common cause variation seen, with consistency in not achieving the target of 60 days completion. The backlog has started to reduce. The ongoing complexity and volume of casework are contributory elements. The average number of days to complete is high and close to the target.

NLAG:
There is common cause variation seen latterly, following a period of completion below the mean, not achieving the target. Similarly to HUTH the backlog, complexity and volume of casework are contributory elements.

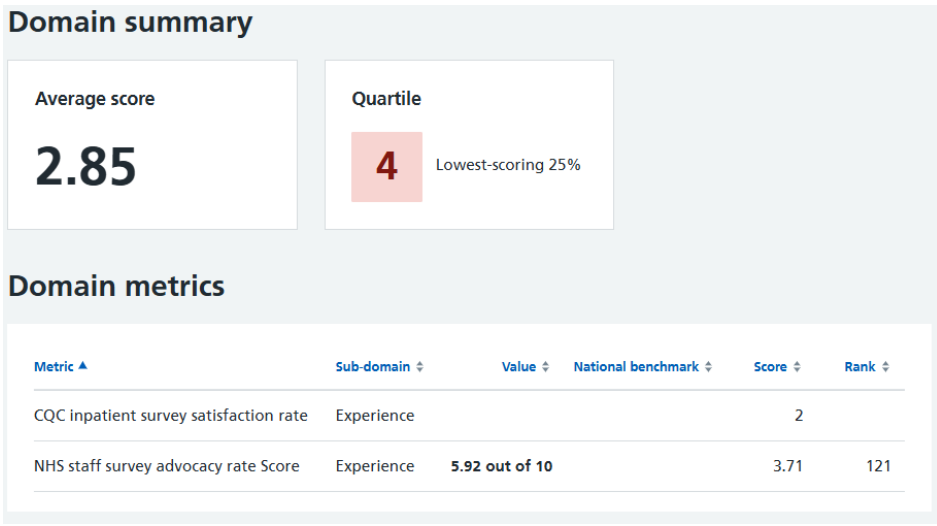
Combined Group Performance
Complaints - 60 day compliance





5.6 NHS Outcomes Framework – Experience of care

HUTH – The latest data from Q1 2026/27 data shows overall quartile 4 performance with a score 2.85, linked to the rank position in the staff survey. This data is static and will only update annually for each of the two metrics shown.	NLAG – The latest data from Q1 2026/27 data shows overall quartile 4 performance, with a score of 2.76. This data is static and will only update annually for each of the two metrics shown.



Domain summary

Average score

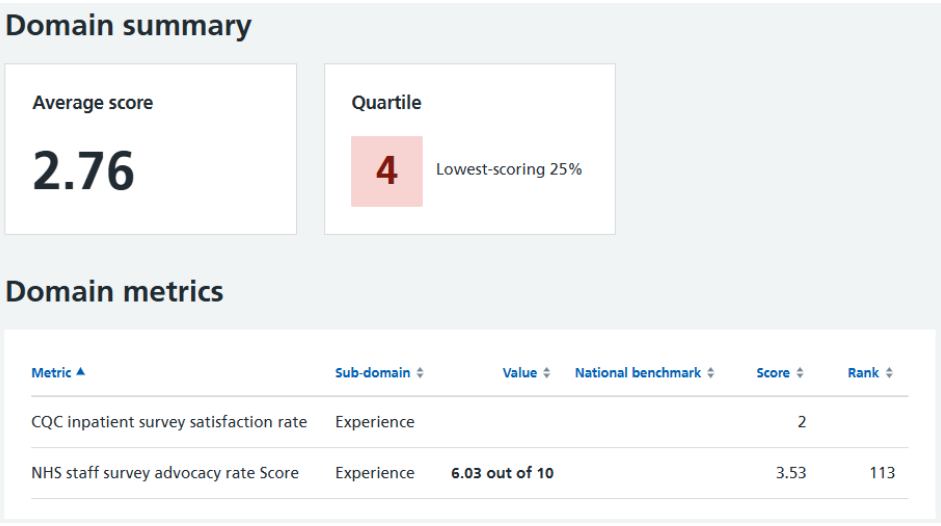
2.85

Quartile

4 Lowest-scoring 25%

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
CQC inpatient survey satisfaction rate	Experience			2	
NHS staff survey advocacy rate Score	Experience	**5.92 out of 10**		3.71	121



Domain summary

Average score

2.76

Quartile

4 Lowest-scoring 25%

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
CQC inpatient survey satisfaction rate	Experience			2	
NHS staff survey advocacy rate Score	Experience	**6.03 out of 10**		3.53	113

8 Safety

Summary

Safety performance remains mixed. HUTH's overall Care Hours per Patient Day remains under target at 7.4, driven by the unregistered staff group. NLAG is at 8.5 overall, and also has pressure in unregistered staffing, impacting on the overall CHPPD position now below target. Registered workforce is at the target for both HUTH and NLAG. Infection prevention remains a key safety risk, with C. difficile, MRSA and E. coli requiring continued oversight.
The NHS Outcomes framework performance is quartile 4 performance overall, impacting from staff survey in both Trusts. Also HUTH having a new metric of the Audit outliers impacting with some challenged IPC outcomes. NLAG is also quartile 4 performance due to IPC outcomes.

Progress

For infection indicators, the latest FYTD position is C. difficile: HUTH 61 and NLAG 35. MRSA is HUTH 1 YTD and 1 latest month, while NLAG is 1 YTD with 0 in the latest reporting period. E. coli is HUTH 106 FYTD and NLAG 51 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 also at NLAG. 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.

Safety 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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Safe	Patient Safety	Care Hours per Patient Day - Overall	≥ 9.0	7.2	7.6	7.6	7.5	7.4	7.3	7.4	7.6	7.4	7.6	7.4		
		Care Hours per Patient Day - Registered	≥ 5.0	4.9	5.0	5.2	5.2	5.1	5.0	5.1	5.2	5.0	5.2	5.0		
		Care Hours per Patient Day - Unregistered	≥ 4.0	2.3	2.6	2.4	2.3	2.3	2.3	2.3	2.4	2.4	2.4	2.4		
		Falls - Serious harm or death		4	1	0	5	4	4	3	1	2	2	2	3	1
		Falls - Total incidents		279	286	258	271	308	262	284	222	235	214	244	206	226
		Infections - C.Difficile		8	6	6	8	16	9	11	16	10	8	5	9	
		Infections - E.Coli		19	17	14	13	12	16	14	23	17	13	16	21	
		Infections - Klebsiella		3	7	10	5	7	3	10	6	5	8	7	4	
		Infections - MRSA		0	0	0	1	0	0	1	0	0	0	0	0	
		Infections - MSSA		8	12	7	5	8	11	8	11	3	5	7	3	
		Infections - Pseudomonas aeruginosa		3	6	1	4	1	1	2	2	3	1	3	2	
		Medication Incidents		148	103	120	127	94	109	115	100	117	105	102	99	119
		Patient Safety Incidents - % Harmful		3.2%	3.8%	2.7%	3.2%	2.6%	2.1%	2.4%	1.5%	2.0%	1.8%	2.6%	2.3%	2.0%
		Patient Safety Incidents - Fatal		7	4	2	8	3	4	7	2	5	3	4	3	2
		Patient Safety Incidents - Moderate harm		49	63	44	51	43	32	44	29	34	28	50	40	36
		Patient Safety Incidents - Severe harm		9	12	5	5	8	6	5	2	2	5	3	5	3
		Pressure Ulcers - Category 3		0	4	1	2	2	1	1	0	1	1	3	1	3
		Pressure Ulcers - Category 4		0	0	0	0	0	1	0	0	1	0	0	1	0
		Pressure Ulcers - Community acquired		310	390	346	353	406	371	458	416	388	376	397	401	371
		Pressure Ulcers - Hospital acquired		59	109	110	132	129	114	129	146	148	116	135	147	135
		Pressure Ulcers - Suspected deep tissue injury		16	19	26	34	29	22	26	32	27	29	24	38	29

Safety NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight | CQC

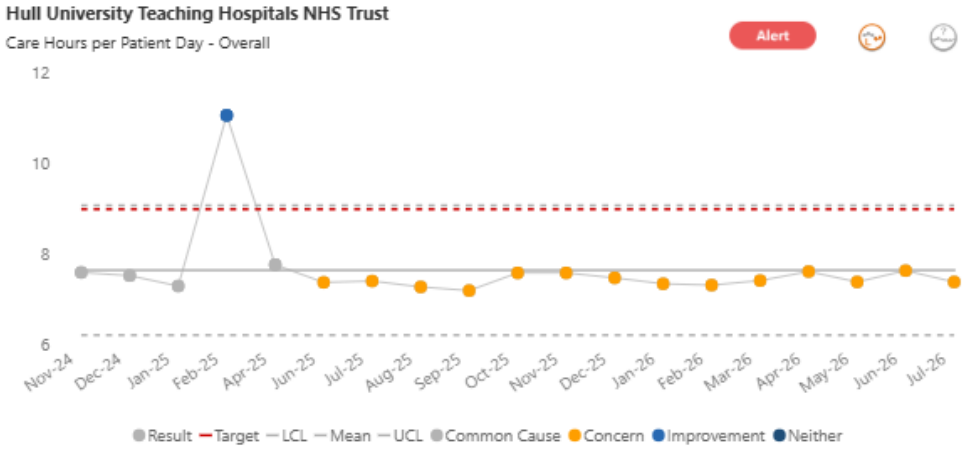
Domain	Subject Area	Metric	National Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Safe	Patient Safety	Care Hours per Patient Day - Overall	≥ 9.0	9.5	9.2	9.3	9.0	9.2	9.1	9.7	9.5	9.4	8.5	8.5		
		Care Hours per Patient Day - Registered	≥ 5.0	5.7	5.5	5.7	5.6	5.6	5.6	6.0	5.8	5.8	5.2	5.2		
		Care Hours per Patient Day - Unregistered	≥ 4.0	3.8	3.7	3.7	3.4	3.6	3.5	3.8	3.7	3.7	3.3	3.3		
		Falls - Serious harm or death		0	2	0	3	2	0	0	0	0	2	3	0	2
		Falls - Total incidents		107	149	119	136	139	107	108	125	116	122	128	121	129
		Infections - C.Difficile		1	5	3	4	2	3	5	4	1	4	5	8	
		Infections - E.Coli		6	12	7	9	6	9	7	3	10	14	7	7	
		Infections - Klebsiella		3	5	5	4	2	5	3	3	2	2	2	0	
		Infections - MRSA		0	1	0	0	1	0	1	0	0	1	0	0	
		Infections - MSSA		4	2	3	2	1	1	2	3	3	1	2	1	
		Infections - Pseudomonas aeruginosa		1	1	2	2	0	1	1	0	3	1	2	1	
		Medication Incidents		58	69	89	76	82	78	76	65	71	76	79	81	81
		Patient Safety Incidents - % Harmful		3.2%	3.9%	3.9%	3.2%	2.9%	2.6%	3.2%	2.8%	2.7%	2.8%	3.4%	3.9%	3.1%
		Patient Safety Incidents - Fatal		0	1	1	3	1	3	0	0	0	1	2	1	0
		Patient Safety Incidents - Moderate harm		44	60	55	41	46	36	48	46	43	44	47	53	50
		Patient Safety Incidents - Severe harm		3	6	5	4	2	0	0	0	1	2	6	3	3
		Pressure Ulcers - Category 3		11	6	5	10	13	10	6	5	16	8	16	12	12
		Pressure Ulcers - Category 4		2	4	1	1	0	1	2	0	0	1	1	3	0
		Pressure Ulcers - Community acquired		298	382	368	359	390	364	357	405	399	398	377	349	338
		Pressure Ulcers - Hospital acquired		200	244	222	210	267	213	231	210	240	245	207	232	228
		Pressure Ulcers - Suspected deep tissue injury		43	42	40	45	59	54	48	35	51	46	34	46	62

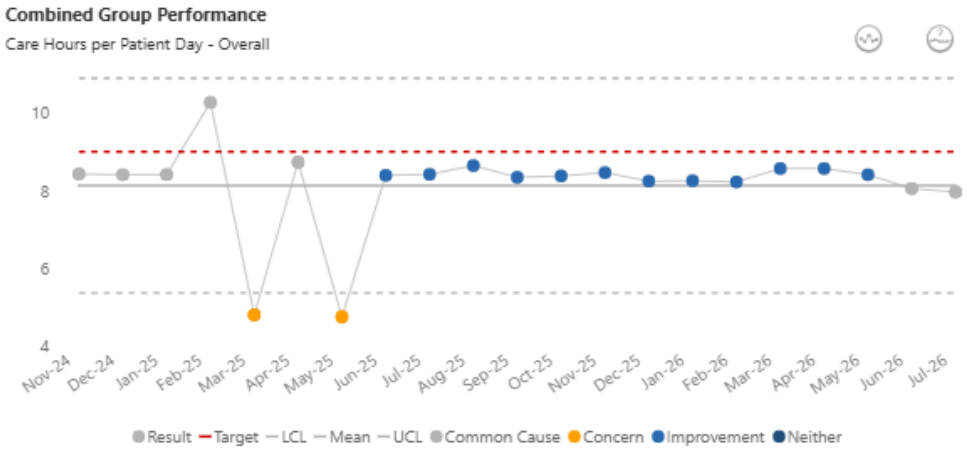
6.1 Care Hours per Patient Day

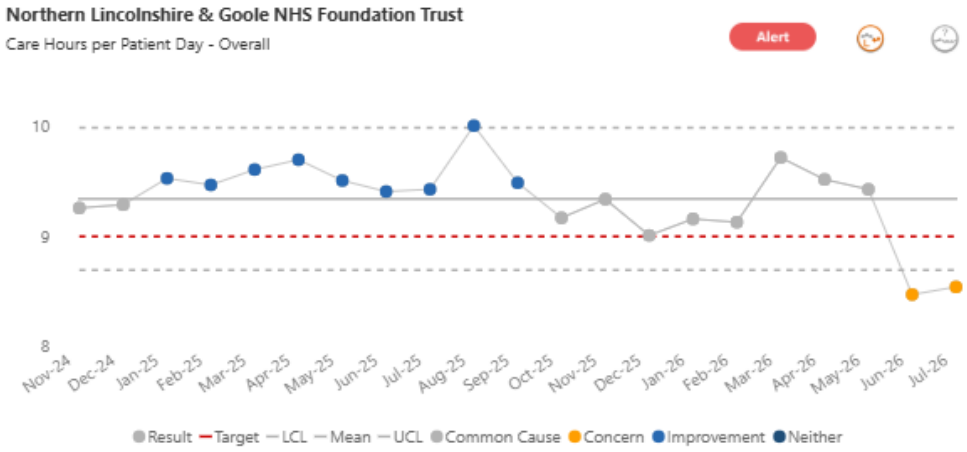
The latest available data in the public domain is from July 2026.

HUTH:
HUTH's overall Care Hours per Patient Day remains under target at 7.4, 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 a reduction below the target for the last two data points, at 8.5 in July 2026.The reduction correlates with unregistered and registered workforce reductions for the same period. The unregistered workforce is below the target and so impacts on the overall CHPPD. Registered workforce remains achieving the target.





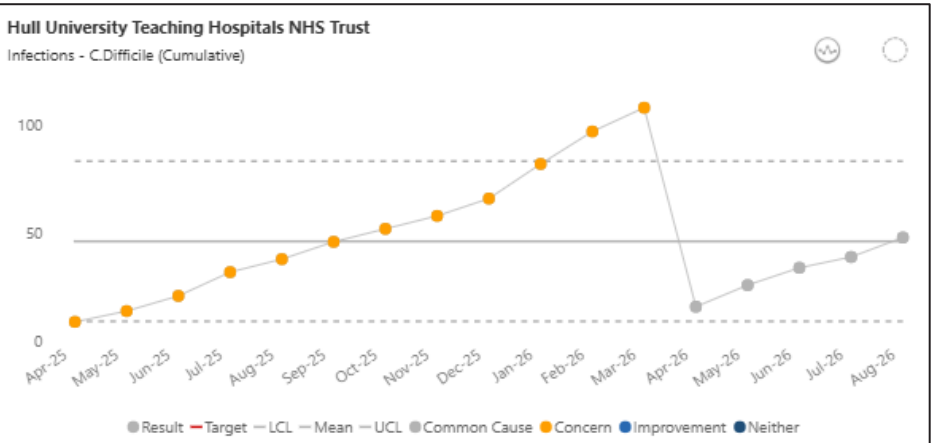


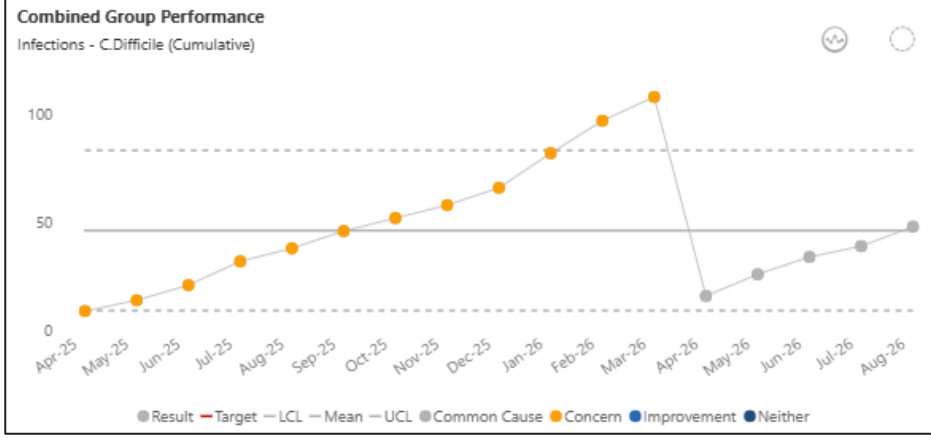
6.2 C.Difficile Cases

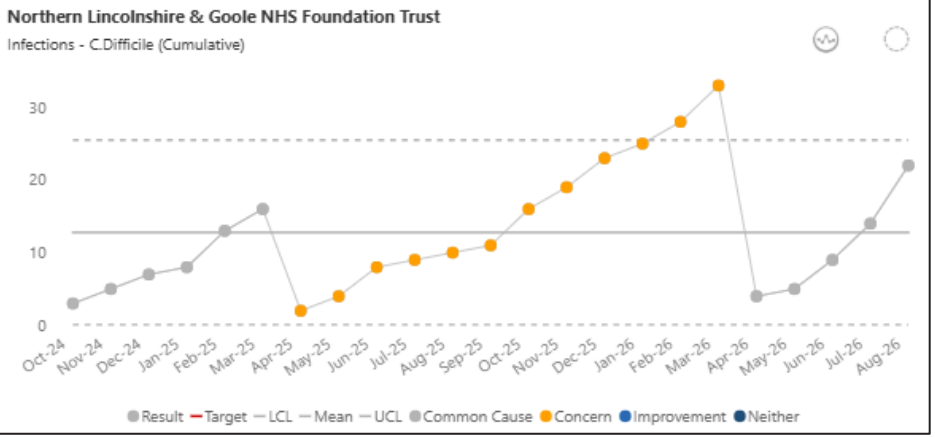
HUTH:
There have been 61 cases in the financial year to date, with a threshold of 61 for the year, so at the threshold for the financial year at month six.

NLAG:
There have been 35 cases in the financial year to date, with a threshold of 18, so over the financial year threshold at month 5. The August and September 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







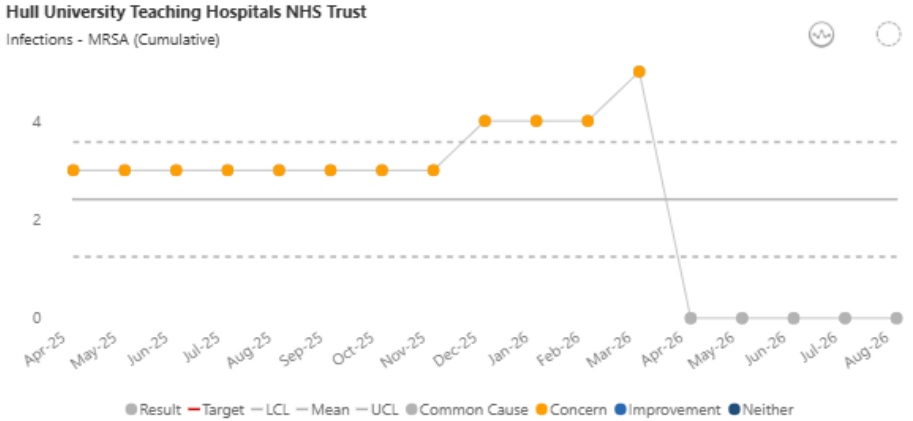
6.2 MRSA Cases

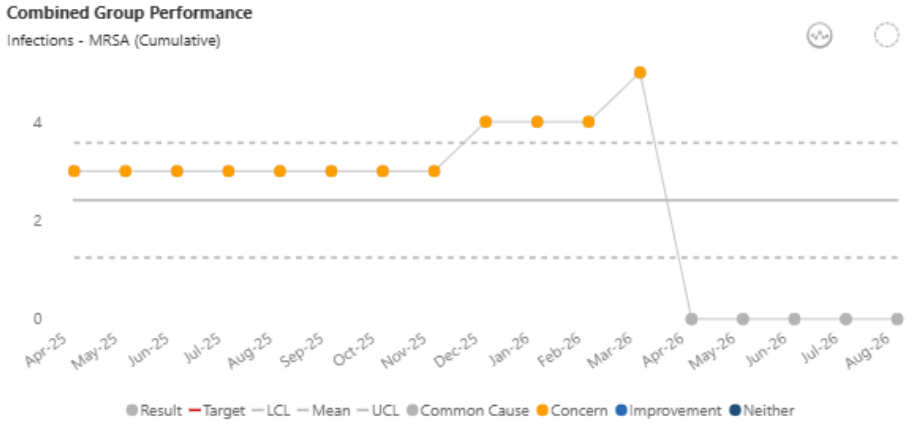
HUTH:
MRSA cases are 1 YTD, with 1 cases in the latest month.

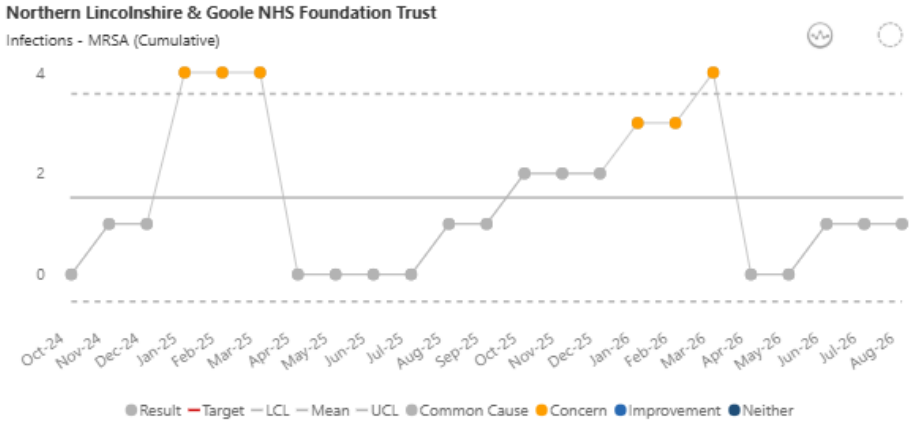
NLAG:
MRSA cases are 1 YTD, with 0 cases in the latest month.

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.





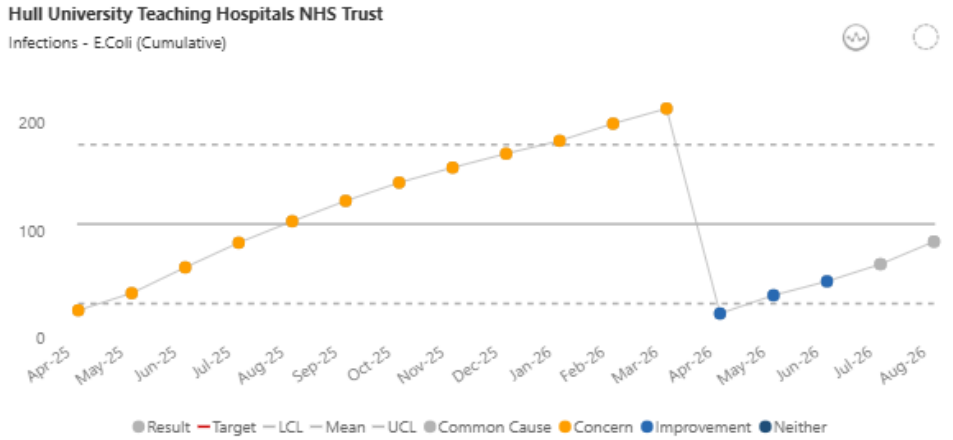


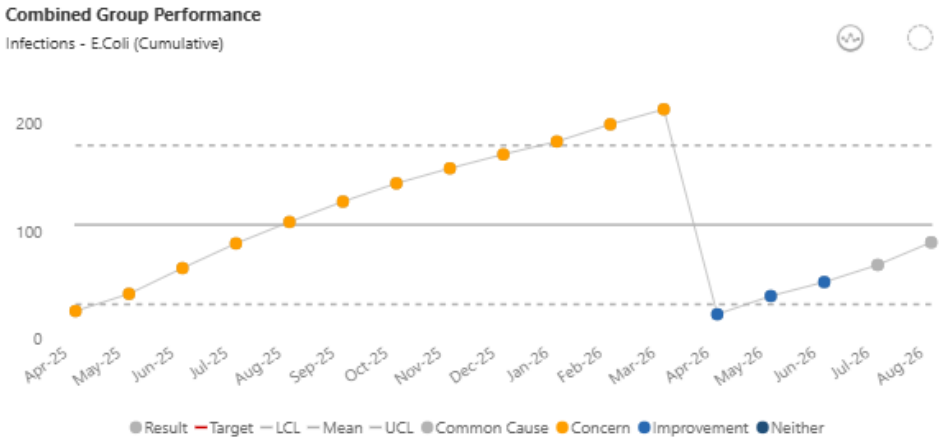
6.3 E.Coli Cases

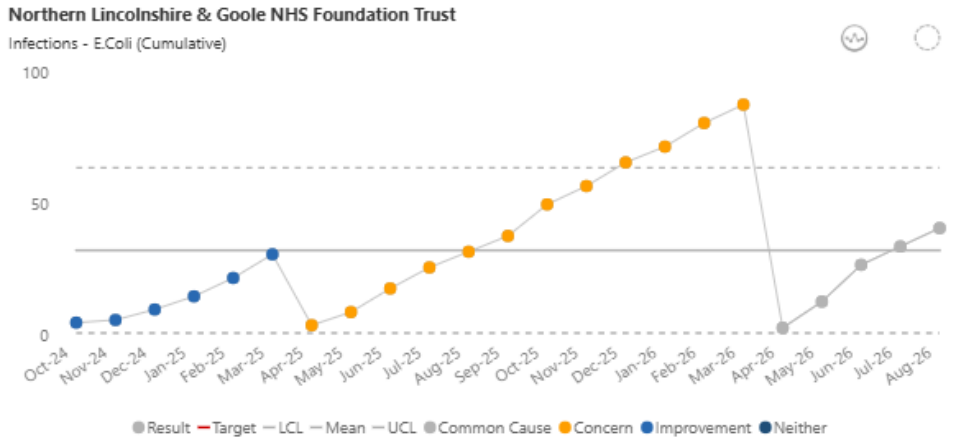
HUTH:
There have been 106 cases reported in the financial year to date against a 192 annual threshold. There is common cause variation for the recent period and more points over the mean in the year to date, so over trajectory, but within the national set threshold.

NLAG:
There have been 51 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.







6.4 NHS Outcomes Framework – Patient safety

HUTH – The latest data from Q1 2026/27 data shows overall quartile 4 performance, with average performance score improvement from 3.28 to 2.98. New indicator breadth and depth of clinical audit outliers is scored 3 along similar scores to before, with the adjustments for this set of metrics.	NLAG – The latest data from Q1 2026/27 data shows overall quartile 4 performance, with average performance score improvement from 3.46 to 2.72. New indicator breadth and depth of clinical audit outliers is scored 1 along similar scores to before, with the adjustments for this set of metrics.

Domain summary

Average score

2.98

Performance improved
3.28 in previous quarter

Quartile

4 Lowest-scoring 25%

No change
Quartile 4 in previous quarter

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
Breadth and depth of clinical audit outliers Score	High quality care			3	
NHS Staff survey – raising concerns sub-score	Safe culture	**6.04 out of 10**		3.53	113
Number of MRSA bacteraemia cases	Safe outcomes	**2 count**	0 count	2.24	
Rate of C. difficile	Safe outcomes			3	
Rate of E. coli	Safe outcomes			2	

Domain summary

Average score

2.72

Performance improved
3.46 in previous quarter

Quartile

4 Lowest-scoring 25%

No change
Quartile 4 in previous quarter

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
Breadth and depth of clinical audit outliers Score	High quality care			1	
NHS Staff survey – raising concerns sub-score	Safe culture	**6.09 out of 10**		3.44	109
Number of MRSA bacteraemia cases	Safe outcomes	**5 count**	0 count	3.13	
Rate of C. difficile	Safe outcomes			4	
Rate of E. coli	Safe outcomes			4	

7 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, however they impact as quartile 4 performance in the NOF, along with HUTH Delayed induction rate, impacting on the overall quartile 4 performance for HUTH and quartile 3 for NLAG.

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 multifactorial 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. Induction of labour is an area of focus in the maternity service.

Effectiveness 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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Effective	Effectiveness	Inpatient - Emergency Readmissions within 30 days		10.3%	10.5%	10.2%	10.5%	10.3%	10.4%	10.4%	10.1%	10.2%	10.0%	9.9%	9.7%	
		Mortality - Crude Mortality (non-elective)		2.5%	2.8%	3.2%	3.2%	3.2%	3.2%	2.9%	2.6%	2.8%	2.4%	2.3%	2.7%	2.3%
		Mortality - HSMR	≤ 100.0	101.0	99.9	100.1	100.1	98.6	98.7	98.9	98.9	98.8	98.1			
		Mortality - SHMI	≤ 1.0	1.025	1.018	1.023	1.027	1.024	1.038	1.047	1.054	1.063				
Safe	Patient Safety	Clinical Harm Reviews - Cancer 104 day wait		71					0	0	0	0	0	0	0	0
		Clinical Harm Reviews - RTT 78 week wait		0									0	0	0	
		VTE Risk Assessment	≥ 95.0%	93.5%	92.4%	92.1%	92.5%	91.8%	91.8%	92.0%	92.3%	92.6%	92.9%	92.1%	92.5%	92.1%
		VTE Risk Assessment 14 Hour Standard	≥ 95.0%	91.7%	90.5%	90.7%	90.9%	90.1%	90.8%	91.2%	91.8%	92.0%	92.2%	91.7%	91.5%	

Effectiveness 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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Effective	Effectiveness	Inpatient - Emergency Readmissions within 30 days		11.7%	11.5%	10.9%	11.3%	11.2%	11.6%	11.0%	11.3%	11.0%	11.0%	11.0%	11.5%	
		Mortality - Crude Mortality (non-elective)		1.6%	1.6%	1.8%	2.4%	1.8%	1.9%	1.9%	1.9%	2.3%	1.9%	1.6%	1.5%	1.6%
		Mortality - HSMR	≤ 100.0	92.3	90.6	89.8	88.5	85.4	85.3	84.8	84.8	85.6	85.7			
		Mortality - SHMI	≤ 1.0	1.021	1.009	1.001	0.999	0.976	0.977	0.993	0.994	0.997				
Safe	Patient Safety	Clinical Harm Reviews - Cancer 104 day wait											0			0
		Clinical Harm Reviews - RTT 78 week wait											0			0
		VTE Risk Assessment	≥ 95.0%	96.5%	95.4%	92.2%	95.6%	96.1%	95.8%	95.7%	96.9%	96.8%	96.6%	96.4%	96.1%	96.0%
		VTE Risk Assessment 14 Hour Standard	≥ 95.0%	93.7%	93.1%	88.1%	92.6%	93.6%	93.2%	93.3%	94.8%	94.8%	94.5%	94.3%	93.3%	

7.1 VTE Assessment within 14hrs

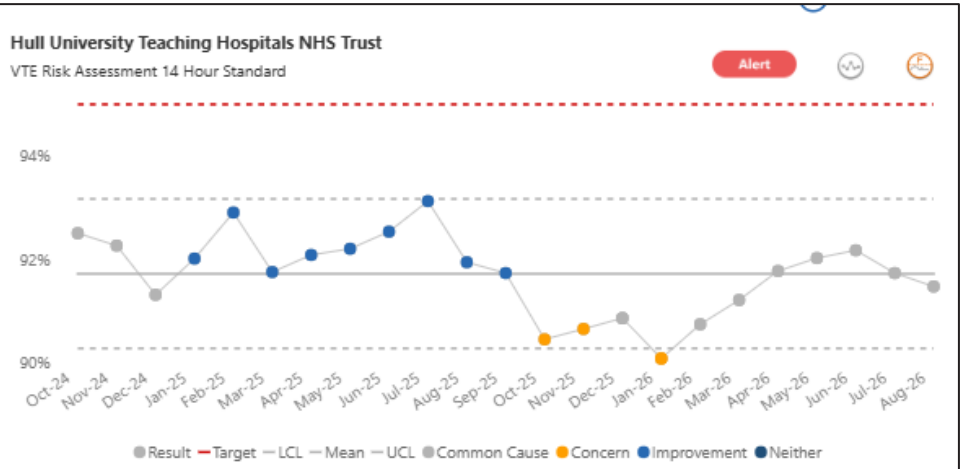
VTE Risk Assessment 14 Hour Standard

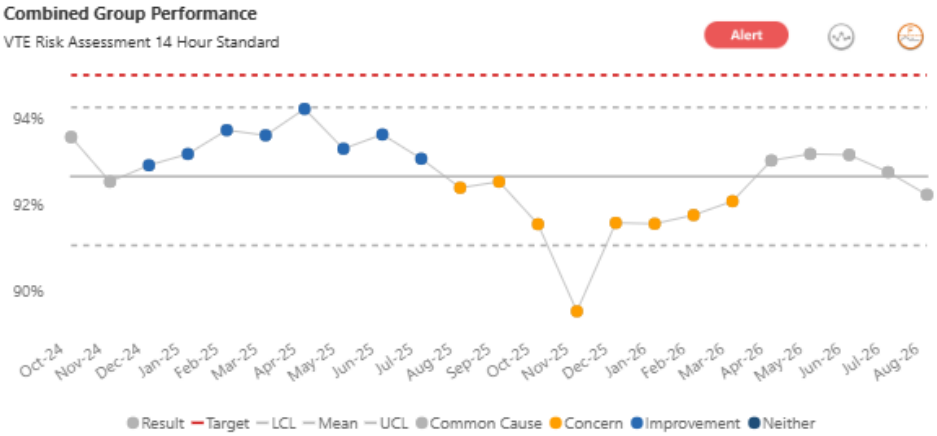
HUTH:
The charts show common cause variation and below the 14 hour target. The dashboard shows overall untimed compliance is also below the 95% target at 91.5%.92.1% is achieved overall, beyond the 14 hour standard.

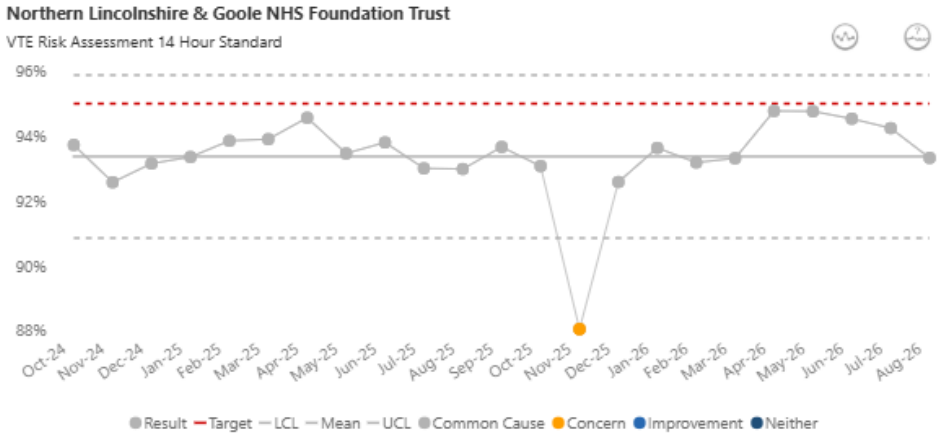
NLAG:
The charts show common cause variation and below the 14 hour target. The dashboard shows overall untimed compliance is over the 95% target at 93.3%. 96% is achieved overall, beyond the 14 hour standard.

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



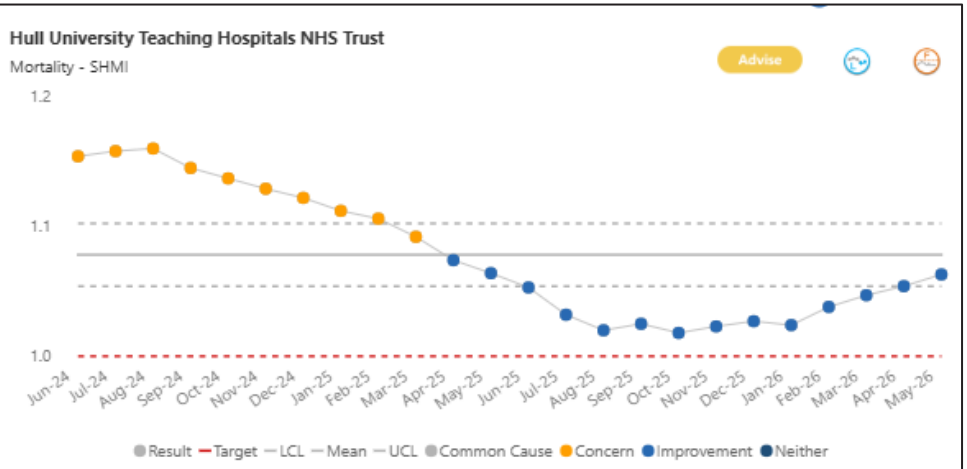


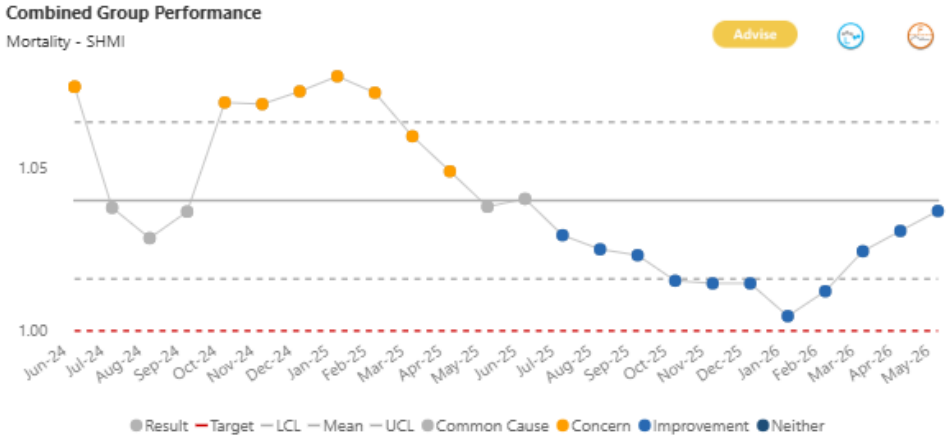


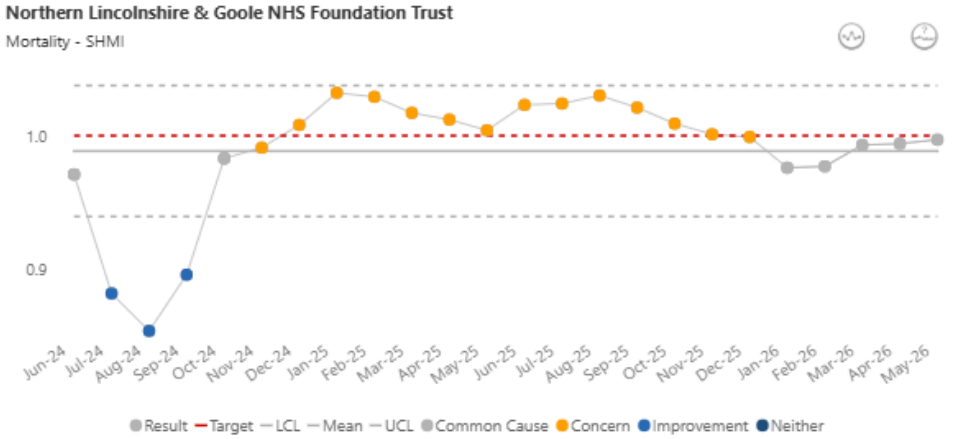
7.2 Summary Hospital Mortality Indicator

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.





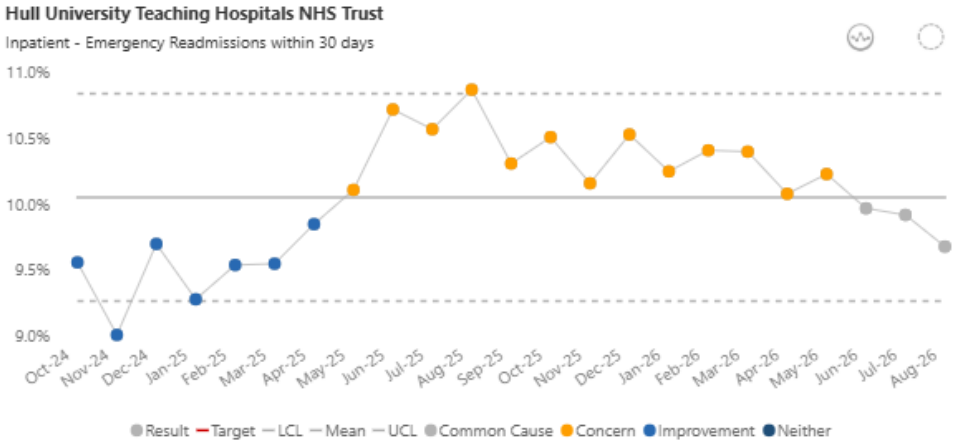


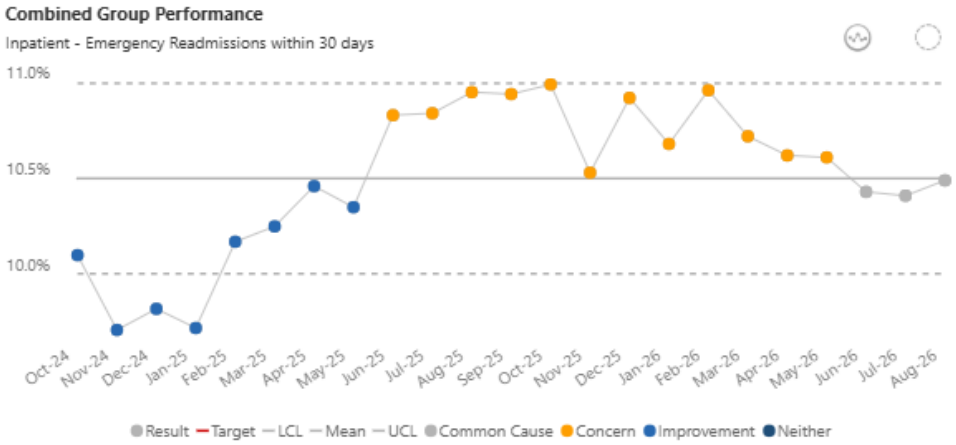
7.3 Emergency Readmissions within 30 Days

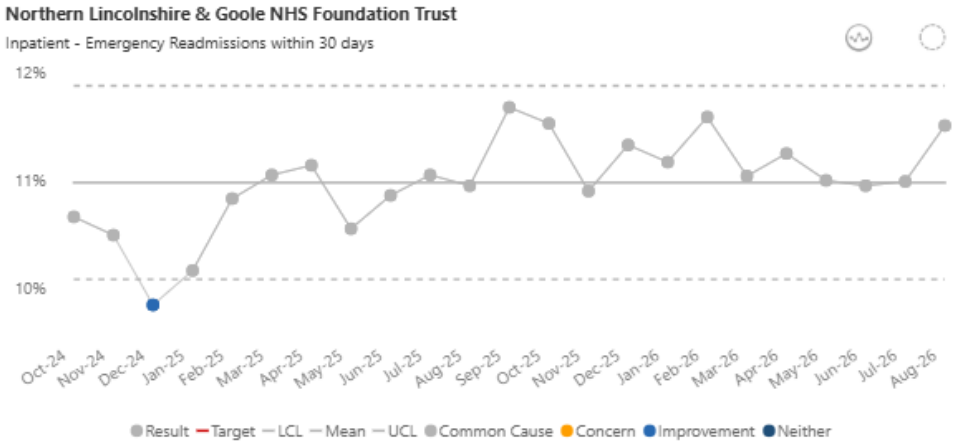
Emergency readmission rates can assist in identifying discharge planning effectiveness, with specialty level analysis over time. The position should continue to be monitored through specialty-level review, with focus on discharge quality, follow-up arrangements and readmission themes where variation 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 common cause variation.

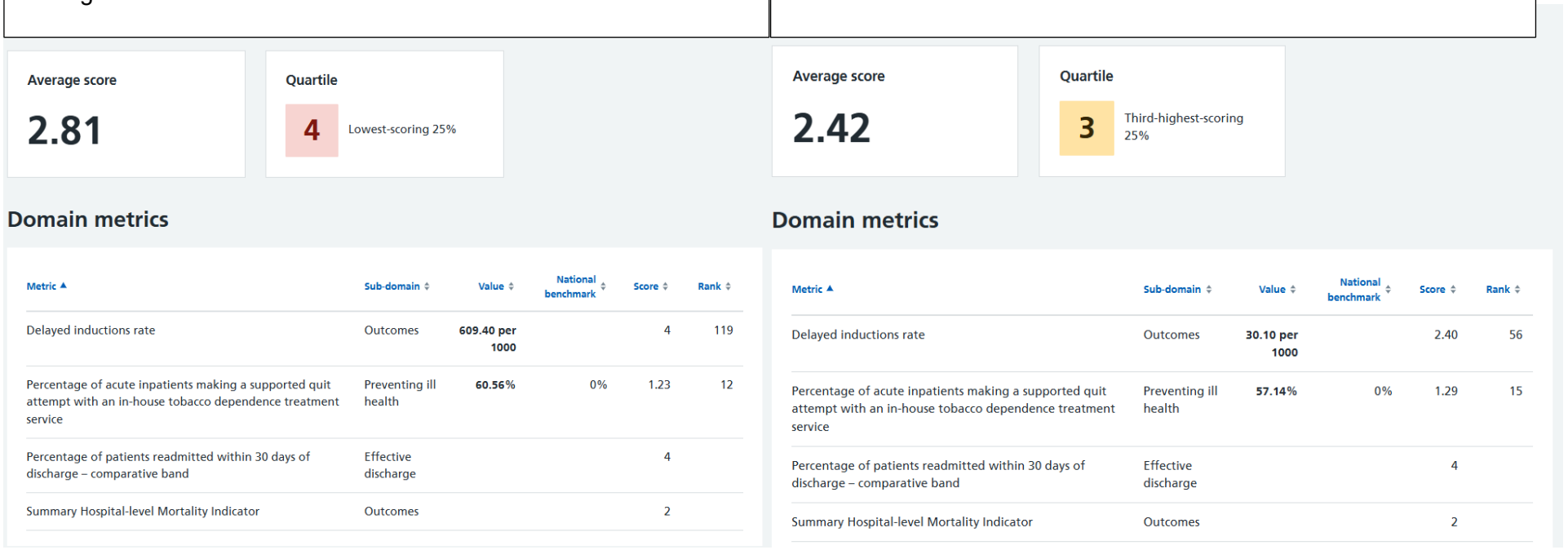






7.4 NHS Outcomes framework

HUTH – The latest data from Q1 2026/27 data shows overall quartile 4 performance, with an average performance score of 2.81. Delayed induction rate and percentage of patients readmitted within 30 days are both classified as quartile 4, impacting on the overall average.	NLAG – The latest data from Q1 2026/27 data shows overall quartile 4 performance, with an average performance score of 2.42. The percentage of patients readmitted within 30 days is classified as quartile 4, impacting on the overall average.



Average score

2.81

Quartile

4 Lowest-scoring 25%

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
Delayed inductions rate	Outcomes	**609.40 per 1000**		4	119
Percentage of acute inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Preventing ill health	**60.56%**	0%	1.23	12
Percentage of patients readmitted within 30 days of discharge – comparative band	Effective discharge			4	
Summary Hospital-level Mortality Indicator	Outcomes			2	

Average score

2.42

Quartile

3 Third-highest-scoring 25%

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
Delayed inductions rate	Outcomes	**30.10 per 1000**		2.40	56
Percentage of acute inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Preventing ill health	**57.14%**	0%	1.29	15
Percentage of patients readmitted within 30 days of discharge – comparative band	Effective discharge			4	
Summary Hospital-level Mortality Indicator	Outcomes			2	

8. HHP Group Executive Summary – Workforce

Executive Lead: Helen Marks, Group Chief People Officer Accountable to:

Hull University Teaching Hospitals NHS Trust

Provider displayed

Metric (right click to drill through to SPC chart)	Period	Target	Result	Var	Asr
Finance - Agency YTD actual spend against previous year (0...	Aug-26	≤ 70.0%	71.6%		
Finance - Bank YTD actual spend against previous year (000's)	Aug-26	≤ 70.0%	105.9%		
Finance - ECP YTD actual spend against previous year (000's)	Aug-26	≤ 70.0%	107.7%		
Finance - Overtime YTD actual spend against previous year (...	Aug-26	≤ 70.0%	93.3%		
Healthcare Worker Flu Vaccination Rate	Apr-26	≥ 60.0%	51.0%		
Staff Appraisal Rate (AfC)	Aug-26	≥ 85.0%	82.5%		
Staff e-Job Planning	Sep-26	≥ 95.0%	82.1%		
Staff Mandatory Training - Core	Aug-26	≥ 85.0%	89.2%		
Staff Mandatory Training - Role Specific	Aug-26	≥ 85.0%	82.6%		
Staff Sickness Absence Rate	Aug-26	≤ 4.0%	4.6%		
Staff Survey - Engagement Theme Score	Sep-26	≥ 6.6	0.0		
Staff Survey - Raising Concerns sub-score	Sep-26		6.0		
Staff Time to Employment Checks	Aug-26	≤ 20.0	25.9		
Staff Time to Offer	Jul-26	≤ 2.0	2.4		
Staff Time to Shortlist	Aug-26	≤ 5.0	9.8		
Staff Turnover Annual FTE Rate	Aug-26	≤ 8.0%	6.8%		

Northern Lincolnshire and Goole NHS Foundation Trust

Provider displayed

Metric (right click to drill through to SPC chart)	Period	Target	Result	Var	Asr
Finance - Agency YTD actual spend against previous year (0...	Aug-26	≤ 70.0%	64.9%		
Finance - Bank YTD actual spend against previous year (000's)	Aug-26	≤ 70.0%	67.7%		
Finance - ECP YTD actual spend against previous year (000's)	Aug-26	≤ 70.0%	325.7%		
Finance - Overtime YTD actual spend against previous year (...	Aug-26	≤ 70.0%	85.2%		
Healthcare Worker Flu Vaccination Rate	Apr-26	≥ 60.0%	51.1%		
Staff Appraisal Rate (AfC)	Aug-26	≥ 85.0%	80.9%		
Staff e-Job Planning	Sep-26	≥ 95.0%	66.0%		
Staff Mandatory Training - Core	Aug-26	≥ 85.0%	84.8%		
Staff Mandatory Training - Role Specific	Aug-26	≥ 85.0%	82.3%		
Staff Sickness Absence Rate	Aug-26	≤ 4.0%	5.3%		
Staff Survey - Engagement Theme Score	Sep-26	≥ 6.6	0.0		
Staff Survey - Raising Concerns sub-score	Sep-26		6.1		
Staff Time to Employment Checks	Aug-26	≤ 20.0	24.4		
Staff Time to Offer	Aug-26	≤ 2.0	8.5		
Staff Time to Shortlist	Aug-26	≤ 5.0	13.3		
Staff Turnover Annual FTE Rate	Aug-26	≤ 8.0%	7.2%		

8.1 Chief People Officer Update – Workforce Overview (September 2026)

Summary

The workforce position remains mixed across the Group, with workforce availability, recruitment responsiveness and workforce cost controls presenting the greatest risks. HUTH sickness absence increased to 4.6% in August, remaining above the SPC centreline for a fourth consecutive month and 0.6 percentage points above target, whilst NLAG sickness absence reduced slightly from 5.3% to 5.2% and remains broadly stable. Recruitment timeliness remains variable, with NLAG Time to Offer remaining in Alert. Agency expenditure continues to reduce across both Trusts, although progress has plateaued, whilst bank expenditure has increased in line with the strategy to reduce higher-cost agency usage. Extra Contractual Pay remains elevated, particularly at HUTH, and overtime expenditure continues to reduce but remains an area of focus.

Progress

HUTH continues to experience deterioration in sickness absence performance, whilst appraisal and role-specific mandatory training remain inconsistent across both Trusts. Recruitment performance remains variable, with the greatest risk continuing to sit within the NLAG offer stage. Agency spend reductions have been sustained across both organisations, supported by increased utilisation of bank staffing. However, ECP expenditure remains high and overtime reduction programmes require continued focus to ensure sustainable workforce deployment and delivery of financial recovery objectives.

Action

Continue targeted sickness absence interventions at both HUTH and NLAG, including hotspot reviews, attendance management and wellbeing support. Strengthen oversight of appraisal and mandatory training compliance through routine workforce governance. Maintain focus on end-to-end recruitment performance, particularly reducing delays in shortlisting, offer approval and employment checks, with priority escalation of NLAG Time to Offer. Continue reducing reliance on premium workforce expenditure through strengthened agency controls, optimisation of bank usage, tighter oversight of ECP approvals and further reduction of overtime through workforce planning and roster efficiencies.

a. Hull University Teaching Hospital Workforce AAA Summary

Count: 10

Alert

Finance - Bank YTD actual spend against previous year (000's)
Finance - ECP YTD actual spend against previous year (000's)
Finance - Overtime YTD actual spend against previous year (000's
Healthcare Worker Flu Vaccination Rate
Staff Appraisal Rate (AfC)
Staff Mandatory Training - Role Specific
Staff Sickness Absence Rate
Staff Survey - Engagement Theme Score
Staff Survey - Raising Concerns sub-score
Staff Time to Shortlist

Count: 2

Advise

Staff Time to Employment Checks
Staff Time to Offer

Count: 2

Assure

Staff Mandatory Training - Core
Staff Turnover Annual FTE Rate

b. Northern Lincolnshire & Goole Hospitals Workforce AAA Summary

Count: 9

Alert

Finance - ECP YTD actual spend against previous year (000's)
Finance - Overtime YTD actual spend against previous year (000's
Healthcare Worker Flu Vaccination Rate
Staff Appraisal Rate (AfC)
Staff Mandatory Training - Role Specific
Staff Sickness Absence Rate
Staff Survey - Engagement Theme Score
Staff Time to Offer
Staff Time to Shortlist

Count: 2

Advise

Staff Time to Employment Checks
Staff Turnover Annual FTE Rate

Count: 1

Assure

Staff Survey - Raising Concerns sub-score

c. Staff Culture & Experience

Summary

Staff Culture and Experience remains mixed. HUTH sickness absence continues to deteriorate, with four consecutive months above the SPC mean, while NLAG absence remains broadly stable. Appraisal and role-specific mandatory training compliance remain below the level required across both Trusts and continue to require focused improvement.

Progress

Targeted sickness absence interventions are being progressed at both NLAG and HUTH; however, a sustained improvement is not yet evident. Appraisal and role-specific mandatory training compliance continue to show variable performance across both Trusts, with no consistent upward trend.

Action

Maintain focus on reducing sickness absence through divisional hotspot reviews, attendance management and wellbeing support. Strengthen accountability for appraisal and mandatory training completion through routine performance monitoring, escalation of non-compliance and targeted recovery actions.

Workforce - 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	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
	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	Financial Balance	Finance - Agency YTD actual spend against previous year (000's)	≤ 70.0%								79.1%	74.0%	70.7%	71.3%	71.6%
		Finance - Bank YTD actual spend against previous year (000's)	≤ 70.0%								94.9%	103.3%	102.3%	103.5%	105.9%
		Finance - ECP YTD actual spend against previous year (000's)	≤ 70.0%								93.5%	80.6%	98.7%	105.1%	107.7%
		Finance - Overtime YTD actual spend against previous year (000's)	≤ 70.0%								126.1%	106.8%	100.6%	95.1%	93.3%
	People & Workforce	Staff Appraisal Rate (AfC)	≥ 85.0%	79.7%	80.7%	81.4%	82.3%	80.9%	80.8%	80.1%	81.5%	81.6%	82.2%	82.0%	82.5%
		Staff Mandatory Training - Core	≥ 85.0%	86.6%	87.7%	88.2%	88.4%	89.4%	89.0%	89.8%	89.8%	87.8%	88.5%	87.4%	89.2%
		Staff Mandatory Training - Role Specific	≥ 85.0%	80.4%	82.6%	82.0%	82.7%	83.0%	82.0%	82.8%	83.1%	83.3%	83.5%	81.2%	82.6%
		Staff Sickness Absence Rate	≤ 4.0%	4.2%	4.2%	4.2%	4.3%	4.3%	4.4%	4.4%	4.4%	4.4%	4.4%	4.5%	4.6%

Workforce NLAG Scorecard

Tier 1 - Foundation Scorecard

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

Oversight

Domain	Subject Area	Metric	National Target	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
	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	Financial Balance	Finance - Agency YTD actual spend against previous year (000's)	≤ 70.0%								79.1%	72.9%	69.9%	64.7%	64.9%
		Finance - Bank YTD actual spend against previous year (000's)	≤ 70.0%								58.6%	64.0%	67.1%	66.9%	67.7%
		Finance - ECP YTD actual spend against previous year (000's)	≤ 70.0%								294.8%	322.4%	329.4%	316.7%	325.7%
		Finance - Overtime YTD actual spend against previous year (000's)	≤ 70.0%								117.9%	112.0%	96.3%	88.6%	85.2%
	People & Workforce	Staff Appraisal Rate (AfC)	≥ 85.0%	79.4%	77.9%	78.6%	79.3%	79.3%	78.9%	77.7%	79.1%	79.8%	81.4%	81.1%	80.9%
		Staff Mandatory Training - Core	≥ 85.0%	86.4%	86.9%	87.5%	84.6%	87.1%	86.9%	89.1%	89.2%	85.1%	85.5%	83.0%	84.8%
		Staff Mandatory Training - Role Specific	≥ 85.0%	84.7%	83.4%	84.2%	82.7%	80.9%	80.8%	81.5%	80.9%	79.5%	82.0%	81.3%	82.3%
		Staff Sickness Absence Rate	≤ 4.0%	5.6%	5.5%	5.5%	5.5%	5.5%	5.3%	5.4%	5.4%	5.4%	5.4%	5.2%	5.3%

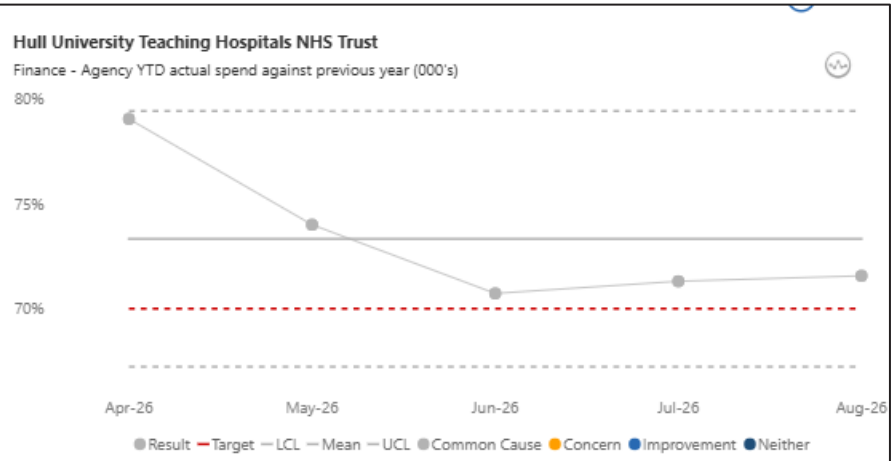
8.2 Finance – Agency YTD actual spend against previous year

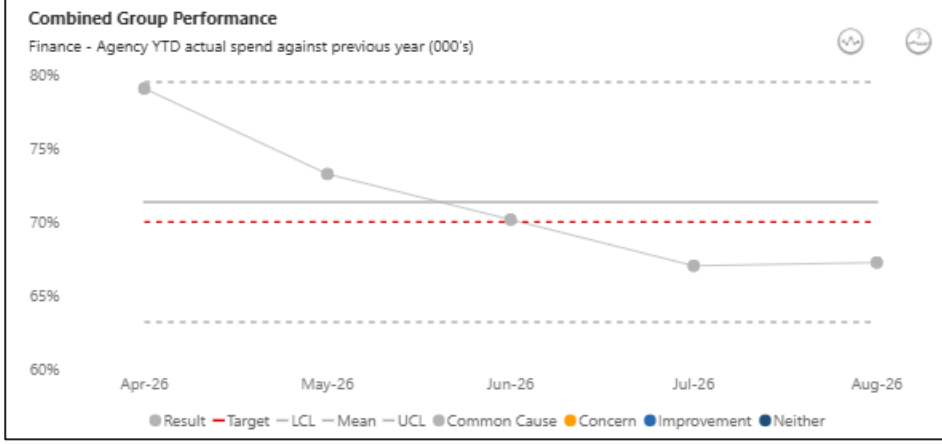
Finance - Agency YTD actual spend against previous year (0...

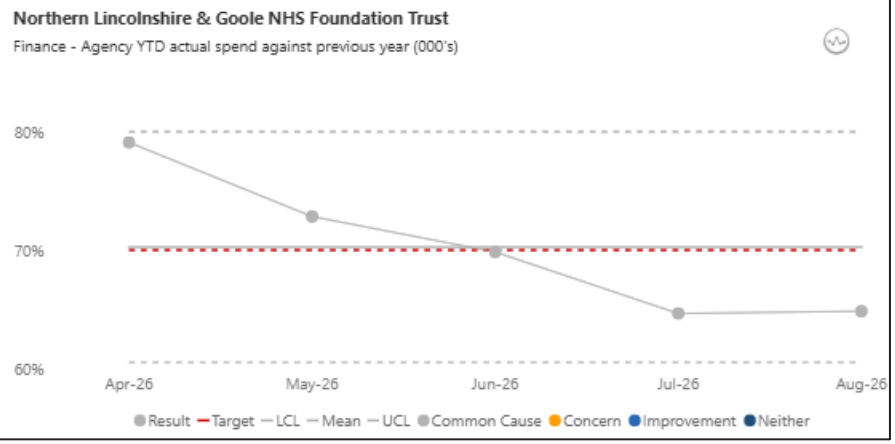
HUTH:
Considerable effort has been made to reduce the use and cost of agency workers and great progress has been made towards the target reduction. This trend of reducing agency spend has plateaued over recent months as improvement gains become more challenging. To deliver the necessary reduction the building blocks of sustainable change are being put in place which will result in improved efficiencies and oversight and control of the use of agency workers.

NLAG:

The improvements implemented have reduced agency spend and the spend is currently below the target. However, further improvement will continue to aid sustaining and further improving this reduction.







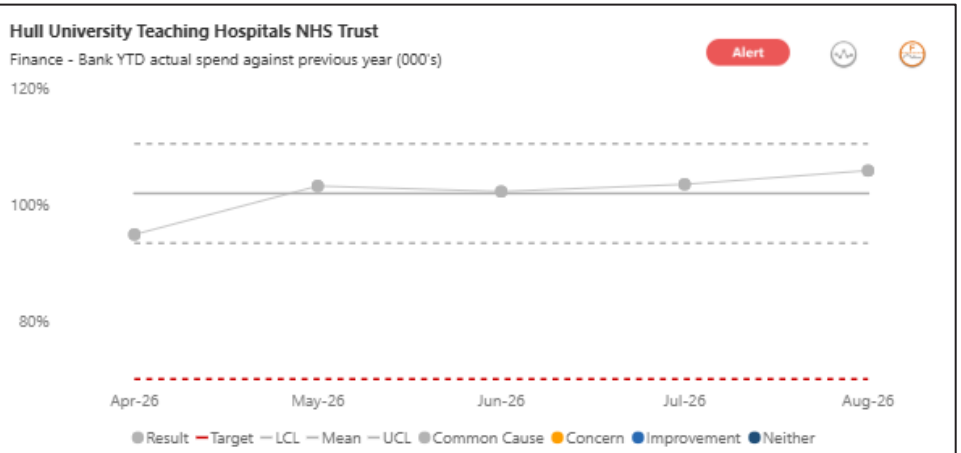
8.3 Finance – Bank YTD actual spend against previous year

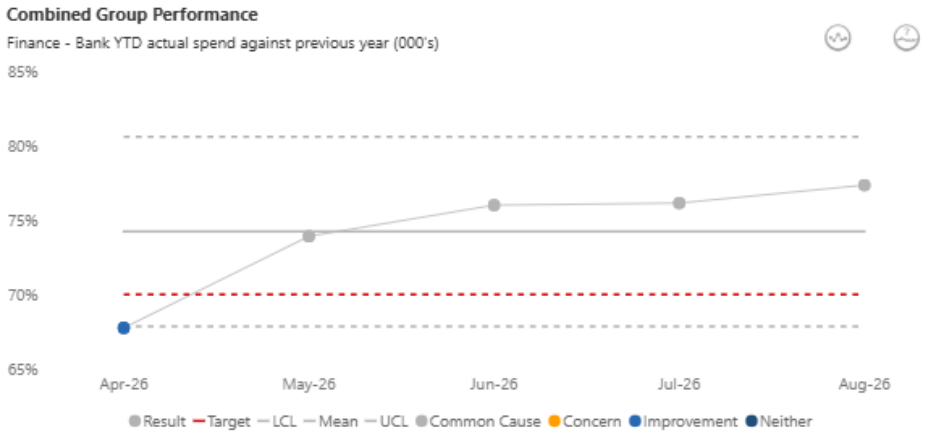
Finance - Bank YTD actual spend against previous year (000's)

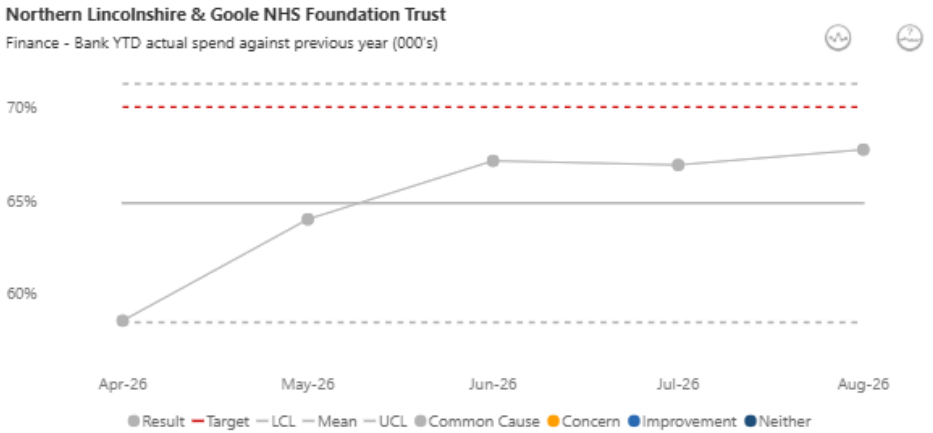
HUTH:
The cost of bank workers has slightly increased from the level of spend last year. Whilst increased spend is ordinarily a negative indicator, the strategy is to move the use of contingency workers to the lowest cost option. Therefore, it is anticipated that the spend on bank will increase as we look to utilise bank worker capacity to aid reduction in higher cost options such as agency.

NLAG:

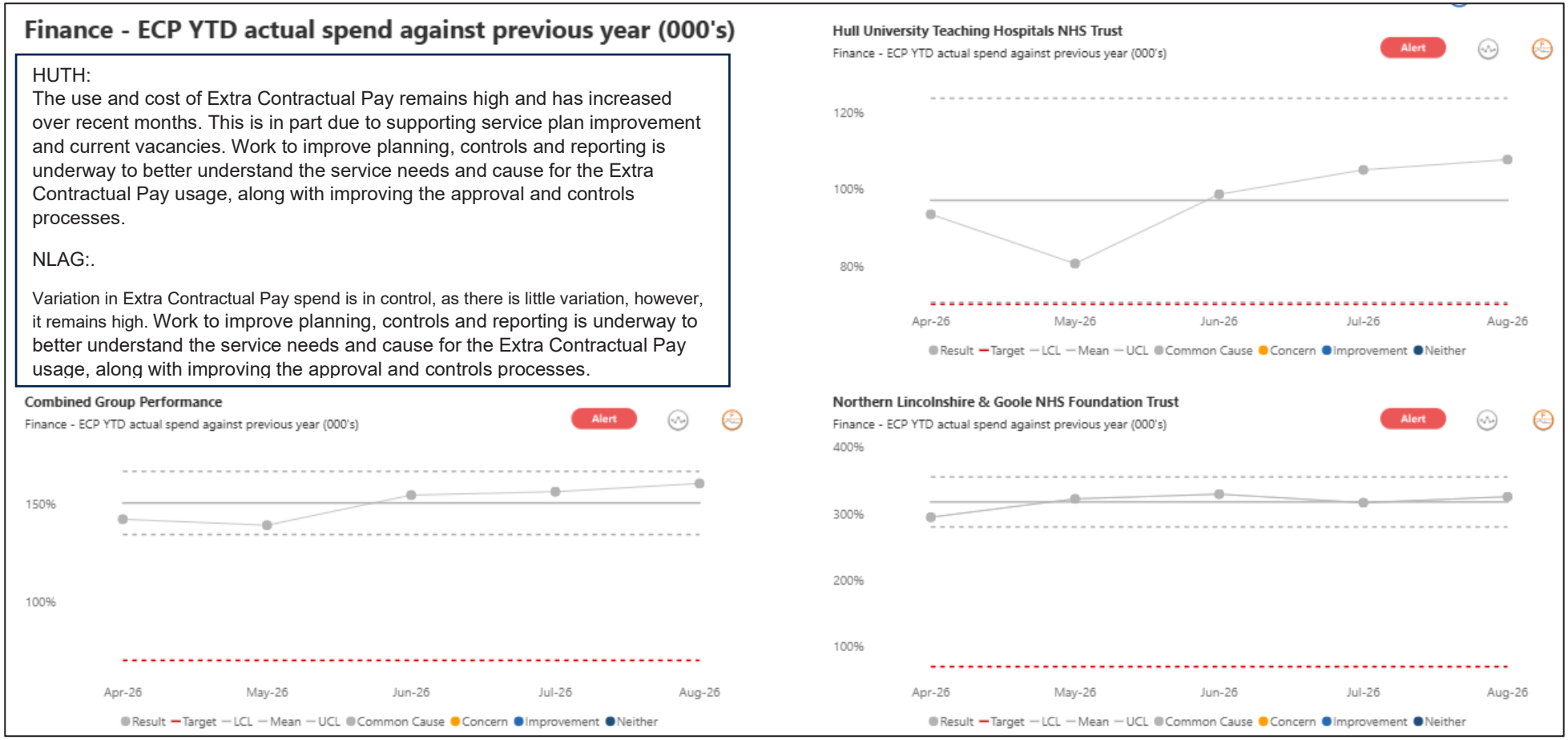
Similarly, the cost of bank has increased as it is utilised to reduce higher cost alternatives. The bank is far more established, and capacity is greater at NLAG, therefore it can be optimised far more quickly.



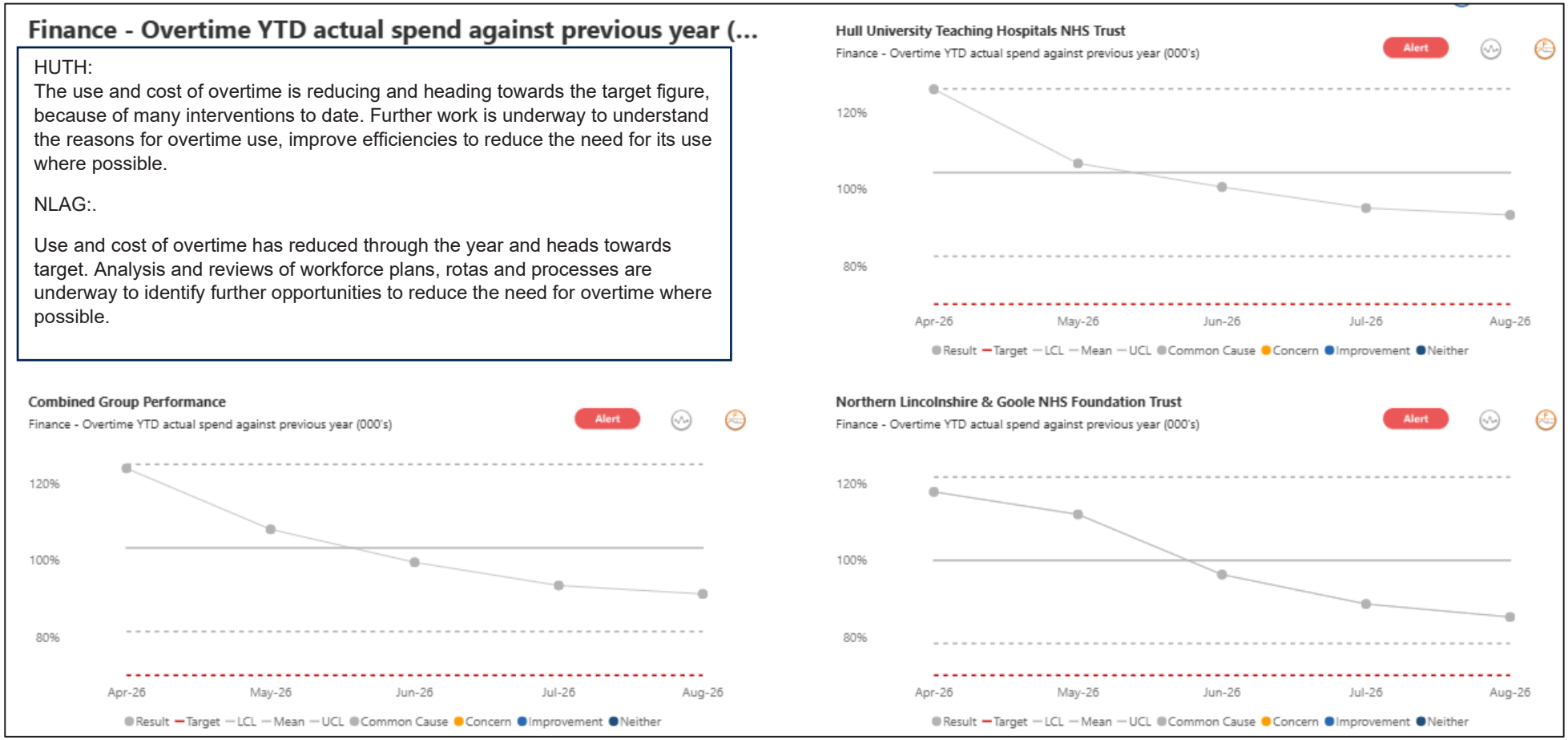




8.4 Finance – ECP YTD actual spend against previous year



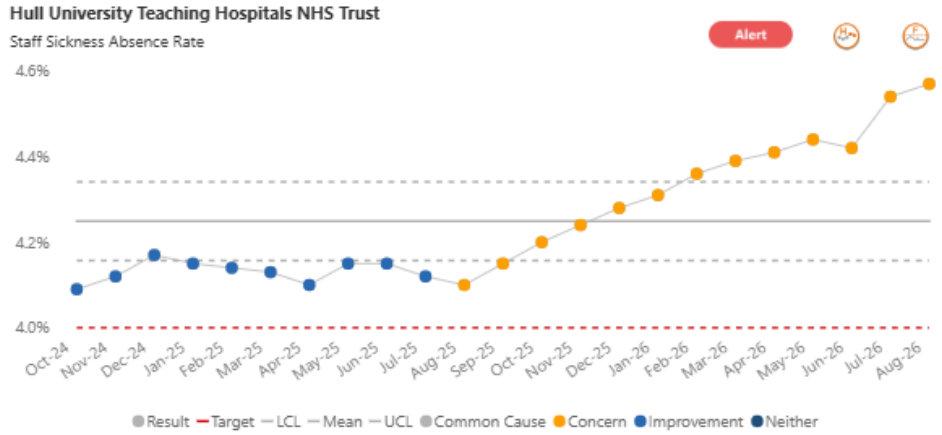
8.5 Finance – Overtime YTD actual spend against previous year

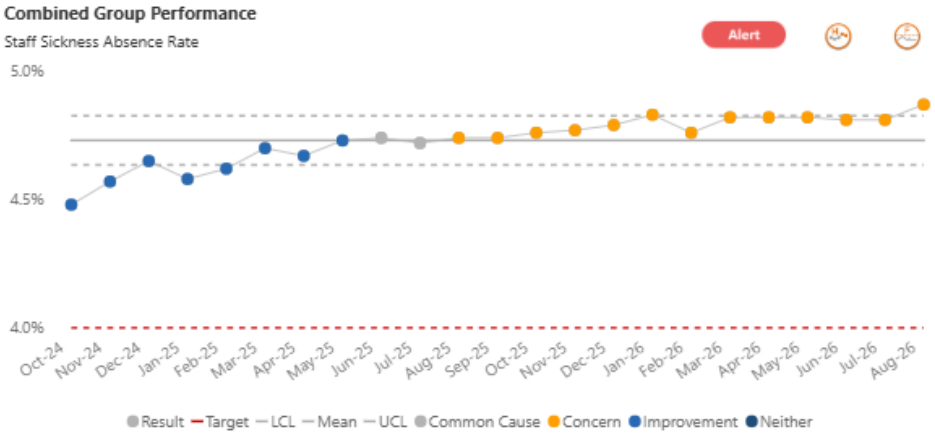


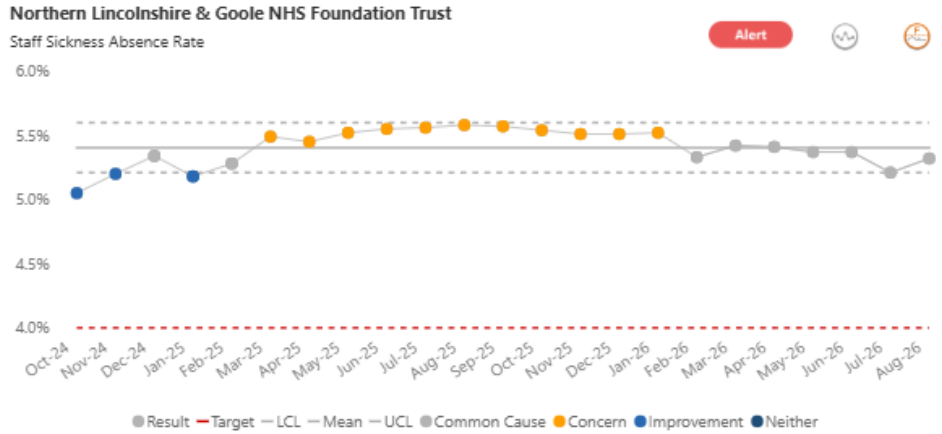
8.6 Staff Sickness Absence Rate

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.







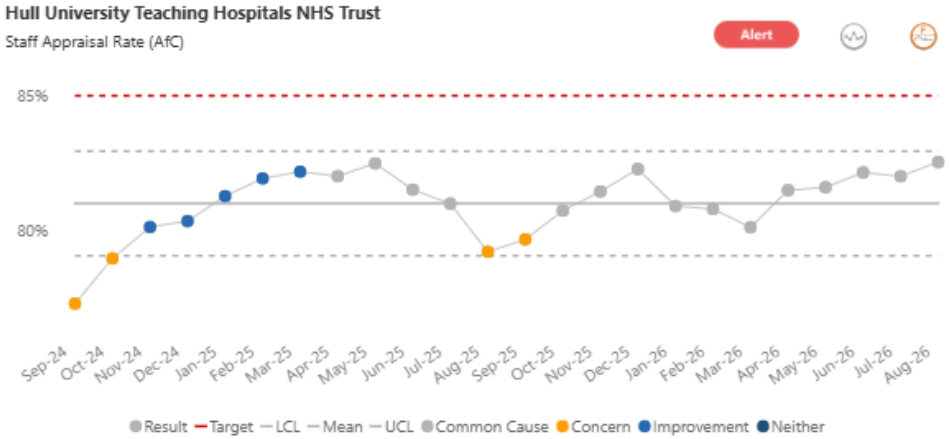
8.7 Staff Appraisal Rate (AfC)

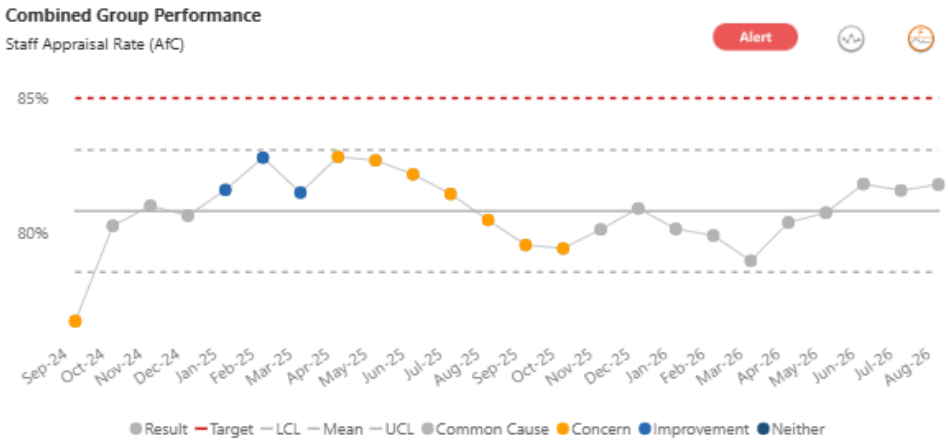
HUTH:

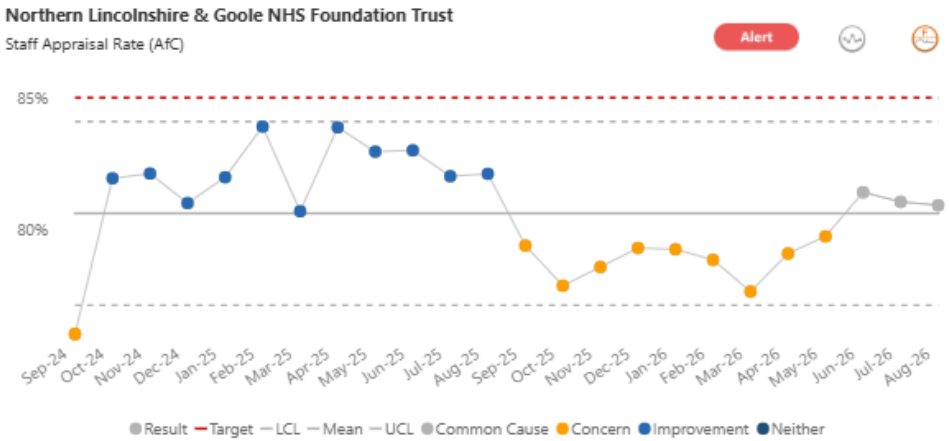
Staff appraisal performance remains variable and does not show a sustained improving trend. Recent data points appear to continue around the mean, indicating normal variation rather than clear recovery. Continued divisional focus is required to improve completion rates and ensure appraisal compliance 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.







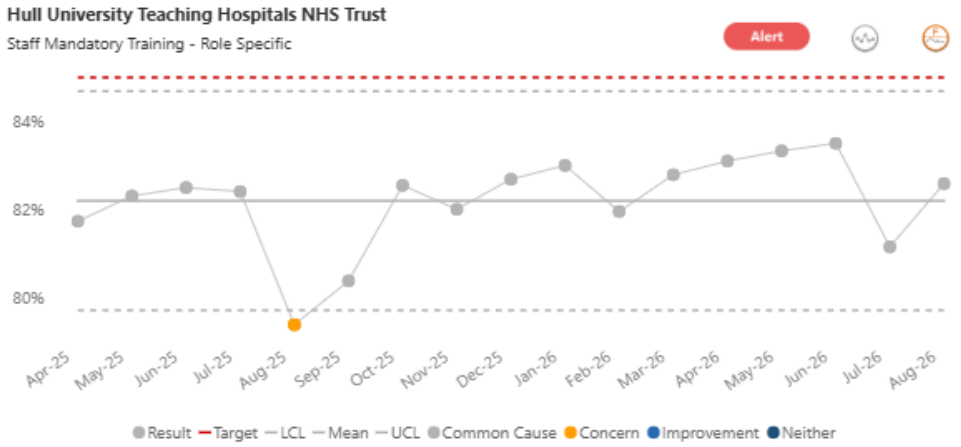
8.8 Staff Mandatory Training – Role Specific

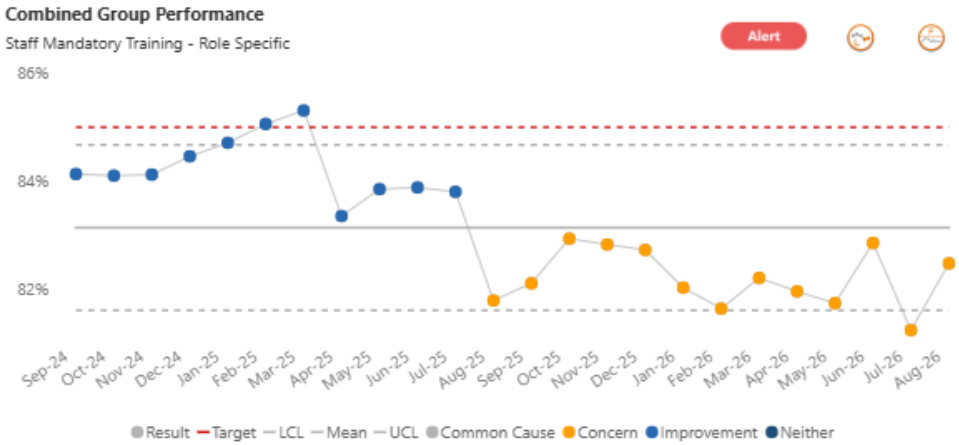
HUTH:

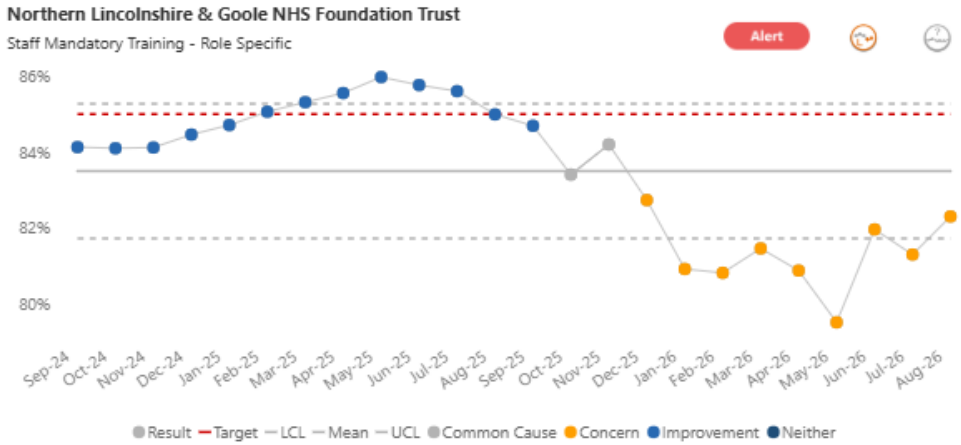
The latest position suggests compliance is not yet consistently improving at the required pace, requiring continued divisional grip, targeted follow-up with areas below trajectory and active monitoring through workforce governance.

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.







8.9 Head Count Reduction

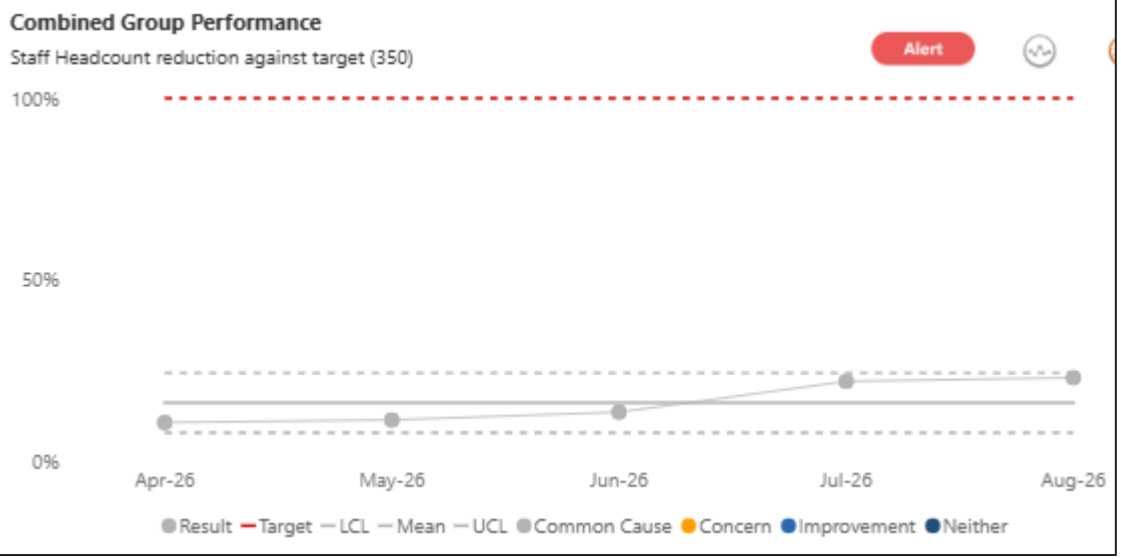
Staff Headcount reduction against target (350)

HUTH:

There has been relatively little change in the number of substantively employed colleagues through the year with numbers increasing by 0.2% from April to August 2026. The Trust self-imposed a pause to recruiting non-essential roles from July 2026 to support the Trusts financial position, and during this period there has been no growth in workforce numbers.

NLAG:

There has been a reduction of 0.9% in the workforce numbers at NLAG from April to August 2026. During the Trusts self-imposed pause to recruitment of non-essential roles from July to support the financial recovery, workforce numbers dropped by 0.47%.



9. Recruitment & Retention

Summary

Recruitment process timeliness remains variable across HUTH and NLAG, with no clear sustained improvement across shortlisting, offer or employment checks, and a deteriorating position in August. The greatest concerns are Staff Time to Shortlist at HUTH and NLAG and Staff Time to Offer at NLAG, indicating delays in progressing candidates to interview and offer and a continuing risk to timely appointments and workforce supply.

Progress

Both HUTH and NLAG shows deterioration in performance in various degrees across all metrics in August. Particular risk is time to shortlist at HUTH and NLAG, and time to offer at NLAG. In addition, time to complete employment checks has deteriorated, which is partly due to seasonal variance seen annually relating to capacity due to resident doctors rotation, and exacerbated by sickness and vacancies within the recruitment team.

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. Improvement in performance is expected to show in October data due to decreased sickness and completion of work relating to resident doctor intake.

Recruitment 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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Safe	People & Workforce	Staff Time to Employment Checks	≤ 20.0	38.8	38.5	36.4	27.7	48.2	13.8	12.6	13.6	16.0	18.9	21.0	25.9	
		Staff Time to Offer	≤ 2.0	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	9.4	8.6	9.0	8.2	8.5	7.1	7.2	7.0	6.6	7.6	7.6	9.8	
Well Led	People & Workforce	Staff Turnover Annual FTE Rate	≤ 8.0%	6.4%	6.7%	6.4%	6.2%	5.8%	6.2%	6.4%	6.3%	6.5%	6.4%	7.5%	6.8%	

Recruitment 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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Safe	People & Workforce	Staff Time to Employment Checks	≤ 20.0	41.2	34.6	41.2	41.3	37.4	27.5	27.0	22.0	17.3	17.8	21.6	24.4	
		Staff Time to Offer	≤ 2.0	3.1	2.8	2.6	2.5	2.4	2.2	2.5	2.9	3.4	3.5	7.4	8.5	
		Staff Time to Shortlist	≤ 5.0	50.6	68.2	95.7	110.8	52.3	48.8	47.8	6.1	6.8	6.9	7.5	13.3	
Well Led	People & Workforce	Staff Turnover Annual FTE Rate	≤ 8.0%	8.4%	8.4%	8.3%	8.0%	8.0%	7.8%	7.6%	6.5%	7.2%	7.0%	7.2%	7.2%	

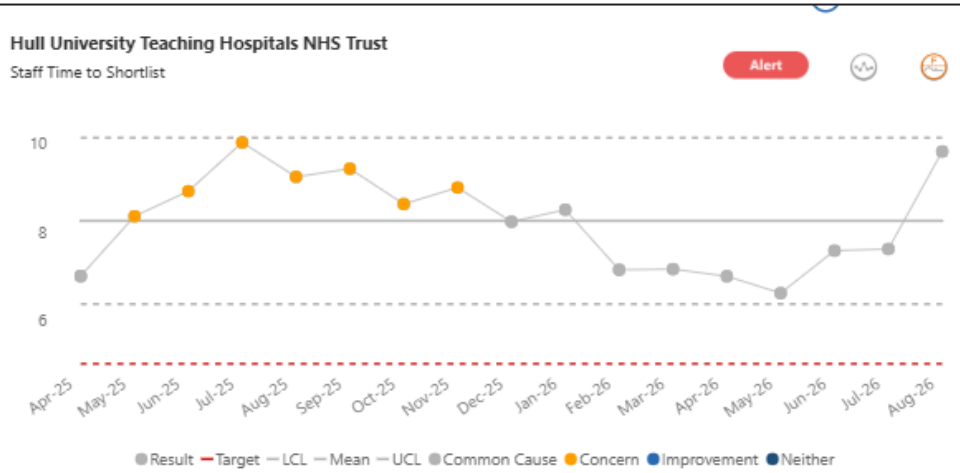
9.2 Staff Time to Shortlist

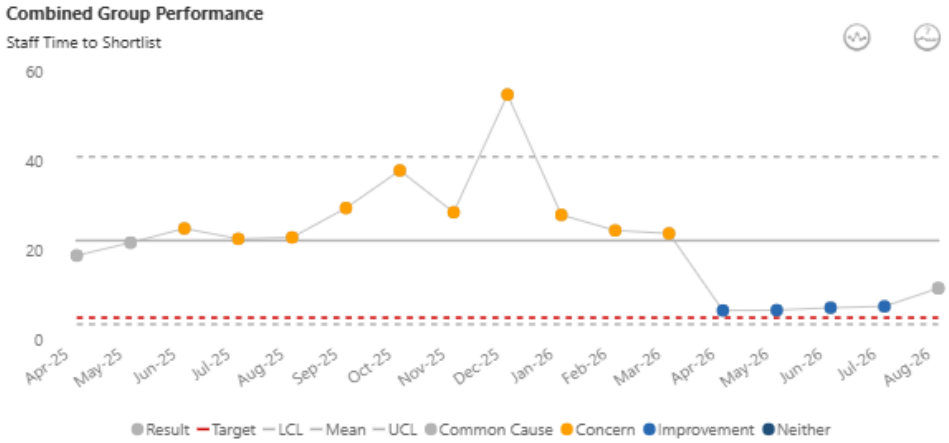
HUTH:

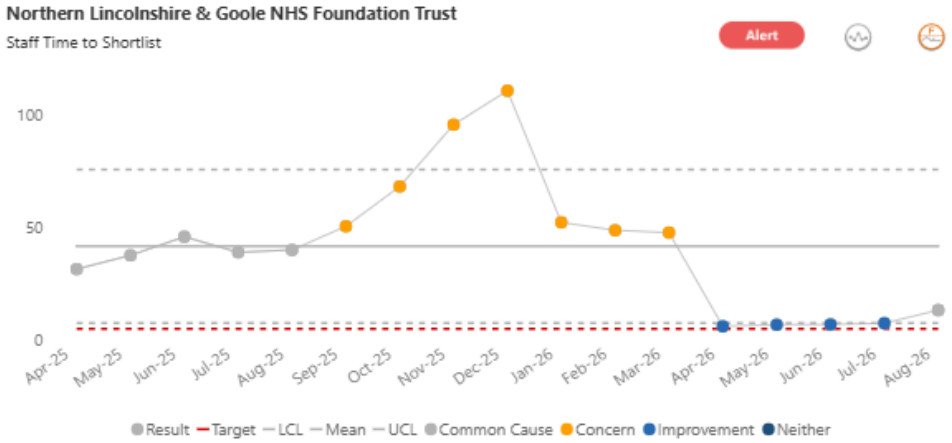
Staff Time to Shortlist shows continued variation across the period, with no clear sustained improvement. The latest position suggests the process remains vulnerable to delays at the early recruitment stage, requiring continued focus on timely vacancy review, manager shortlisting and recruitment team 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.







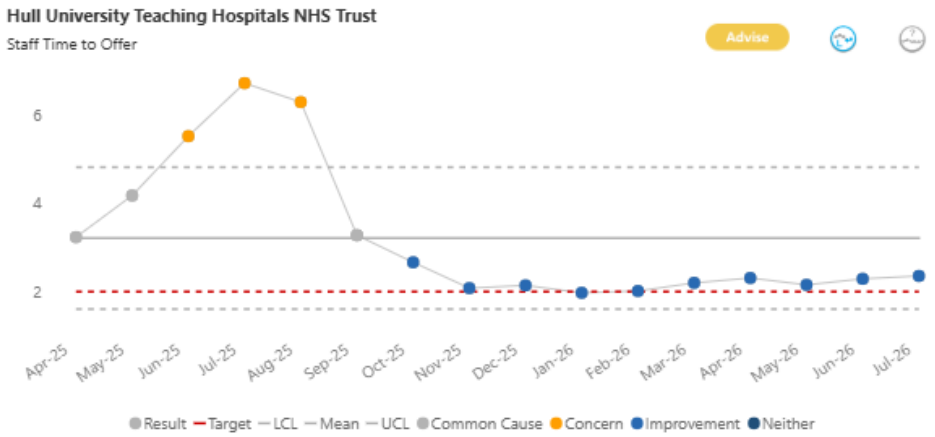
9.3 Staff Time to Offer

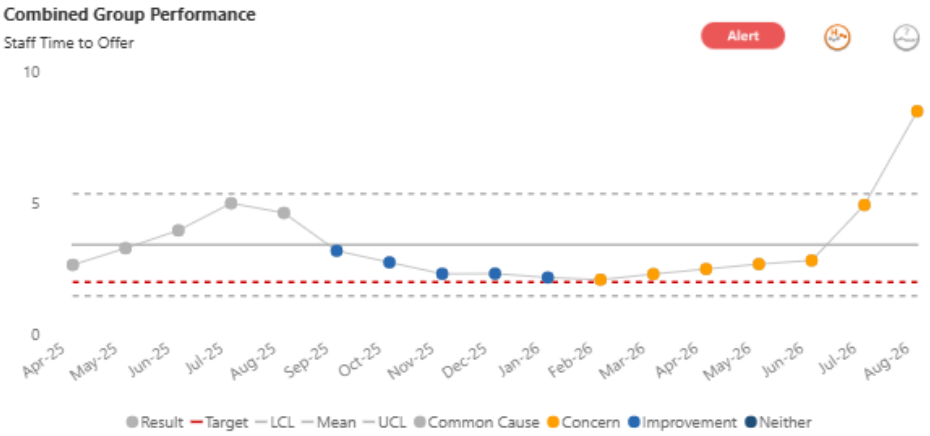
HUTH:

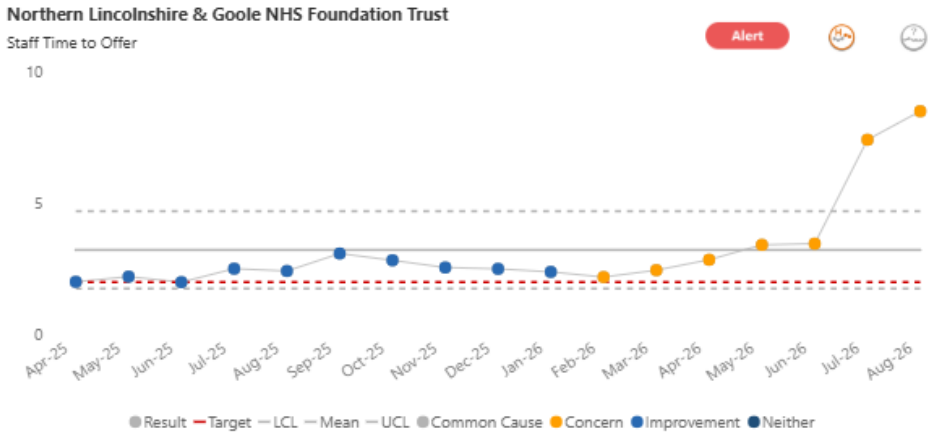
Staff Time to Offer shows variation across the period, with no clear sustained improvement. The recent position appears broadly stable but remains above the level required for consistent recruitment responsiveness, so continued focus is needed on timely interview outcomes, approval steps and offer processing.

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.







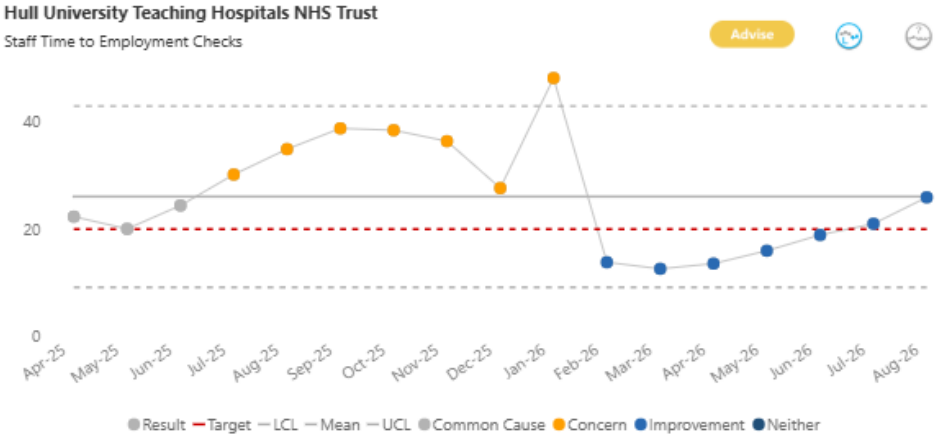
9.4 Staff Time to Employment Checks

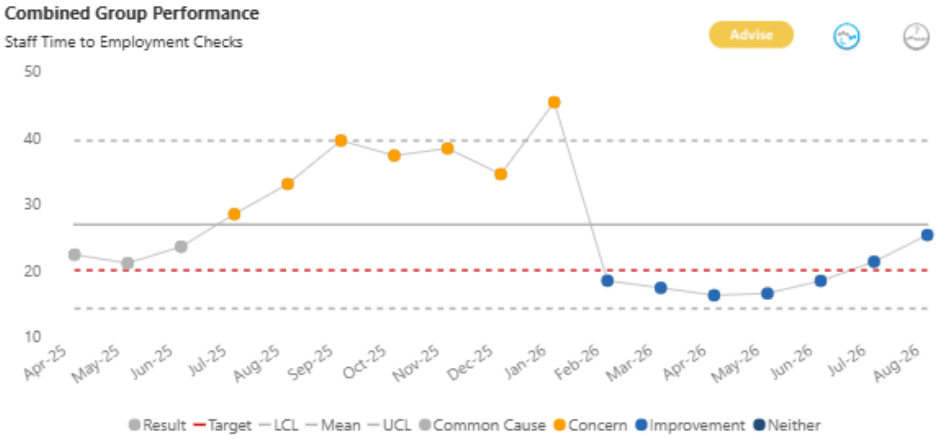
HUTH:

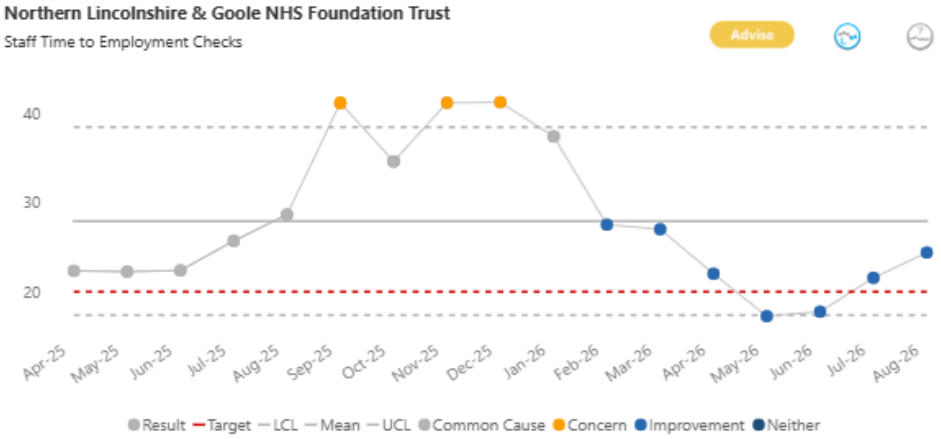
Time to employment checks shows a broadly stable trend with no clear sustained improvement; performance remains variable and should continue to be monitored to ensure checks do not become a recruitment delay point.

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

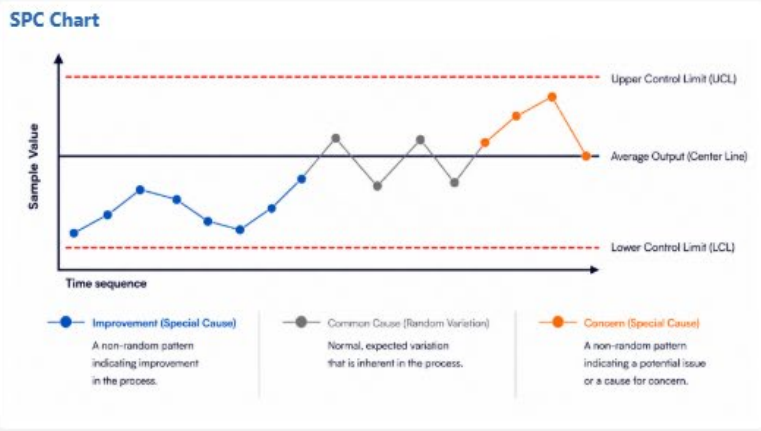
These indicate how reliably the target is being met.
Blue indicates target is consistently achieved; **Amber** indicates target is not consistently achieved; **Grey** indicates target is inconsistently achieved due to random variation.

Triple-A Status

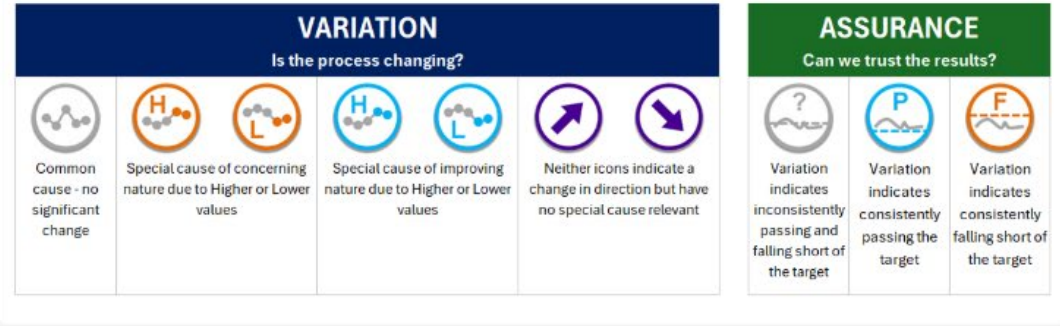
Combines variation and assurance to give an overall rating:
Assure, **Advise**, or **Alert**.

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

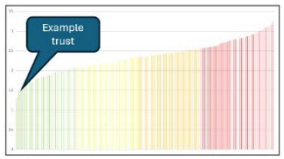
Step two: determine overall score

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:

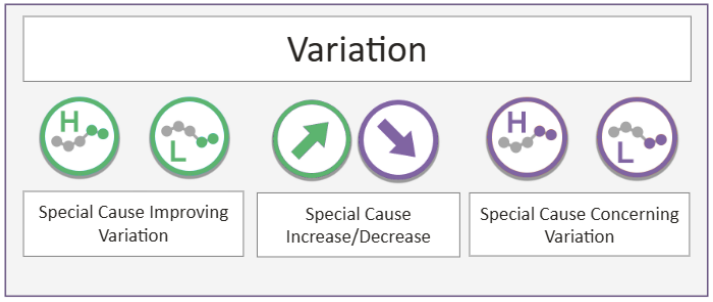
An organisation's organisational delivery score, adjusted if applicable for financial deficit, translates directly to the segment it is allocated. For some providers that are allocated to segment 4, the relevant NHS England region will consider their capability rating and determine whether they should be entered into the Provider Improvement Programme (PIP).

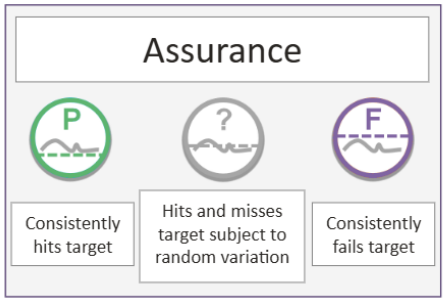
All providers in the PIP will be placed in segment 5.

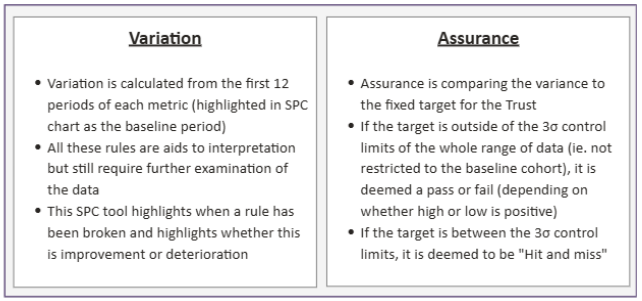
3. Using Data Insights to identify Alert, Advise and Assure status

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 – Q1 2025/26

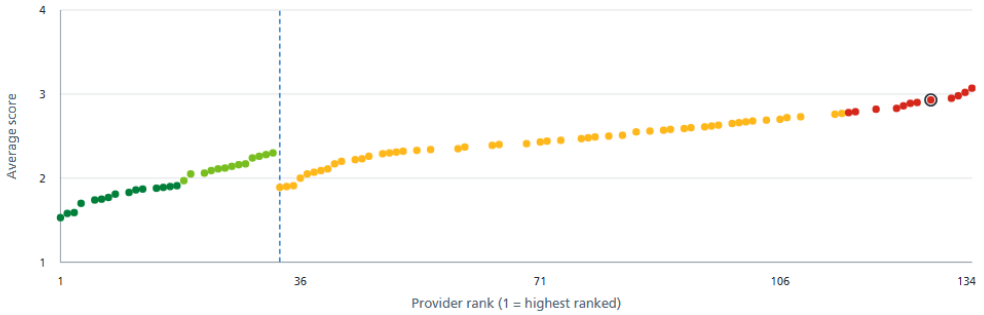
Domain quartiles

All metrics for this provider grouped by NOF domain. Each metric receives a score between 1 and 4, with 1 being the highest rating.

Access to services	Patient safety	Finance, productivity and innovation
Quartile	Quartile	Quartile
4 Lowest-scoring 25%	4 Lowest-scoring 25%	3 Third-highest-scoring 25%
No quartile change Quartile 4 in previous quarter	No quartile change Quartile 4 in previous quarter	Quartile performance improved Quartile 4 in previous quarter

People	Experience of care	Effectiveness of care and population health
Quartile	Quartile	Quartile
3 Third-highest-scoring 25%	4 Lowest-scoring 25%	4 Lowest-scoring 25%
No quartile change Quartile 3 in previous quarter		

Chart | Data



Selected organisation is marked with its segment colour, a white gap, and a black outline.

Comparative League table in Appendices

NLAG Overview – Q1 2025/26

Domain quartiles

All metrics for this provider grouped by NOF domain. Each metric receives a score between 1 and 4, with 1 being the highest rating.

Access to services

Quartile

4 Lowest-scoring 25%

No quartile change
Quartile 4 in previous quarter

Patient safety

Quartile

4 Lowest-scoring 25%

No quartile change
Quartile 4 in previous quarter

Finance, productivity and innovation

Quartile

4 Lowest-scoring 25%

No quartile change
Quartile 4 in previous quarter

People

Quartile

4 Lowest-scoring 25%

Quartile performance declined
Quartile 3 in previous quarter

Experience of care

Quartile

4 Lowest-scoring 25%

Effectiveness of care and population health

Quartile

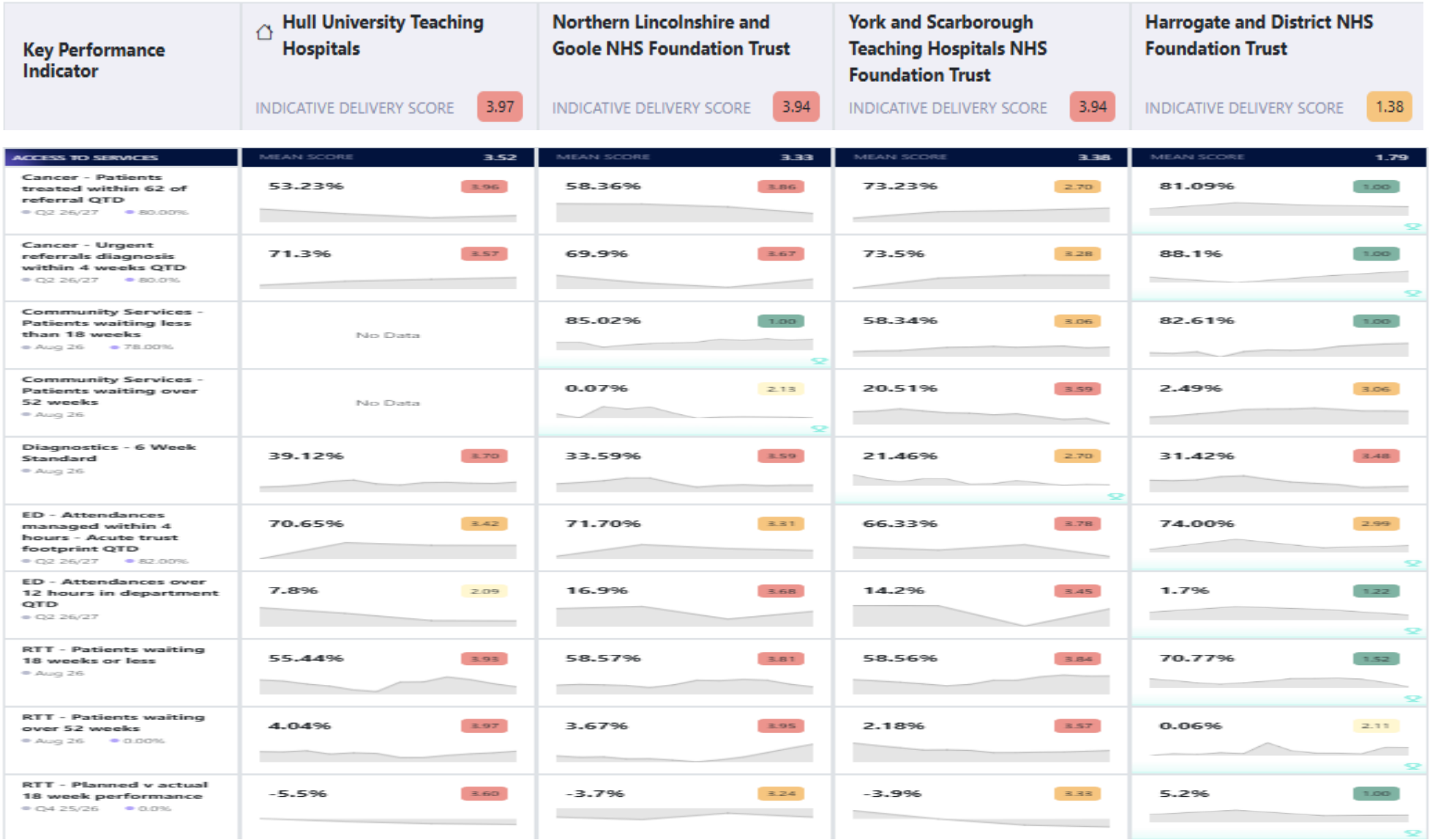
3 Third-highest-scoring 25%

Chart | Data

Selected organisation is marked with its segment colour, a white gap, and a black outline.

Regional Context – Public View Data Source

Access to Services



Key Performance Indicator	Hull University Teaching Hospitals	Northern Lincolnshire and Goole NHS Foundation Trust	York and Scarborough Teaching Hospitals NHS Foundation Trust	Harrogate and District NHS Foundation Trust
	INDICATIVE DELIVERY SCORE 3.97	INDICATIVE DELIVERY SCORE 3.94	INDICATIVE DELIVERY SCORE 3.94	INDICATIVE DELIVERY SCORE 1.38
ACCESS TO SERVICES	MEAN SCORE 3.52	MEAN SCORE 3.33	MEAN SCORE 3.38	MEAN SCORE 1.79
Cancer - Patients treated within 62 of referral QTD Q2 26/27 80.00%	53.23% 3.96	58.36% 3.86	73.23% 2.70	81.09% 1.00
Cancer - Urgent referrals diagnosis within 4 weeks QTD Q2 26/27 80.0%	71.3% 3.57	69.9% 3.67	73.5% 3.28	88.1% 1.00
Community Services - Patients waiting less than 18 weeks Aug 26 78.00%	No Data	85.02% 1.00	58.34% 3.06	82.61% 1.00
Community Services - Patients waiting over 52 weeks Aug 26	No Data	0.07% 2.13	20.51% 3.59	2.49% 3.06
Diagnostics - 6 Week Standard Aug 26	39.12% 3.70	33.59% 3.59	21.46% 2.70	31.42% 3.48
ED - Attendances managed within 4 hours - Acute trust footprint QTD Q2 26/27 82.00%	70.65% 3.42	71.70% 3.31	66.33% 3.78	74.00% 2.99
ED - Attendances over 12 hours in department QTD Q2 26/27	7.8% 2.09	16.9% 3.68	14.2% 3.45	1.7% 1.22
RTT - Patients waiting 18 weeks or less Aug 26	55.44% 3.93	58.57% 3.81	58.56% 3.84	70.77% 1.52
RTT - Patients waiting over 52 weeks Aug 26 0.00%	4.04% 3.97	3.67% 3.95	2.18% 3.57	0.06% 2.11
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	Northern Lincolnshire and Goole NHS Foundation Trust	York and Scarborough Teaching Hospitals NHS Foundation Trust	Harrogate and District NHS Foundation Trust
	INDICATIVE DELIVERY SCORE 3.97	INDICATIVE DELIVERY SCORE 3.94	INDICATIVE DELIVERY SCORE 3.94	INDICATIVE DELIVERY SCORE 1.38
EXPERIENCE OF CARE	MEAN SCORE 2.95	MEAN SCORE 2.79	MEAN SCORE 3.16	MEAN SCORE 1.73
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	2,151 3.12	1,831 2.83	5,797 3.88	1 1.59
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 May 26	1.06 2.00	1.00 2.00	0.90 2.00	1.01 2.00

Patient Safety

Key Performance Indicator	Hull University Teaching Hospitals INDICATIVE DELIVERY SCORE 3.97	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.94	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.94	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 1.38
PATIENT SAFETY	MEAN SCORE 3.13	MEAN SCORE 2.76	MEAN SCORE 2.86	MEAN SCORE 1.46
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% 1.32	3.7% 3.68	2.0% 1.75
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 3.00	2.11 4.00	0.92	1.04 3.00
Rate of E-Coli bacteraemia Jul 26	0.00 2.00	0.00 4.00	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	Northern Lincolnshire and Goole NHS Foundation Trust	York and Scarborough Teaching Hospitals NHS Foundation Trust	Harrogate and District NHS Foundation Trust
	INDICATIVE DELIVERY SCORE 3.97	INDICATIVE DELIVERY SCORE 3.94	INDICATIVE DELIVERY SCORE 3.94	INDICATIVE DELIVERY SCORE 1.38
FINANCE, PRODUCTIVITY AND INNOVATION	MEAN SCORE 3.06	MEAN SCORE 3.07	MEAN SCORE 3.28	MEAN SCORE 2.60
Clinical trials set up within 90 days Q1 26/27 95.00%	71.43% 4.00	0.00% 4.00	60.00% 4.00	100.00% 1.00
Data Quality Maturity Index (DQMI) Jun 26	96.7 1.23	93.2 2.42	90.6 3.19	87.5 3.86
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 Jun 26	-3.6% 3.59	-0.3% 3.03	-2.6% 3.37	2.4% 2.17
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	Northern Lincolnshire and Goole NHS Foundation Trust	York and Scarborough Teaching Hospitals NHS Foundation Trust	Harrogate and District NHS Foundation Trust
	INDICATIVE DELIVERY SCORE 3.97	INDICATIVE DELIVERY SCORE 3.94	INDICATIVE DELIVERY SCORE 3.94	INDICATIVE DELIVERY SCORE 1.38
PEOPLE	MEAN SCORE 2.64	MEAN SCORE 3.15	MEAN SCORE 2.79	MEAN SCORE 1.68
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 3.59	64.44 4.00	75.25 2.76	81.26 1.32
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	4.27% 1.63	5.09% 2.69	5.40% 3.26	4.93% 2.49
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

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

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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

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5. HHP Foundation Scorecards

Embedded in the HHP NOF Scorecard are 4 Foundation Scorecards:

- Quality (CQC: Caring, Safe, Effective),
- Performance (CQC: Responsive)
- Finance (CQC: Effective, Well-led)
- Workforce (CQC: Effective, Well-led)

Each Foundation Scorecard will contain every relevant metric signed off by lead Exec.

Subject to available thresholds each metric will be RAG rated. All RAG rated metrics will be used to derive sub-domain and domain assessment scores

Each metric will also be identified as a defined or enabling NHSE NOF Indicator along with the defined Subject Area (Elective Care, Cancer, UEC, Financial Balance, Productivity).

Each metric will be allocated a unique identifier allowing any combination of summary scorecards to be generated

Every Metric has clear definitions and SPC graphs to support further understanding and act as presentational templates for Care Group performance updates

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)301

Name of Meeting	Trust Boards-in-Common (Private meeting)
Date of the Meeting	**12 November 2026**
Director Lead	Lyn Simpson, Group and Hull University Teaching Hospitals NHS Trust Chief Executive
Contact Officer / Author	Ben Smith – NHSE Programme Lead supporting the Improvement Programmes
Title of Report	HHP Transition Programme October Report
Executive Summary	Humber Health Partnership (HHP) is progressing its Transition Programme to support the move from the current group arrangements towards two separate sovereign organisations: Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). The Transition Programme has moved from mobilisation into delivery, with formal governance arrangements established, transition principles agreed and all seven workstreams progressing. October has seen tangible progress in establishing the programme infrastructure, undertaking the clinical and corporate inventories, and developing the dissolution timeline and the Safe Landing Conditions that must be met before disestablishment of the Group. Ten Safe Landing Conditions from the Strategic Business Case have been tested and endorsed by the Programme Delivery Group (PDG) and the Transition Steering Group (TSG). These Safe Landing Conditions cover three domains: • Clinical continuity and patient safety • Regulatory, corporate and financial continuity • Leadership and workforce readiness These conditions will form the basis of a structured assurance process and will determine organisational readiness for dissolution. Consistent with the agreed transition principles, readiness rather than a predetermined date will determine whether dissolution proceeds. The proposed timeline identifies seven workstreams operating in parallel and works towards a target dissolution date of 31 March 2027, with 31 May 2027 identified as a contingency date should additional time be required to achieve the Safe Landing Conditions. A formal go/no-go decision will be taken against an assurance framework that will be developed and brought back to the Boards-in-Common for approval. The immediate priorities are to complete and validate clinical and corporate inventories, develop the assurance framework, progress

	the IRP Recovery Compact, clarify decision rights and accountability arrangements, and commence the development of the strategic vision and operating models for the Trusts. The programme must also ensure that existing improvement, financial recovery and regulatory commitments are not fragmented or lost during transition. The Boards-in-Common are asked to note programme progress, approve the updated Terms of Reference for the Transition Steering Group, Safe Landing Conditions, and target dissolution timeline.
Background Information and/or Supporting Document(s) (if applicable)	• Attachment 1 - Terms of Reference for the Transition Steering Group • Attachment 2 - Terms of Reference for the Programme Delivery Group (for reference) • Attachment 3 - Safe Landing Conditions and Target Dissolution Timeline
Prior Approval Process	The Boards-in-Common approved the Terms of Reference for the Transition Steering Group in the October meeting and requested amendments to the Programme Delivery Group Terms of Reference for equality of representation from HUTH and NLaG – the amended ToR have been brought back to this meeting. The Transition Steering Group subsequently approved the updated Terms of Reference for the Programme Delivery Group under their decision making authority. The proposed Safe Landing Conditions were initially developed through the Strategic Business Case process and have subsequently been reviewed and refined by the Programme Delivery Group and Transition Steering Group. The dissolution timeline has been developed with workstream leads and tested through both groups prior to submission to the Boards-in-Common for approval.
Financial Implication(s) (if applicable)	There are no direct financial decisions requested within this paper. The proposed Safe Landing Conditions include arrangements relating to financial continuity, contractual arrangements and the development and agreement of the IRP Recovery Compact to support long-term organisational sustainability. The Transition Programme budget is being developed and will be reviewed with the relevant Chief Executives and Group Chief Financial Officer. Any additional resource requirements will remain subject to appropriate financial scrutiny and approval.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	No adverse equality, diversity or health inequality implications have been identified as a result of approving the Safe Landing Conditions and dissolution timeline. Any substantive organisational or service changes resulting from future decisions will be subject to appropriate Equality Impact Assessment processes.
Recommended action(s) required	✓ Approval ✓ Information ✓ Assurance ☐ Other – please detail below:

1. Transition Programme Progress October 2026

1.1 Recommended action

The Boards-in-Common are invited to note progress made during October 2026 in mobilising and delivering the Transition Programme, with all seven workstreams currently reporting on track.

1.2 Overall programme position

During October, the Transition Programme moved from mobilisation into delivery, with governance arrangements established and all seven workstreams progressing. The Transition Office has been established along with initial reporting arrangements, providing a clearer approach for delivery, accountability and escalation. The programme has also progressed the development of transition principles, safe landing conditions, dissolution timeline, and clinical and corporate inventories.

While the programme is progressing against its mobilisation milestones, several activities are in-progress. These relate principally to the completion and validation of inventories, development of the strategic vision and future operating models for care groups and corporate services, and the assurance framework to demonstrate readiness for dissolution.

1.3 Workstream delivery position

Workstream	October status	Key progress & focus
1. Strategy	On Track	Strategy development approach mobilised; establishing clinical engagement approach.
2. People and Leadership	On Track	Interim NLaG Chief Executive and Chair appointed; further Executive recruitment progressing; OD plan developed; commencing work to develop care-group structures.
3. Operating Models and ICB Commissioning	On Track	Initial ICB commissioning implications identified; commencing work to develop target operating models for clinical and corporate services.
4. Governance, Board and Legal	On Track	Draft governance manuals developed for both Trusts; legal advice received and progressing on decision rights and accountable officer arrangements.
5. Communications and Engagement	On Track	Communications and engagement plan developed; transition principles shared; supporting ongoing communications about the programme.
6. Quality, Safety and Clinical Continuity	On Track	Clinical inventory process mobilised; commencing review of existing clinical collaborations.
7. Finance and Resources	On Track	Corporate inventory process established; commencing review of existing corporate collaborations.

1.4 Key achievements during October 2026

The principal achievements during October included:

- Mobilising seven workstreams and the Transition Office.
- Establishing the Programme Delivery Group and formal programme reporting arrangements.

- Agreeing and communicating transition principles.
- Developing revised safe landing conditions.
- Developing the revised timeline to dissolution and workstream delivery arrangements.
- Issuing clinical inventory templates to care groups.
- Issuing corporate inventory templates to corporate directorates.
- Progressing the Clinical Reference Group and clinical engagement arrangements.
- Developing draft governance manuals for both organisations.
- Developing proposals on accountable officers, decision rights and dissolution arrangements.
- Developing approach for the IRP Recovery Compact.

These developments provide the foundation for the next phase of transition delivery.

1.5 Priorities for November 2026

The next phase of the Transition Programme will focus on moving from mobilisation and planning into delivery.

The principal priorities are:

- Develop the supporting assurance framework for safe dissolution, evidence requirements, Executive ownership and approval arrangements.
- Clarify the decision-rights, accountable officer responsibilities and the governance arrangements that will apply before and after dissolution.
- Complete and validate the clinical and corporate inventories, identifying the existing collaborations between HUTH and NLaG.
- Commence the development of the strategic vision and collaboration approach for HUTH and NLaG.
- Commence the development of target operating models for care groups and corporate services.
- Progress Executive recruitment, clarify future organisational arrangements and strengthen staff engagement and communications.
- On-going communications and engagement alongside organisational development activities.
- Finalise the approach and commence development of the IRP Recovery Compact with the relevant parties, including on-going work on updating the financial plan.

1.6 Key risks and dependencies

The principal risks and dependencies, and how they are being managed, are:

- Readiness and premature separation: milestones may progress without evidence of readiness, or informal separation may occur before the formal dissolution gateway. Mitigated through the assurance framework and by maintaining Group governance until formally changed.
- Dependence on external organisations to progress the IRP Recovery Compact: the ICB, Regional NHSE and national NHSE may not sign up to the actions and timelines needed for the Trusts to progress their actions in the Recovery Compact. Mitigated through the Transition Steering Group and continuing communication with national team.
- Clinical continuity: clinical capacity to complete and validate inventories is a significant dependency. Mitigated by resourcing clinical engagement and addressing continuity risks through safe landing assurance.
- Workforce and leadership: uncertainty about future care-group structures and roles is causing concern among staff, particularly those in group roles. Mitigated through timely decisions, Executive recruitment and clear communication.
- Governance and decision rights: accountable officer responsibilities and decision rights require

clarification. Mitigated through legal advice, governance manuals and the decision-rights framework.
- Finance and shared services: arrangements for financial accountability, assets, liabilities and shared services are not yet defined. Mitigated through the corporate inventory and collaboration agreements.
- Communications: staff are seeking clarity, but there is no dedicated communications resource for the transition. Mitigated by strengthening capacity and providing timely, consistent updates.

2. Updated Terms of Reference

2.1 Recommended action

The Boards-in-Common are invited to:

- Approve the amended Terms of Reference for the Transition Steering Group to add two non-executive directors from the Boards-in-Common.
- Note the amended Terms of Reference for the Programme Delivery Group to ensure equality of representation of HUTH and NLaG, as approved by the Transition Steering Group.

2.2 Transition Steering Group (Attachment 1)

The Transition Steering Group is an independently chaired group, accountable to the Boards-in-Common, which provides an independent opinion on the Programme Delivery Group's recommendations regarding the safe landing conditions, shadow running, go/no-go and the dissolution date, before the Boards take those decisions. It determines matters referred by the Programme Delivery Group, including any decision that would affect the two Trusts differently. It may also escalate any matter it considers puts a safe dissolution at risk to the relevant authority, which would include the Boards-in-Common, the Integrated Care Board and the NHS England Intensive Recovery Programme Oversight Group.

The current membership of the Transition Steering Group comprises the Chief Executive of HUTH (Group Chief Executive of the Humber Health Partnership), the Interim Chief Executive of NLaG, the Chief Executive of Humber and North Yorkshire Integrated Care Board, a Non-executive Director from each Trust, the Interim NHS England North East and Yorkshire Regional Director, and the NHS England Deputy Chief Financial Officer. Carnall Farrar is providing interim chairing arrangements pending any appointment of a new Independent Chair by the Boards-in-Common, in agreement with NHS England.

The current Terms of Reference were approved in the October Boards-in-Common meeting. On request from the Board Chairs and Chief Executives, the Independent Chair has proposed an amendment to the membership in the Terms of Reference to add an additional Non-Executive Director from each Trust. The Boards-in-Common are invited to review and approve this amendment in the November meeting.

2.3 Programme Delivery Group (Attachment 2)

The Programme Delivery Group is an executive group, accountable to the Boards-in-Common through the Transition Steering Group, which provides executive leadership of the transition and holds the seven workstreams to a single plan. It monitors progress against the safe landing conditions and assesses readiness at the go/no-go decision for final decision-making by the Boards-in-Common.

The group is chaired by the two Chief Executives on a quarterly rotation and meets weekly. Its

membership includes the executive leads for each workstream, staff-side, clinical and local authority representatives, and the Integrated Care Board.

The Boards-in-Common in the October meeting provided feedback on the Programme Delivery Group membership outlined in the Terms of Reference. The Terms of Reference have since been updated and approved by the Transition Steering Group to ensure equality of membership for HUTH and NLaG in the Programme Delivery Group and the seven workstreams. The Boards-in-Common are invited to note the amended Terms of Reference in the November meeting.

3. Safe Landing Conditions and Dissolution Timeline (Attachment 3)

3.1 Recommended action

The Boards-in-Common are invited to:

- Approve the ten Safe Landing Conditions as the basis for determining readiness for dissolution of the Humber Health Partnership Group.
- Approve the proposed dissolution timeline, including the planning assumption of 31 March 2027 as the target dissolution date and 31 May 2027 as a contingency date.
- Note that progression to dissolution will be readiness-led and subject to a formal assurance process that will be developed and a go/no-go decision against the approved Safe Landing Conditions.

3.2 Safe landing conditions

The safe landing conditions will determine whether the Group can safely dissolve and HUTH and NLaG are sufficiently prepared to operate as separate sovereign organisations. They ensure that organisational separation takes place only when the necessary leadership, governance, clinical, operational, financial and corporate arrangements are in place, with clear ownership of existing commitments and effective controls over any remaining risks.

Ten Safe Landing Conditions from the Strategic Business Case have been tested and endorsed by the Programme Delivery Group (PDG) and the Transition Steering Group (TSG). These Safe Landing Conditions cover three domains:

- Clinical continuity and patient safety
- Regulatory, corporate and financial continuity
- Leadership and workforce readiness

The Safe Landing Conditions were discussed at the Boards-in-Common Development Session on 4 November. Small amendments to the wording of conditions:

- Safe Landing Condition 1 – updated the wording to specify that every service will have a named accountable executive in “each organisation” rather than “a single organisation”.
- Safe Landing Condition 2 – updated the wording to specify that cross-cover rotas and clinical networks will continue without “disruption” rather than “a gap”.
- Safe Landing Condition 7 – removed the requirement for the IRP Recovery Compact to include agreed financial trajectories.

These conditions will form the basis of a structured assurance process and will determine organisational readiness for dissolution. Consistent with the agreed transition principles, readiness rather than a predetermined date will determine whether dissolution proceeds.

The Boards-in-Common are invited to approve the ten Safe Landing Conditions as the basis for

determining readiness for dissolution of the Humber Health Partnership Group.

3.3 Timeline for dissolution

The proposed timeline works towards a target dissolution date of 31 March 2027, subject to the Safe Landing Conditions being met. A contingency date of 31 May 2027 has been identified should additional time be required. Readiness, rather than the target date, will determine whether dissolution proceeds, through the go/no-go process described below.

Following feedback from the Boards-in-Common Development Session, the timeline has been updated to show that the work does not stop at dissolution. Activities will continue after the dissolution date, with the Programme Delivery Group meeting quarterly during the first year to monitor delivery against trajectory and complete the first review of collaboration arrangements between HUTH and NLaG.

The Boards-in-Common are invited to approve the proposed dissolution timeline, including 31 March 2027 as the target dissolution date and 31 May 2027 as a contingency date.

3.4 Development of assurance approach to support go/no-go decision

Each safe landing condition will require a defined set of evidence demonstrating readiness.

The assurance framework will be developed to establish:

- The specific condition and intended outcome.
- The accountable Executive(s) or workstream lead(s).
- The evidence required to demonstrate completion.
- The agreed acceptance criteria.
- The current assurance assessment.
- Outstanding risks, dependencies and mitigating actions.
- The route for review, challenge and formal sign-off.

The programme will need to distinguish between conditions that have been fully met, conditions where further evidence is required and conditions where outstanding risks may prevent safe separation.

Formal dissolution will be subject to a structured, evidence-based go/no-go process. The Programme Delivery Group and Transition Steering Group will provide the Boards-in-Common with a consolidated readiness assessment against each approved safe landing condition, including outstanding risks, dependencies, exceptions and any proposed transitional arrangements. The precise governance, approval authorities and escalation arrangements for this process will require formal confirmation.

Dissolution should proceed only when the Boards-in-Common and relevant external parties have sufficient assurance that the agreed safe landing conditions have been met and any remaining risks are appropriately controlled.

The Boards-in-Common are invited to note that the assurance framework and approach will be developed for their approval in the December meeting.

4. Overall conclusion

The Transition Programme made positive progress in October, with governance and delivery arrangements established and all seven workstreams reporting on track. The programme is now entering a more complex phase, in which assurance must move from mobilisation to completing

activities and assessing whether both organisations are ready to operate safely and independently.

The assurance framework will be central to this, providing a transparent basis for assessing readiness and informing the go/no-go decision. The transition will remain readiness-led, with existing HHP governance maintained until formally changed, so that patient safety, operational continuity and regulatory commitments are protected throughout.

5. Recommendations

The Boards-in-Common are invited to:

1. Note progress made during October 2026 in mobilising and delivering the Transition Programme, with all seven workstreams currently reporting on track.
2. Approve the amended Terms of Reference for the Transition Steering Group to add two non-executive directors from the Boards-in-Common.
3. Note the amended Terms of Reference for the Programme Delivery Group to ensure equality of representation of HUTH and NLaG, as approved by the Transition Steering Group.
4. Approve the ten Safe Landing Conditions as the basis for determining readiness for dissolution of the Humber Health Partnership Group.
5. Approve the proposed dissolution timeline, including the planning assumption of 31 March 2027 as the target dissolution date and 31 May 2027 as a contingency date.
6. Note that progression to dissolution will be readiness-led and subject to a formal assurance process that will be developed and a go/no-go decision against the approved Safe Landing Conditions.

TRANSITION STEERING GROUP

(Humber Health Partnership)

Membership and Terms of Reference

Reference:	[to confirm]
Version:	0.3
This version issued:	10/11/26
Result of last review:	Amended – additional members
Date approved by owner (if applicable):	N/A
Date approved:	[to confirm]
Approving body:	Boards in Common
Date for review:	Six months from approval [to confirm]
Owner:	Group Chief Executive (HHP)
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)

1. Purpose

1.1 The purpose of the Transition Steering Group is to provide independent oversight of the transition of the Humber Health Partnership to two sovereign trusts, and to give the Boards in Common, the Humber and North Yorkshire Integrated Care Board and NHS England an independent view of progress, risk and readiness for dissolution and / or to escalate risks to the achievement of a safe dissolution.

1.2 The Programme Delivery Group reports to the Transition Steering Group through its Chair for the transition programme. The Transition Steering Group does not direct the workstreams or take delivery decisions, other than deciding matters referred to it by the Programme Delivery Group under paragraph 2.5: the transition workstreams report to the Programme Delivery Group and not to the Transition Steering Group.

1.3 The Transition Steering Group is independently chaired. That independence is the basis on which its opinion is offered to the Boards.

1.4 The Transition Steering Group is not a committee of either board and has no executive powers other than those set out in these terms of reference. Its authority is set out at section 2.

2. Authority

2.1 Following the decision of the Boards in Common of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) to dissolve the Humber Health Partnership and return to two sovereign trusts, the Boards in Common have agreed to establish a group to be known as the Transition Steering Group. The Transition Steering Group derives its authority by delegation from the Boards in Common.

2.2 The Transition Steering Group is authorised by the Boards in Common to seek any information or assurance it requires from the Programme Delivery Group, the transition office and any transition workstream, and all employees are directed to co-operate with any such request.

2.3 The Transition Steering Group gives the Boards in Common an independent opinion on the Programme Delivery Group's recommendations on the safe landing conditions, the start of shadow running, on go or no-go, and on the dissolution date, before the Boards decide. Where it does not support a recommendation, it says so and gives its reasons.

2.4 The Transition Steering Group may escalate any matter directly to the Boards in Common, to the Integrated Care Board and to the NHS England Intensive Recovery Programme Oversight Group, without first referring it to the Programme Delivery Group.

2.5 Where the Programme Delivery Group cannot reach a decision on a matter within its authority, it refers the matter to the Transition Steering Group for a decision. The Programme Delivery Group also refers to the Transition Steering

Group, before it is acted on, any decision that would affect the two organisations differently. Where the Transition Steering Group cannot reach a decision, it refers the matter to the Boards in Common under paragraph 6.10.

2.6 The Boards in Common authorise the Transition Steering Group to approve the terms of reference of the Programme Delivery Group and any changes to them, other than the delegated authority at Appendix A of those terms, which is reserved to the Boards in Common.

2.7 The schedule of matters delegated to the Transition Steering Group and those which are reserved to the Boards in Common are set out in Appendix A.

2.8 Nothing in these terms of reference alters the decisions reserved in law to the Boards in Common, the responsibilities of each Trust's Accountable Officer, or the operational decisions of the joint executive team, until dissolution.

3. Accountability & Reporting Arrangements

3.1 The Transition Steering Group is accountable to the Boards in Common.

3.2 The Transition Steering Group will report to the Humber Health Partnership Boards in Common as required, and in any event at each decision point on shadow running, go or no-go and the dissolution date.

3.3 The Transition Steering Group will report to the NHS England Intensive Recovery Programme Oversight Group as required. Transition reporting sits alongside recovery reporting into the Intensive Recovery Programme, and not instead of it.

3.4 The Transition Steering Group receives from the Programme Delivery Group the transition plan and delivery position, the transition risk register and, once approved, the safe landing conditions and progress against them, together with any recommendation for the Boards.

3.5 The Independent Chair and both Chief Executives will meet ahead of each Board decision point, so that the independent opinion and the executive recommendation reach the Boards at the same time and any difference between them is visible.

3.6 On the dissolution date, the Terms of Reference for the Transition Steering Group will be reviewed.

4. Responsibilities

4.1 To review progress against the transition plan and to form an independent view of whether the transition is being delivered safely and to time.

4.2 To review the transition risk register and to satisfy itself that risks are properly identified, owned and mitigated, and that the escalation threshold is being applied.

4.3 To satisfy itself that the safe landing conditions are being developed to an adequate standard and, once approved, that they are being honestly tested.

4.4 To give the Boards in Common an independent opinion on the recommendation on the safe landing conditions, the recommendation to start shadow running, on go or no-go, and on the dissolution date.

4.5 To decide matters referred by the Programme Delivery Group under paragraph 2.5, and to refer to the Boards in Common any matter on which it cannot reach a decision.

4.6 To test that the transition is not diverting leadership attention or resource from recovery and from business as usual, and to say so plainly to the Boards, the Integrated Care Board and NHS England where it is.

4.7 To satisfy itself that the collaboration agreement will be in force before the Group is dissolved; that existing cross-Humber clinical arrangements continue unless changed through an explicit agreed decision; and that appropriate ICB-led commissioning and contractual arrangements are in place for services that will continue to operate across the Humber.

4.8 To provide independent challenge on the sequencing of appointments to the two boards and executive teams, and on whether each organisation will be able to run itself from the dissolution date.

4.9 To provide recommendations to the Boards in Common, the Integrated Care Board and NHS England on the IRP Recovery Compact.

4.10 To escalate to the Boards in Common, the Integrated Care Board and NHS England any matter it considers puts a safe dissolution at risk.

4.11 To agree an annual work plan for the Transition Steering Group and monitor its delivery.

4.12 The Transition Steering Group is a time limited group. In the first year after the dissolution date it provides independent oversight of delivery against trajectory, reporting to both Trust Boards and to the NHS England Intensive Recovery Programme. It is stood down by agreement of both Trust Boards, having reported completion of the transition plan and of the first collaboration review, and with the agreement of NHS England through the Intensive Recovery Programme.

5. Membership

Core Membership

- Independent Chair, appointed by the Boards in Common in agreement with NHSE IRP
- Chief Executive, Hull University Teaching Hospitals NHS Trust (current Group Chief Executive), who is Accountable Officer for the transition until dissolution
- Interim Chief Executive, Northern Lincolnshire and Goole NHS Foundation Trust
- Chief Executive, Humber and North Yorkshire Integrated Care Board

- Two Non-executive Directors, Hull University Teaching Hospitals NHS Trust
- Two Non-executive Directors, Northern Lincolnshire and Goole NHS Foundation Trust
- Interim NHS England North East and Yorkshire Regional Director
- NHS England Deputy Chief Financial Officer

Other Persons Attending Meetings (as the agenda dictates / by invitation)

- Interim Chief Policy Officer, Humber Health Partnership
- Workstream executive owners, by invitation of the Chair for a specific item only, other than the Chief Executives, who are core members and co-lead the Strategy workstream. The workstreams report to the Programme Delivery Group and do not report to the Transition Steering Group
- Other senior officers of either Trust, and other people invited by the Chair, for a specific item

5.1 The Independent Chair must have no current executive or non-executive role in either Trust, and no material interest in the outcome of the transition. The appointment, its term and any remuneration are matters for the Boards in Common.

5.2 Members may nominate deputies to represent them in their absence. Deputies must be of sufficient seniority, must understand the work of the Transition Steering Group, and must be able to decide in the member's absence. A deputy attending without that authority does not count towards the quorum. The Independent Chair may not nominate an executive of either Trust as deputy.

5.3 Members act in the interests of patients and of the Humber population as a whole, and not solely in the interests of the organisation they come from.

6. Procedural Issues

Frequency of Meetings

6.1 Meetings will be held fortnightly from mobilisation. Once the transition is established the Transition Steering Group may move to monthly, and may return to fortnightly or weekly as the dissolution date approaches. The frequency is set by the Independent Chair and confirmed at each review point. Where required and in agreement with the Chair, additional meetings may be convened to consider matters that require urgent attention, including ahead of a Board decision point.

Chairperson

6.2 The Transition Steering Group shall be chaired by an Independent Chair appointed by the Boards in Common.

6.3 In the absence of the Independent Chair, the meeting is deferred unless the members present agree that the business is routine, in which case a member

who is not an executive of either Trust will chair. No independent opinion under paragraph 2.3 may be given at a meeting the Independent Chair has not chaired.

Secretary

6.4 Secretarial support to the Transition Steering Group will be provided by the transition office, which will agree the agenda with the Independent Chair, collate and circulate papers, maintain the action tracker and prepare draft reports for the Chair's approval.

Attendance

6.5 Attendance by core members is required at a minimum of 75% of meetings. Attendance is recorded and reported to the Boards in Common. Repeated non-attendance is escalated by the Chair to the relevant Board, the Integrated Care Board or NHS England.

Quorum

6.6 Meetings will be deemed to be quorate when the Independent Chair and at least four other members or authorised deputies are present, including at least one member from each Trust and at least one member from NHS England.

6.7 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.8 Meetings may be held in person or virtually. Members attending virtually count towards the quorum.

Decision Making

6.9 Wherever possible, members will seek to reach a common view. Where a common view cannot be reached on an opinion the Transition Steering Group is to give the Boards, the opinion of the Independent Chair is reported together with any dissent, so that the Boards see the difference rather than a compromise.

6.10 Where agreement cannot be reached on a matter that has to be settled, the Independent Chair reports the differing views and refers the matter to the body holding the relevant statutory or delegated authority, including NHS England through the Intensive Recovery Programme as appropriate.

6.11 The Chief Executives may present, but do not take part in deciding, any matter referred under paragraph 2.5 or the approval of the Programme Delivery Group's terms of reference under paragraph 2.6.

Administration and Minutes of Meetings

6.12 Notice of a meeting shall be sent to all members no less than seven days in advance, containing the date, time and location of the meeting.

6.13 Formal agendas and minutes will be prepared and distributed with supporting papers no less than 3 clear working days prior to each meeting. No late papers

will be accepted without the express agreement of the Chair, and papers tabled on the day are for information only.

6.14 Minutes of each meeting, together with an action log, will be circulated within 5 working days of each meeting for comment by members, and presented to the Boards in Common with the Transition Steering Group's report.

6.15 A standing agenda is set out at Appendix B.

7. Monitoring & Compliance

7.1 In accordance with the requirements of good governance and in order to ensure its ongoing effectiveness, the Transition Steering Group will evaluate its performance and attendance levels at each review point set out at section 8. Where gaps in compliance are identified, an action plan will be developed and implementation monitored by the Transition Steering Group, and the outcome reported to the Boards in Common.

7.2 The effectiveness of the transition governance arrangements will also continue to be tested as part of other relevant internal and external assurance processes, including the NHS England Intensive Recovery Programme, internal audit and external governance reviews.

8. Review

8.1 These Terms of Reference take effect on approval by the Boards in Common.

8.2 They will be reviewed six months after approval, at the start of shadow running and at the dissolution date, and may be reviewed at other times reflecting the experience of the Transition Steering Group in fulfilling its functions. The Transition Steering Group will recommend any changes to the Boards in Common for approval.

Date approved:

Approver:

Date of next review:

The electronic copy of this document is held by Document Control within the Office of the Group Director of Assurance.

Appendix A

Matters Delegated to the Transition Steering Group (Humber Health Partnership)

Type of Matter	Delegated to the Transition Steering Group	Reserved for the Boards in Common
Governance arrangements	*Approving the terms of reference of the Programme Delivery Group and changes to them, under paragraph 2.6.*	*The decisions delegated to the Programme Delivery Group (Appendix A of its terms of reference)*
General	Forming and reporting an independent view on the delivery, risk and readiness of the transition	
	Seeking any information or assurance it requires from the Programme Delivery Group, the transition office and any workstream	
	Receiving any decision that would affect the two organisations differently before it is acted on, and deciding it under paragraph 2.5	
	Referring a matter that cannot be agreed to the body holding the relevant statutory or delegated authority, including NHS England through the Intensive Recovery Programme as appropriate, under paragraph 6.10	
Programme	Approving the transition plan for submission to the Boards in Common	Approval of the transition plan
	Approving transition funding and the funding route for submission to the Boards in Common	Approval of transition funding and of the funding route
Risk	Reviewing the transition risk register and escalating any matter it considers puts a safe dissolution at risk	Acceptance of escalated risk
Dissolution	Giving the Boards in Common an independent opinion on the Programme Delivery Group's recommendations on the start of shadow running, on go or no-go and on the dissolution date	Approval of the start of shadow running The go or no-go decision The dissolution date
	Satisfying itself that the safe landing conditions are adequate and honestly tested	Approval of the safe landing conditions
Collaboration	Independent challenge on readiness of the collaboration agreement and of what continues to be shared, and approving the agreement for submission to the Boards in Common	Approval of the collaboration agreement
Appointments	Independent challenge on the sequencing of appointments to the two boards and executive teams	

Recovery	Testing that the transition is not diverting attention or resource from recovery and business as usual, and reporting where it is	
Delivery	Deciding matters referred by the Programme Delivery Group that fall within its delegated authority, under paragraph 2.5. The Transition Steering Group does not otherwise direct the workstreams or take delivery decisions.	Matters outside the Programme Delivery Group's delegated authority, on the recommendation of the Transition Steering Group.

Appendix B

Standing Agenda

	Item	Purpose
1	Declarations of interest, gifts and hospitality, minutes and action log	Record
2	Report from the Programme Delivery Group: delivery position and plan	Assurance
3	Decisions referred by the Programme Delivery Group under paragraph 2.5	Decision
4	Transition risk register and escalations	Assurance
5	Matters for the Boards in Common, the Integrated Care Board and NHS England	Escalation

Appendix C

List of Members

The Chair of the Transition Steering Group is:

Position	Name
Independent Chair	Catherine Skilton

The members of the Transition Steering Group are:

Position	Name
Chief Executive, Hull University Teaching Hospitals NHS Trust (current Group Chief Executive)	Lyn Simpson
Interim Chief Executive, Northern Lincolnshire and Goole NHS Foundation Trust	Therese Patten
Chief Executive, Humber and North Yorkshire Integrated Care Board	Teresa Fenech
Non-executive Directors, Hull University Teaching Hospitals NHS Trust	Alan Downey [To be confirmed]

Non-executive Directors, Northern Lincolnshire and Goole NHS Foundation Trust	Murray Macdonald [To be confirmed]
Interim NHS England North East and Yorkshire Regional Director	Samantha Allen
NHS England Deputy Chief Financial Officer	Nicci Briggs

PROGRAMME DELIVERY GROUP

(Humber Health Partnership)

Membership and Terms of Reference

Reference:	[To confirm]
Version:	0.4
This version issued:	10/11/26
Result of last review:	Amended – Equal representation & clinical members
Date approved by owner (if applicable):	N/A
Date approved:	[To confirm]
Approving body:	Boards in Common
Date for review:	Six months from approval
Owner:	Group Chief Executive
Document type:	Terms of Reference
Number of pages:	15 (including front sheet)
Author / Contact:	Programme Manager, Transition Office

1.0 Purpose

1.1 The purpose of the Programme Delivery Group is to provide executive leadership to the transition of the Humber Health Partnership to two sovereign trusts working under a collaboration agreement, to hold the transition workstreams to a single plan and a single sequence, and to provide assurance to the Boards in Common that the Group can be dissolved without disrupting patients, staff or the recovery trajectory and / or to escalate risks to the achievement of that objective.

1.2 The transition is an organisational and governance change and does not in itself require changes to clinical services. Existing cross-Humber service arrangements will continue by default through the transition and should only change through a specific, agreed decision through the appropriate governance and, where relevant, commissioning route. The Programme Delivery Group exists to make that true, and to be able to demonstrate to both Boards that it is true before the dissolution date is confirmed.

1.3 The Programme Delivery Group is an executive group and not a committee of either board. Its authority is set out at section 2.0.

1.4 The Transition Steering Group, which is independently chaired, provides independent oversight of the transition to the Boards, the Integrated Care Board and NHS England. It has its own terms of reference. The Programme Delivery Group reports into the Transition Steering Group through the Chair, and provides it with the transition plan, the risk register and, once approved, the safe landing conditions and progress against them. The transition workstreams report to the Programme Delivery Group and not to the Transition Steering Group.

1.5 The Programme Delivery Group does not commission clinical service change. This is the responsibility of the Integrated Care Board. Where services or specialties need to operate across the Humber, the Programme Delivery Group will support the ICB in putting in place the necessary commissioning and contractual arrangements.

2.0 Authority

2.1 Following the decision of the Boards in Common of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to dissolve the Humber Health Partnership and return to two sovereign trusts, the Boards in Common have agreed to establish a Transition Steering Group. The Programme Delivery Group terms of reference are approved by the Transition Steering Group under authority given to it by the Boards in Common. The Programme Delivery Group reports to the Boards in Common through the Transition Steering Group.

2.2 The Programme Delivery Group has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the Transition Steering Group. Authorisation by the Programme Delivery Group tests whether a decision is properly worked up, affordable and safe; it does not test whether the Group would have made the same decision itself.

2.3 The Programme Delivery Group is authorised by the Transition Steering Group to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within these terms of reference, and to require any workstream to bring a decision to it. This includes referral of matters for consideration to the Transition Steering Group.

2.4 The Programme Delivery Group recommends the start of shadow running, go or no-go, and the dissolution date to the Boards in Common through the Transition Steering Group. Each recommendation is considered by the Transition Steering Group, which gives the Boards an independent opinion on it, before the Boards decide.

2.5 The following matters remain with the relevant Trusts Accountable Officer and cannot be delegated to the Programme Delivery Group: the deficit, financial recovery and any regulatory undertakings; and anything that binds both organisations in law until dissolution, including the NLaG provider licence and the CQC registrations.

2.6 Where the Programme Delivery Group cannot reach a decision on a matter within its authority, it refers the matter to the Transition Steering Group for a decision under paragraph 2.5 of the Transition Steering Group's terms of reference.

2.7 Any decision that would affect the two organisations differently is referred to the Transition Steering Group before it is acted on. This includes the allocation of assets, liabilities, staff, services or cost between them, and any decision that leaves one organisation carrying a burden the other does not. The Chair makes the referral, and the Transition Steering Group makes the decision, under paragraph 2.5 of its terms of reference, before it takes effect. This applies from mobilisation.

2.8 The schedule of decisions delegated to the Programme Delivery Group, the role of the Transition Steering Group and those which are reserved to the Boards in Common are set out in Appendix A.

2.9 The delegated authority and reserved decisions at Appendix A are to be confirmed with legal advice and reflected in each Trust’s scheme of delegation during mobilisation.

2.10 Nothing in these terms of reference alters the decisions reserved in law to the Boards in Common, the responsibilities of the relevant Accountable Officer, or the operational decisions of the joint executive team, until dissolution.

3.0 Accountability & Reporting Arrangements

3.1 The Programme Delivery Group is accountable to the Boards in Common and reports to them through the Transition Steering Group.

3.2 The Programme Delivery Group will provide a highlight / escalation report to the Transition Steering Group after each meeting. The Chair presents that report to the Transition Steering Group and answers for the delivery position.

3.3 The Programme Delivery Group will provide the Transition Steering Group with the transition plan and delivery position, the transition risk register and, once approved, the safe landing conditions and progress against them, together with any recommendation it wishes to be made to the Boards.

3.4 Reporting to the NHS England Intensive Recovery Programme Oversight Group on the transition is the responsibility of the Transition Steering Group. Recovery reporting into the Intensive Recovery Programme continues unchanged and is not displaced by transition reporting.

3.5 The Programme Delivery Group will receive a routine report from each of the transition workstreams that report into it, as detailed within the work plan.

4.0 Responsibilities

4.1 To review progress across the transition workstreams, with recovery and business as usual reported alongside them.

4.2 To maintain the dependency map between workstreams, and to require any decision that binds another workstream to come to the Programme Delivery Group rather than be taken within the workstream.

4.3 To hold the transition risk register, covering strategic, programme, operational and workstream risk; to apply the escalation threshold that brings workstream risks onto it; to review mitigations against named owners and timescales; and to agree which risks are escalated through the Transition Steering Group.

4.4 To oversee the transition office and the resourcing of the transition. Recovery and business as usual are separately resourced and remain the responsibility of the relevant Trust executives.

4.5 To agree at mobilisation what data each workstream needs, from whom and by when, and to escalate unmet data requests on a fixed timescale rather than allowing the workstream to absorb the delay.

4.6 To develop the safe landing conditions against which the dissolution date will be tested, submit them, through the Transition Steering Group, to the Boards in Common for approval, and thereafter test them at every meeting from the

start of shadow running so that gaps surface ahead of the go or no-go point. The safe landing conditions have not yet been finalised; agreeing them is a priority task of the Programme Delivery Group, and until they are approved no dissolution date can be recommended.

4.7 To recommend, through the Transition Steering Group, the start date for shadow running, and go or no-go and the dissolution date, to the Boards in Common, the latter tested against the approved safe landing conditions. Where a condition will not be met, to agree the recovery action and a revised date, so that the dissolution date moves by agreement and not by drift.

4.8 To ensure that clinical and staff-side voice is heard on every material transition decision, through the standing places held under section 5.0 and the workstream teams drawn from both Trusts under paragraph 4.14.

4.9 To provide leadership on the engagement of staff, partners, governors, the public and elected representatives, so that the single agreed narrative is carried to every audience across the Humber.

4.10 To provide assurance that the transition does not divert leadership attention from recovery and from business as usual.

4.11 To agree an annual work plan for the Programme Delivery Group, monitor its delivery, and provide feedback on progress and issues to the organisations represented by its members.

4.12 To ensure escalation to the Transition Steering Group of issues covered by these terms of reference and requiring action or decision by the Boards in Common, in accordance with the schedule at Appendix A.

4.13 The Programme Delivery Group oversees seven transition workstreams. Each has a named executive owner who is accountable to the Programme Delivery Group. Until the NLaG interim or substantive executive in the same area of business is appointed, the Group executive is the sole owner; from that appointment, the two co-lead the workstream, under paragraph 5.2:

4.13.1 Strategy, owned by the Group Chief Executive (Chief Executive of HUTH) and the Interim Chief Executive of NLaG as co-leads: establish the direction of each organisation, with full strategies following after dissolution and owned by each Board.

4.13.2 People and leadership, owned by the Group Chief People Officer: put two permanent executive teams in place, manage the transition of care group leadership and handle the joint posts.

4.13.3 Operating models and Integrated Care Board commissioning, owned by the Group Chief Delivery Officer: give each organisation a working structure on day one and one model for how the two work together, and lead the commissioning conversation with the Integrated Care Board.

4.13.4 Governance, Board and legal, owned by the Group Board Secretary: constitute two sovereign boards including chairs, non-executive directors and committees; and unpick what has been joined in law, including contracts, licences, leases, assets and liabilities.

4.13.5 Communications and engagement, owned by the Group Director of Communications: carry the single agreed narrative to every audience across the Humber.

4.13.6 Quality, safety and clinical continuity, owned by the Group Deputy Chief Medical Officer and Group Deputy Chief Nurse Officer as co-lead: ensure every service, rota and clinical network continues without a gap through dissolution.

4.13.7 Finance and resources, owned by the Group Chief Financial Officer: separate ledgers, banking and contracts, and resource the transition.

4.14 Below executive level, each workstream team is drawn equally from both Trusts, with at least one named representative from HUTH and one from NLaG in each area of business it covers. This is so that staff in both organisations can see that the arrangements they will work under after dissolution were developed with an equal voice from each. The representatives are not members of the Programme Delivery Group but may be invited to attend for items on their workstream, under section 5.0.

4.15 The Programme Delivery Group is a time limited group. In the first year after the dissolution date, it monitors delivery against trajectory, reporting to the Transition Steering Group, with its membership revised at the dissolution date to reflect two sovereign organisations. It is stood down by agreement of the Transition Steering Group, having reported completion of the transition plan and of the first collaboration review.

5.0 Membership

Core Membership

- Chair (rotating quarterly), being one of:
  - Chief Executive of Hull University Teaching Hospitals NHS Trust (current Group Chief Executive), who is Accountable Officer for the transition until dissolution
  - Interim Chief Executive, Northern Lincolnshire and Goole NHS Foundation Trust
- Programme Lead of the Transition Office
- Group Chief Executive (Chief Executive of Hull University Teaching Hospitals NHS Trust) and the Interim Chief Executive of Northern Lincolnshire and Goole NHS Foundation Trust as co-leads (Strategy)
- Group Chief People Officer (People and leadership)
- Group Chief Delivery Officer (Operating models and ICB commissioning)

- Group Board Secretary (Governance, Board and legal)
- Group Director of Communications (Communications and engagement)
- Group Deputy Chief Medical Officer / Group Deputy Chief Nurse Officer (Quality, safety and clinical continuity)
- Group Chief Financial Officer (Finance and resources)
- Interim or substantive executives of NLaG, from appointment, as workstream co-leads (paragraph 5.2)
- Site based Chief Medical Officers and Chief Nursing Officers, once appointed
- Staff-side representative from each Trust
- Clinical representative, North bank
- Clinical representative, South bank
- Local authority representative, North bank
- Local authority representative, South bank
- Executive Director of Insight and Commissioning Strategy, Humber and North Yorkshire Integrated Care Board

Other Persons Attending Meetings (as the agenda dictates / by invitation)

- The Independent Chair of the Transition Steering Group, by invitation
- Other senior officers of either Trust, and other people invited by the Chair with the support of members, for a specific item

5.1 The Chair is the reporting line between the Programme Delivery Group and the Transition Steering Group. The Chair presents the Programme Delivery Group's report to each meeting of the Transition Steering Group, carries its recommendations, and brings back the matters the Transition Steering Group refers to it.

5.2 Group executive contracts are held by Hull University Teaching Hospitals NHS Trust, so Group executive roles become HUTH roles and the Group Chief Executive is the Chief Executive of HUTH. Once NLaG executive appointments are made (interim or substantive), they then join the Programme Delivery Group as a full member, succeeded by the substantive appointee. From appointment, each interim executive co-leads the relevant workstream with the Group executive owner named at paragraph 4.13, in the same way that the two Chief Executives co-lead the Strategy workstream. Both chief executives sit on the Programme Delivery Group and the Transition Steering Group, and lead their own organisations from the start of shadow running. The respective responsibilities during shadow running will be clearly defined within the transition plan and schemes of delegation.

5.3 Clinical and staff-side voice is built into the Programme Delivery Group from the start, rather than consulted afterwards. Clinical leadership is from the

Chief Medical Officers and Chief Nursing Officers once appointed, together with a clinical representative from the north bank and from the south bank.

5.4 Members may nominate deputies to represent them in their absence. Deputies must be of sufficient seniority, must understand the work of the Programme Delivery Group, and must be able to decide in the member's absence. A deputy attending without that authority does not count towards the quorum.

5.5 Members act in the interests of patients and of the Humber population as a whole, and not solely in the interests of the organisation or department they come from.

5.6 Membership of the Programme Delivery Group is built on parity between the two Trusts, so that the views of both are heard and weighed equally. The two Chief Executives have equal standing and the Chair rotates between them; staff-side, clinical and local authority representation is drawn equally from the north bank and the south bank; NLaG executives join as members and co-lead their workstreams from appointment, under paragraph 5.2; and each workstream team is drawn equally from both Trusts, under paragraph 4.14.

6.0 Procedural Issues

Frequency of Meetings

6.1 Meetings will be held weekly from mobilisation to the dissolution date, and quarterly in the first year after dissolution. Where required and in agreement with the Chair, additional meetings may be convened to consider matters that require urgent attention.

Chairperson

6.2 The Programme Delivery Group shall be chaired by either the Chief Executive of Hull University Teaching Hospitals NHS Trust (the current Group Chief Executive) or the interim Chief Executive of Northern Lincolnshire and Goole NHS Foundation Trust, rotating quarterly. The Chief Executive of HUTH chairs initially whilst the Chief Executive of NLaG is appointed. Chairing does not change Accountable Officer responsibilities under paragraph 2.5.

6.3 In the Chair's absence, the other Chief Executive takes the meeting. If both are absent, the Chair nominates a member to take the meeting. A member taking the meeting under this paragraph may not take a decision under paragraph 6.5 or make a recommendation under paragraph 2.4; those items are deferred to the next meeting.

6.4 Where a decision would materially benefit or disadvantage one Trust relative to the other, both Chief Executives step back from the decision, and the Chair refers the matter to the Independent Chair of the Transition Steering Group under paragraph 2.7. The recusal and the referral are recorded in the minutes.

6.5 Between meetings the Chair, with the agreement of the other Chief Executive, may take a decision within the authority of the Programme Delivery Group, after consulting the members whose workstreams are affected. The power does not extend to a decision that is material to the transition plan or its cost, that cannot readily be reversed, or that would affect the two organisations differently; those wait for a meeting or, where they cannot wait, go to the Transition Steering Group under paragraph 2.7. The Chair notifies the Independent Chair of the Transition Steering Group of any decision taken under this paragraph within two working days, and it is reported to the next meeting and recorded in the minutes.

Secretary

6.6 Secretarial support to the Programme Delivery Group will be provided by the transition office, which is resourced in addition to current Group capacity so that the Programme Delivery Group has sufficient resource to carry out its duties.

6.7 The transition office maintains the transition risk register, the dependency map and, once the safe landing conditions are approved, the tracker against them, and holds the record of decisions.

Attendance

6.8 Members are expected to attend every meeting, and attendance by core members is required at a minimum of 75% of meetings. Attendance is recorded and reported to the Transition Steering Group. Repeated non-attendance, or a gap in workstream leadership that is not filled, is escalated by the Chair to the relevant Board.

Quorum

6.9 Meetings will be deemed to be quorate when the Chair or a nominated deputy and at least six other members or authorised deputies are present, including at least one member from each Trust.

6.10 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.11 Meetings may be held in person or virtually. Members attending virtually count towards the quorum.

Decision Making

6.12 Wherever possible, members of the Programme Delivery Group will seek to make decisions and recommendations based on consensus. Where the Programme Delivery Group cannot reach a decision on a matter within its authority, it refers the matter to the Transition Steering Group for a decision under paragraph 2.5 of the Transition Steering Group's terms of reference.

Administration and Minutes of Meetings

6.13 Notice of a meeting shall be sent to all members no less than seven days in advance, containing the date, time and location of the meeting.

6.14 Formal agendas and minutes of the previous meeting will be prepared and distributed with supporting papers no less than 2 clear working days prior to each meeting. No late papers will be accepted without the express agreement of the Chair. A member wishing to include an item must notify the Chair through the secretariat no later than seven days before the meeting; inclusion is at the discretion of the Chair.

6.15 Minutes of each meeting, together with an action log and the risks and issues log, will be circulated within 3 working days of each meeting for comment by members. The action log will act as a reminder for the relevant action lead and will assist in ensuring that actions are completed within the agreed timescale.

6.16 Decisions and their rationale are documented as each workstream proceeds, so that continuity does not depend on individuals.

6.17 A standing agenda is set out at Appendix B.

7.0 Monitoring & Compliance

7.1 In accordance with the requirements of good governance and in order to ensure its ongoing effectiveness, the Programme Delivery Group will evaluate its performance and attendance levels at each review point set out at section 8.0. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the Programme Delivery Group. The outcome, including any agreed actions or improvements, will be reported to the Boards in Common through the Transition Steering Group.

7.2 The effectiveness of the transition governance arrangements will also continue to be tested by the Transition Steering Group and as part of other relevant internal and external assurance processes, including the NHS England Intensive Recovery Programme, internal audit and external governance reviews.

8.0 Review

8.1 These Terms of Reference take effect on approval by the Transition Steering Group.

8.2 They will be reviewed six months after approval, at the start of shadow running and at the dissolution date, and may be reviewed at other times reflecting the experience of the Programme Delivery Group in fulfilling its functions. The Programme Delivery Group will recommend any changes to the Transition Steering Group for approval. Changes to the authority at

section 2.0 or the delegations at Appendix A are approved by the Boards in Common, on the recommendation of the Transition Steering Group.

Appendix A

Decisions Delegated to the Programme Delivery Group (Humber Health Partnership)

Type of Decision	Delegated to the Programme Delivery Group	Reserved to the Boards in Common, through the Transition Steering Group
General	Making decisions on any matters of business within its remit and / or ensuring relevant decisions are referred to the Boards in Common	
	Investigating or having investigated and / or seeking further action or assurance in relation to any activity within these terms of reference	
	Referring any decision that would affect the two organisations differently to the Transition Steering Group before it is acted on, under paragraph 2.7	
Programme	Holding the transition workstreams to a single plan and a single sequence, and resolving the dependencies between them	Approval of the transition plan for submission to the Boards in Common
	Overseeing the transition office and the resourcing of the transition	Approval of transition funding and of the funding route for submission to the Boards in Common
Risk	Holding the transition risk register and applying the escalation threshold; agreeing which risks are escalated	Acceptance of risks escalated above the agreed threshold
Dissolution	Developing the safe landing conditions and submitting them for approval; testing them at every meeting from the start of shadow running	Approval of the safe landing conditions for submission to the Boards in Common
	Recommending the start date for shadow running	Approval of the start of shadow running for submission to the Boards in Common
	Recommending go or no-go and the dissolution date, tested against the approved safe landing conditions, for independent opinion by the Transition Steering Group	The go or no-go decision for submission to the Boards in Common The dissolution date for submission to the Boards in Common
Collaboration	Overseeing development of the collaboration agreement and the inventory of what continues to be shared	Approval of the collaboration agreement for submission to the Boards in Common

Chief executives	Authorising the operating model, structures and appointments below board level for each organisation, and the service arrangements each will inherit on day one. Where the two chief executives cannot agree, the Programme Delivery Group decides; where it cannot, the matter is referred to the Transition Steering Group under paragraph 2.6. Both Chief Executives recuse themselves on a matter that would affect the two organisations differently	Board-level appointments
Reserved to the Chair	None. The following cannot be delegated: the deficit, financial recovery and any regulatory undertakings; anything binding both organisations in law until dissolution, including the NLaG provider licence and the CQC registrations	As advised by the joint Chairs

Appendix B

Standing Agenda

	Item	Purpose	Frequency of review
1	Declarations of interest, gifts and hospitality, minutes and action log	Record	Weekly
2	Delivery against the transition plan, by workstream	Review	Weekly
3	Dependencies between workstreams, and decisions escalated from a workstream	Decision	Weekly
4	Transition risk register, mitigations and the risks to be escalated	Review and decision	Weekly
5	Safe landing conditions, their development and, once approved, delivery against them	Assurance	Monthly, then weekly from the start of shadow running
6	Recovery and business as usual, reported alongside	Assurance	Monthly
7	Transition office resourcing, cost and the funding route	Review	Monthly
8	Communications and engagement, including what is said next and to whom	Decision	Fortnightly
9	Matters for the Transition Steering Group and the Boards, including any decision that would	Escalation and referral	Weekly

	affect the two organisations differently, referred under paragraph 2.7		

Appendix C

List of Members

The Chair of the Programme Delivery Group rotates quarterly between:

Position	Name
Chief Executive, Hull University Teaching Hospitals NHS Trust (current Group Chief Executive)	Lyn Simpson
Interim Chief Executive, Northern Lincolnshire and Goole NHS Foundation Trust	Therese Patten

Both Chief Executives are members of the Programme Delivery Group whether or not they are in the Chair.

The members of the Programme Delivery Group are:

Position	Name
Group Chief Executive (Chief Executive of Hull University Teaching Hospitals NHS Trust)	Lyn Simpson
Interim Chief Executive of Northern Lincolnshire and Goole NHS Foundation Trust	Therese Patten
Group Chief People Officer	Helen Marks
Group Chief Delivery Officer	Samuel Peate
Group Board Secretary	Keith Haynes
Group Director of Communications	Myles Howell
Group Deputy Chief Medical Officer	Peter Sedman
Group Deputy Chief Nurse Officer	Joanne Ledger
Group Chief Financial Officer	Emma Sayner
Interim or substantive executives, Northern Lincolnshire and Goole NHS Foundation Trust, from appointment, as workstream co-leads	To be confirmed
Site based Chief Medical Officers, once appointed	To be confirmed
Site based Chief Nursing Officers, once appointed	To be confirmed
Staff-side representative, Hull University Teaching Hospitals NHS Trust	Rachel Waters
Staff-side representative, Northern Lincolnshire and Goole NHS Foundation Trust	Andrea Smith
Clinical representative, north bank	Colin Vize
Clinical representative, south bank	Sakkaf Ahmed Aftab
Local authority representative, north bank	To be confirmed

Local authority representative, south bank	Sharon Wroot
Executive Director of Insight and Commissioning Strategy, Humber and North Yorkshire Integrated Care Board	Anja Hazebroek
Programme Lead, Transition Office	Ben Smith / Ryan Sutton

HUTH & NLAG Transition Programme

Safe Landing Conditions and Dissolution Timeline

6 November 2026

NHS
Humber Health
Partnership

The safe landing conditions outlined in the business case have been updated based on feedback from the Boards-in-Common

NHS Humber Health Partnership

Clinical continuity and patient safety

SL1 Every service will have a named accountable executive in each organisation and a clear line of delegation and authority to act.

SL2 Cross-cover rotas and clinical networks will continue without disruption.

SL3 Patient records, patient administration, information governance and statutory responsibilities will be continuous, for example with Caldicott accountability held in each organisation.

Regulatory, corporate and financial continuity

SL4 CQC registration and the NLAG provider licence will remain unaffected, sitting with each organisation as they do today.

SL5 Payroll, employment contracts and rotas will continue to run without interruption, and anything found to be shared will have a named owner in each organisation.

SL6 Ledgers, banking, supplier contracts and ICB contracts will be in place and tested.

SL7 The IRP Recovery Compact will be signed by all parties before the dissolution date, setting out the actions owned by the Trusts, ICB and NHS England to support long-term clinical and financial sustainability.

Leadership and workforce

SL8 Both boards will be constituted, quorate and meeting before the dissolution date.

SL9 Two executive teams will be appointed and in post.

SL10 Every member of staff knows which organisation employs them and who they report to on day 1 of dissolution.

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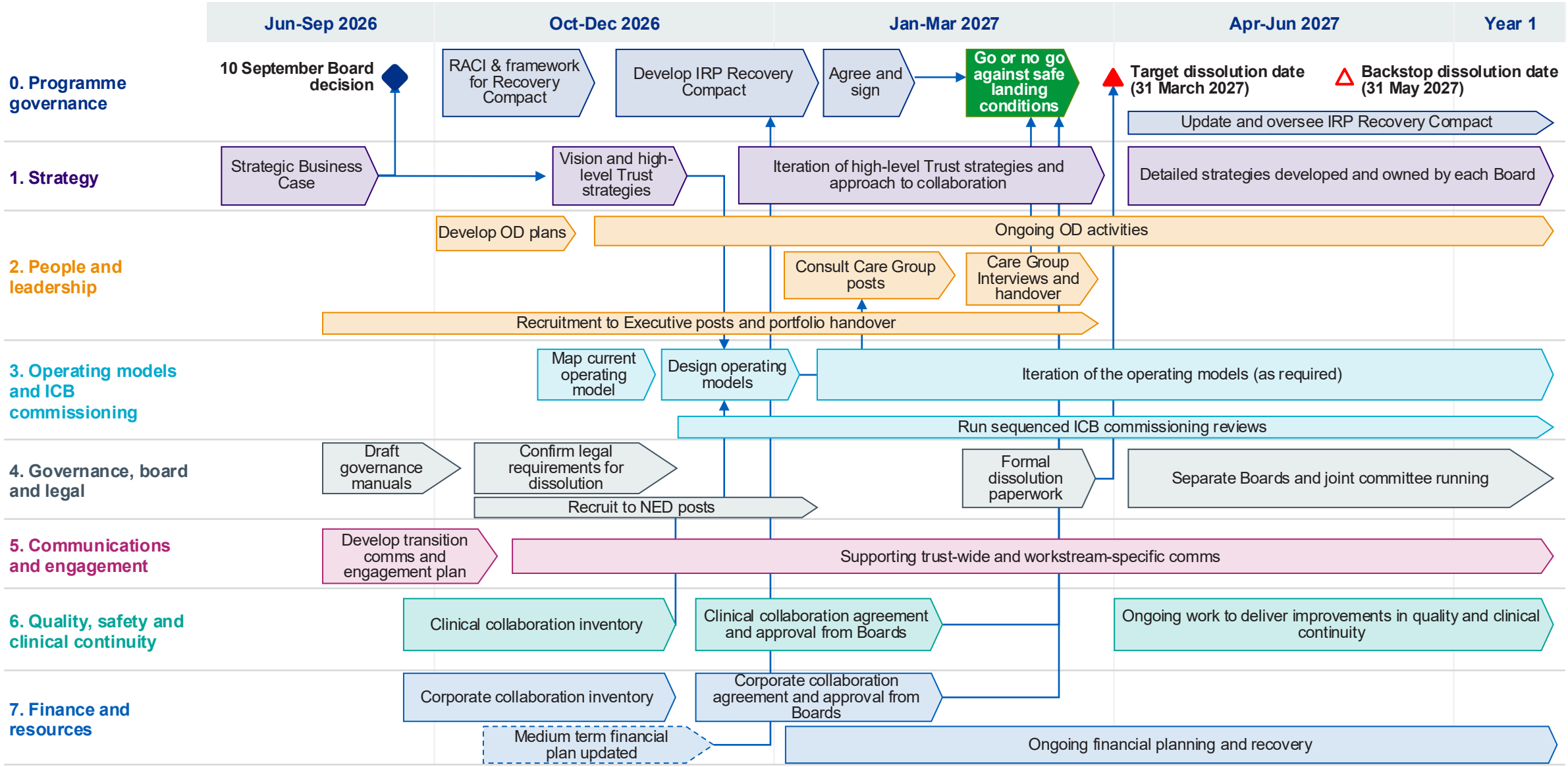
At a high-level, there are seven workstreams that run in parallel, working to a target dissolution date of 31 March 2027

NHS Humber Health Partnership



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Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)305

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 November 2026
Director Lead	Hilda Gwilliams, Group Chief Patient Safety Officer
Contact Officer / Author	Hilda Gwilliams, Group Chief Patient Safety Officer
Title of Report	Care Quality Commission (CQC) Update Report
Executive Summary	This report provides the Trust Boards-in-Common with an update on Care Quality Commission (CQC) regulatory activity and the improvement actions being taken across Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Recent assessments demonstrate improvement across several services and domains. However, following the Well-led assessments in June 2026, CQC issued section 29A Warning Notices for both HUTH and NLAG. The notices confirmed that sustained improvement is required in governance, patient safety learning, complaints and PALS response and learning and infection prevention and control. The report sets out improvements made to date. The immediate priority is to maintain delivery momentum; further strengthen leadership and accountability and ensure the organisational transition does not disrupt progress against regulatory requirements. This will keep patient care at the centre of improvement activity, while maintaining readiness for the further CQC Well-Led assessment expected in Q1 2027/28 and embedding a sustainable approach to continuous improvement. The Trust Boards-in-Common are invited to: • **Note** the improvements through recent CQC assessments. • **Receive** assurance on progress against the wider range of CQC recommendations inclusive of section 29A Warning Notices. • **Recognise** that further work is required to embed and sustain improvements. • **Note** the planned further CQC assessment in Q1 of 2027/28 and the need to maintain momentum during the transition to two sovereign Trusts. • **Support** continuous oversight of the remaining regulatory actions, risks and delivery trajectories via the IIP Oversight Group.
Background Information and/or Supporting Document(s) (if applicable)	Care Quality Commission inspection and assessment findings; CQC Section 29A Warning Notices; Integrated Improvement Plan; Carnall Farrar independent organisational review

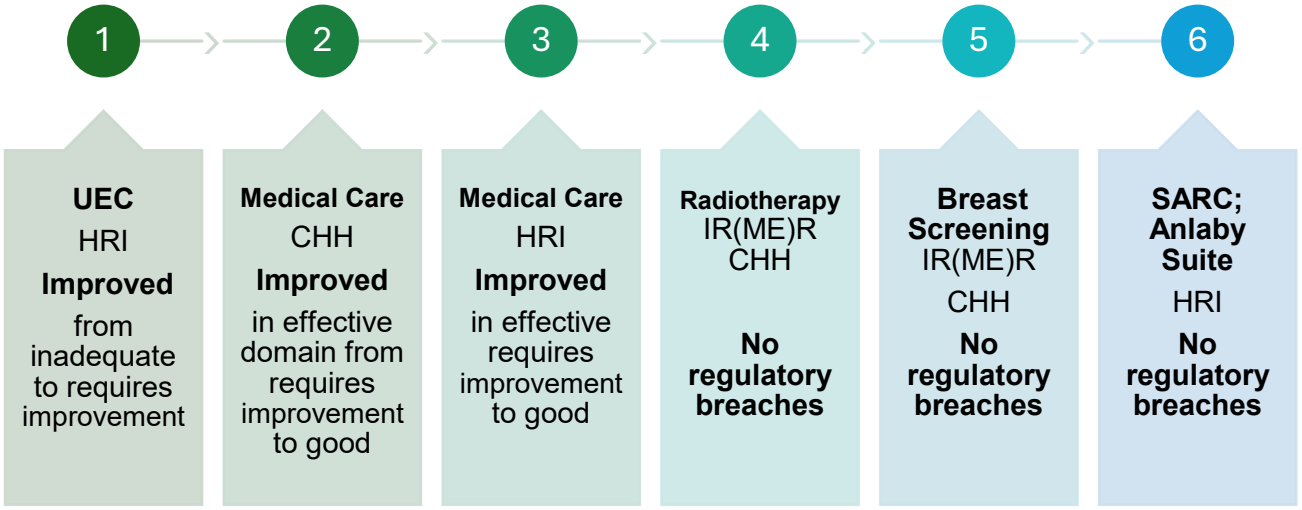
Prior Approval Process	Progress has been overseen through the relevant executive, quality, improvement and governance forums. The report is presented to the Trust Boards-in-Common for assurance.
Financial Implication(s) (if applicable)	No specific financial approval is requested through this report. Delivery of improvement actions and the transition to two sovereign Trusts may have resource implications, which will be managed through established financial and governance processes.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Equality, diversity and inclusion, patient accessibility and health inequalities are considered throughout delivery of the improvement workstreams, including use of patient and staff feedback to inform improvement actions.
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

1. Introduction and background

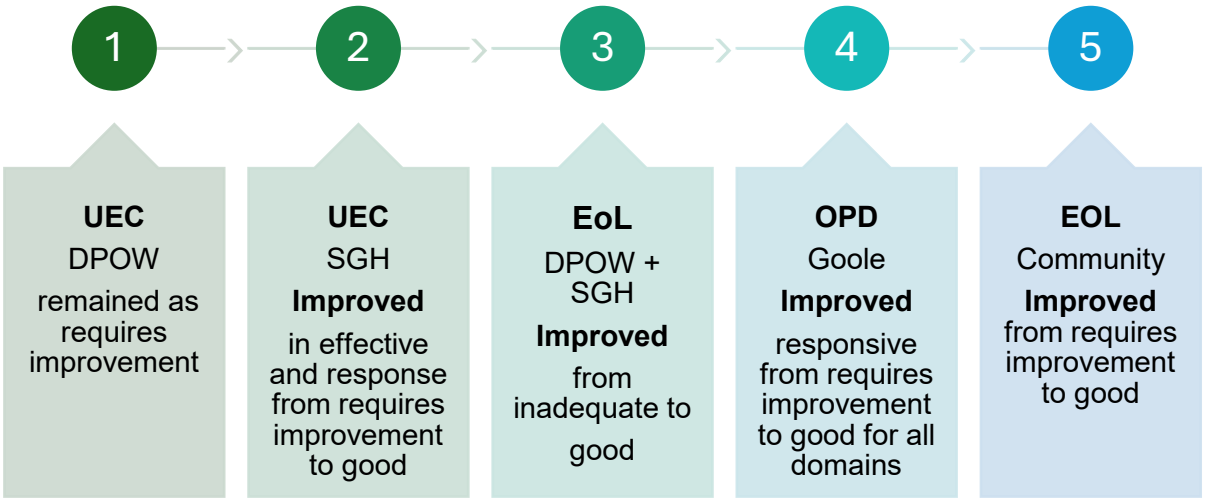
1.1 The Humber Health Partnership (HHP) continues to operate in a highly challenging environment. The Partnership remains within the lowest segment of the NHS Oversight Framework (NOF), and whilst the Care Quality Commission (CQC) outcomes for 2025/26 show improvements, further continuous improvement work is required to achieve an overall good rating. This reflects the scale of the improvement challenge facing the organisation and the need for sustained demonstrable progress across several critical domains.

1.2 CQC's formal assessment journey since September 2025 has seen the following improvements.

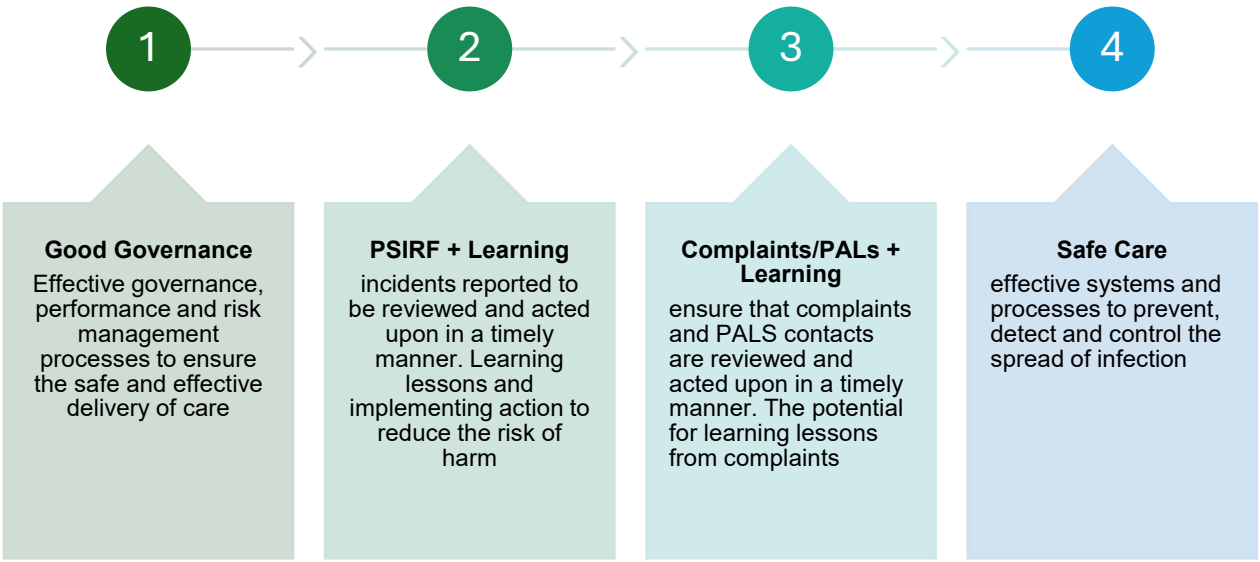
HUTH CQC outcomes demonstrate continuous improvement across 6 services throughout 2025/26.



NLAG CQC outcomes demonstrate continuous improvement across 4 services throughout 2025/26.



1.3 CQC completed a Well-Led assessment at HUTH and NLAG in June 2026. On the 28 July, under Section 29A of the Health and Social Care Act 2008, issued warning notices to notify the Partnership that CQC has formed the view that the quality of health care provided by both Trusts for the regulated activities relating to treatment of disease, disorder or injury requires significant improvement across 4 themes below.



1.4 The Partnership received confirmation from CQC that a further assessment of Well-led incorporating the Warning Notices 29A will take place in Q1 2027/28.

2. Safe, Effective, Caring and Responsive Key Lines of Enquiry (KLOE) Improvements

The KLOE's are the foundation for the CQC's assessment framework, which is used to evaluate the quality of care provided in healthcare. The following section provides examples of improvements made across the Group in response to findings from past CQC inspections. The examples are drawn from completed regulatory actions and improvements seen since previous inspections of the services.

Safe domain

2.1 During the inspection of Urgent and Emergency Care (UEC) at Diana Princess of Wales (DPOW) hospital and Scunthorpe General Hospital (SGH) on 20 and 21 January 2026, it was found that the service was in breach of Regulation 17: Good Governance as the paediatric waiting area at both sites were not compliant with national standards, as there was no audio or visual separation from the adult waiting area which posed a potential risk to children.

Work has since been completed to segregate the paediatric areas from the main waiting areas with a glazed front and door. The area also includes a child-friendly mural, helping to create a more welcoming and reassuring environment for younger patients and their families.

2.2 During the inspection of Outpatients at Goole District General Hospital on 10 and 11 February 2026, it was found that the service was in breach of Regulation 12: Safe Care and Treatment and should ensure that staff have access to the appropriate documents to be able to record the care and observations provided.

Since the inspection, all Outpatient Staff at GDH have received WEBV training and are therefore aware of how to record observations. Computers on wheels are now available across all clinics, enabling direct and speedier access to digital records.

2.3 During the inspection of UEC at Hull Royal Infirmary (HRI) on 16 and 17 September 2025, inspectors identified concerns regarding patients spending prolonged periods on trolleys without pressure-relieving equipment.

Since the inspection, the suitability of trolleys has been reviewed by the Tissue Viability Team, with the Essentials Trezzo high-specification foam mattress identified as the preferred trolley mattress for future replacement. Evidence from reported incidents was also reviewed

and demonstrated no patient harm from hospital-acquired pressure damage within the Emergency Department.

2.4 During the same inspection, the CQC identified gaps within the consultant workforce and found that work was ongoing to address gaps in medical staffing rotas.

Since the inspection, all budgeted Emergency Department consultant posts have been filled, with no consultant vacancies remaining. Staffing continues to be monitored against activity and demand through the CQC and risk management processes.

Effective domain

2.5 During the previous CQC inspection of End-of-Life Care at DPOW, the Effective domain was rated Inadequate, with concerns regarding whether clinical care and treatment was consistently delivered in accordance with national guidance and best practice.

At the 2026 inspection, Effective improved to Good. CQC found that care was now delivered in line with current evidence and national guidance, advance care planning and ReSPECT plans were used to support decision-making, and clinical audits monitored outcomes. 62% of patients died in their preferred place of death, exceeding the Trust target of 60%.

Community End of Life Care also demonstrated significant improvement at its inspection on 5 and 6 May 2026, with the service improving from Requires Improvement to Good across all five domains. CQC found that care was being delivered in line with evidence-based guidance, with multidisciplinary working supporting coordinated care across community, primary care, hospice and hospital services. Clinical board rounds, weekly multidisciplinary meetings and twice-daily huddles supported timely review, information sharing and decision-making.

2.6 During the CQC inspection of Urgent and Emergency Care at Hull Royal Infirmary 16 and 17 September 2025, inspectors found significant improvements to streaming and triage arrangements compared with the previous inspection.

Enhanced waiting areas had improved oversight and patient management, senior staff were allocated across clinical areas, and senior clinician-led board rounds and safety huddles were routinely completed. These improvements contributed to the Safe domain improving from Inadequate to Requires Improvement and demonstrate strengthened clinical oversight and management of patients through the Emergency Department.

2.7 Following the IR(ME)R inspection of Radiotherapy at Castle Hill Hospital on 10 March 2026, improvements have been introduced to strengthen clinical audit and authorisation arrangements. Routine audit has been established to evidence sign-off of additional imaging, specific imaging audits have commenced, and changes were identified to strengthen the treatment decision-making process for authorisation of additional images.

Caring domain

2.8 During the January 2026 inspection of Urgent and Emergency Care at Diana Princess of Wales Hospital, the Caring domain remained rated Good. Inspectors observed kind and caring interactions between staff and patients and found that staff treated people with kindness, empathy and respect for their privacy and dignity. Patient feedback supported this, with 97% of respondents to the most recent Urgent and Emergency Care survey reporting that they were treated with dignity and respect.

CQC also found that staff supported patients according to their individual communication and care needs. Interpretation and sign-language services were available, patient information could be provided in different formats and languages, and 81% of respondents to the UEC

patient survey reported that they had been helped with their communication needs, which was better than the national average.

2.9 During the September 2025 inspection of Urgent and Emergency Care at Hull Royal Infirmary, patients and their families were positive about staff treating them with warmth and kindness. Despite pressures and long waits within the department, patients reported that staff took time to speak with them, explained their care and treatment plans and ensured they knew who to approach with questions or concerns.

The Caring domain remained rated Good. Inspectors also found that staff communicated effectively with patients to support their involvement in care, including patients with communication difficulties. Staff had access to interpretation services and patient passports were being used within the Emergency Department to ensure individual patient needs were understood and appropriately supported.

Responsive domain

2.10 During the CQC inspection of Outpatients at Goole District Hospital in February 2026, the Responsive domain improved from Requires Improvement to Good. This contributed to the service maintaining an overall rating of Good and provides evidence of improved responsiveness to patients' needs since the previous assessment.

2.11 End of Life Care at Diana Princess of Wales Hospital demonstrated a significant improvement in responsiveness during its inspection in February 2026, with the domain improving from Inadequate to Good.

CQC found that care was personalised and regularly reviewed to reflect changes in patients' needs and preferences, with patients and families supported to discuss preferred place of care and death. Care was also coordinated with health, social care and voluntary sector partners to support continuity of care and patients' individual choices.

2.12 Community End of Life Care improved from Requires Improvement to Good for Responsive at its inspection in May 2026.

CQC found that care plans were developed with patients, families and healthcare professionals and regularly reviewed as needs changed. The service worked with external healthcare services to support people to receive coordinated end-of-life care in their preferred place wherever possible, supported by seven-day specialist advice through the Butterfly Line and links with local hospice services.

2.13 During the CQC inspection of Urgent and Emergency Care at Hull Royal Infirmary, inspectors found significant improvements in streaming and triage compared with the previous inspection.

Patients were directed to the most appropriate area following senior nurse review, with trained staff using the Manchester Triage System and senior clinical support available to assess and refer patients directly to specialties. Enhanced waiting areas also enabled improved oversight and management of patients while they waited.

2.14 The inspection also demonstrated improved arrangements for responding to patient feedback and concerns. Staff proactively sought feedback, information about how to make a complaint was available throughout the department, and the five complaints reviewed by inspectors had all been appropriately investigated and responded to within the required timescale, with identified learning shared with staff.

Summary

2.15 Taken together, these findings demonstrate tangible improvements in delivery and experience of care across HUTH and NLaG. These changes include safer care environments, strengthened clinical processes, improved multidisciplinary working, more personalised care and improved access and responsiveness. These improvements are reflected in better CQC domain and service ratings, the closure of regulatory actions and the absence of regulatory breaches in several specialist inspections. A robust assurance and sign of process for all CQC actions is in place. Areas rated with required improvement and actions that remain open continue to be monitored directly with the services.

2.16 The Partnership's journey of continuous improvement remains a priority and whilst the report captures details of the improvement so far, there remains a long road ahead. The aim is to strategically progress to the next highest rating from Requires Improvement to Good.

3. Partnership Well-led Improvement Progress

The CQC well-led domain focuses on ensuring that healthcare providers have strong leadership, effective governance and a positive culture of continuous learning and improvement. The Partnership acknowledges the early improvements reflected in the report, however, recognises the continuous improvement journey stretches over multiple years to deliver high quality, safe and sustainable services.

Leadership: Board Reset

3.1 One of the key factors in board stability is having a low director turnover, minimising changes in executive and non-executive leadership. This is linked to higher standards of care, better financial and performance outcomes. Following the review undertaken by Carnall Farrar and the Board decision to disaggregate the Partnership a transition plan is in place to ensure stability and effective governance arrangements, maintaining patient safety throughout the journey.

Recruitment to the outstanding substantive executive posts is progressing for HUTH in relation to the Chief Medical Officer, Chief Nurse and Corporate Secretary during November 2026.

The appointment of a new Chief Executive and Chairman is completed for NLAG with an associated recruitment plan for the wider executive and non-executive team in place during Q3 of 2026/27.

Governance

3.2 The first draft of the governance manual has been received from the Value Circle, providing a foundation for codifying governance arrangements. Work is now underway to refine the content for separate Governance Manuals for HUTH and NLAG ensuring governance structures, delegations, decision-making processes and accountability arrangements are clearly defined and aligned to Trust's requirements when the new boards are in place.

3.3 A new risk strategy has been developed and is currently progressing through the ratification process. It is strategically focused on risk management incorporating accountabilities and responsibilities including the executive, non-executive and the board and associate committees.

3.4 The Performance and Accountability Framework is drafted and currently in the ratification

process (September 2026). The purpose of this Performance and Accountability Framework is to support the achievement of the HHP strategic objectives in a way which is consistent with the HHP Strategy and values, by providing clarity on how HHP is organised, where responsibilities for decision making lie, how issues and risks are escalated, and how progress is reported and monitored in an open and transparent way.

3.5 A systematic review of the Board Assurance Framework (BAF) is completed (October 2026). Continuous executive support is required to maintain accountability, ensure timely review and ownership of risks and controls, and drive the systematic refresh process so that the BAF becomes a dynamic and effective tool for Board assurance and decision-making.

3.6 The triple AAA reporting methodology has been successfully piloted and rolled out across committee's and executive forums. Wider adoption and embedment are becoming evident across the Partnership.

Clinical Governance

3.7 The Patient Safety Incident Response Framework Policy has been reviewed (October 2026). This policy supports the requirements of the national PSIRF and sets out the organisation's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

3.8 The Partnership is developing a just, learning and restorative culture with work now progressing enabling staff to feel supported to report patient safety incidents, near misses, concerns and examples of good practice. It recognises that openness, psychological safety and systems thinking are essential to continuous improvement.

3.9 The Care Quality Commission (CQC) regulation 20 (Duty of Candour) performance has significantly improved and is now 100% compliant.

3.10 Recovery of PSIRF overdue investigation reports improving position and in line with trajectory for completion in December 2026.

3.11 A learning framework is being co-designed by clinical, education and organisation development colleagues ensuring a strong learning culture is embedded.

3.12 Alignment of the Corporate Risk Register to the BAF refresh has commenced with key risk owners to be completed by December 2026.

Quality and safety

3.13 CQC regulation 16 (Receiving and acting on complaints) shows significant improvement in the historical cases consistently reducing in line with completion trajectory of December 2026.

3.14 An 80% reduction in Patient Advice Liaison Service (PALS) backlog of patient concerns and a 50% increase in complaints answered within agreed timeframes.

3.15 CQC regulation 12 (Safe Care and Treatment) in relation to Infection Prevention and Control, Gram-negative bloodstream infection (GNBSI) improvement activity is progressing, including the revised catheter policy, TWOC pathway and baseline peripheral cannula audits.

- HUTH improvement in performance include Ecoli, MRSA and MSSA
- NLAG improvements in performance include Klebsiella and MSSA

Culture

3.16 The Trusts have been developing a comprehensive Organisation Development (OD) Programme to support the transition to two sovereign organisations and to establish the foundations for long-term organisational success.

3.17 A key objective of the OD Programme is to create the cultural and leadership conditions required to sustain improvement and deliver high-quality patient care. The programme places significant emphasis on leadership development, behavioural expectations and organisational values, ensuring there is a clear and consistent leadership culture from Board level through to frontline teams.

3.18 Recognising that organisational culture is a critical determinant of performance, the programme incorporates a dedicated culture workstream focused on staff and patient voice, psychological safety, leadership visibility and early identification of cultural risks. This includes structured listening programmes, engagement with clinical and operational leaders, patient and community involvement, regular culture pulse assessments, and mechanisms to ensure feedback is acted upon.

4. External Report, Carnal Farrar

4.1 From August 2025, considerable emphasis has been placed on encouraging clinicians and colleagues to speak openly about longstanding challenges and the barriers they faced in delivering improvements. This helped establish a clearer understanding of the issues affecting patient care and informed the basis of the Partnership's Integrated Improvement Plan (IIP).

4.2 However, it was also recognised that addressing individual problems would not necessarily resolve the underlying reasons why many had persisted. The Group Chief Executive therefore worked with NHS England (NHSE) to secure an independent review of the organisational arrangements themselves, examining whether the way HUTH and NLAG had been brought together was contributing to these difficulties. Commissioned by NHSE in April 2026 through its Intensive Recovery Programme (IPR) and undertaken by Carnall Farrar, the review was already underway when CQC carried out its Well-Led inspections in June 2026.

4.3 The review identified fundamental weaknesses in the way the Group model was originally conceived and established in 2022/23. Rather than providing a simpler and more effective organisational structure, the arrangements introduced additional complexity and excessive spans of control. These weaknesses were embedded in the original design of the Group and created structural barriers to effective improvement from the outset.

4.4 The review therefore established that the difficulties facing the two Trusts were also structural. The Group model had made it more difficult for each Trust to respond effectively to the needs of its patients, staff and local health and care system. Addressing these underlying weaknesses was consequently essential to creating the conditions for sustained improvement.

4.5 Following consideration of the independent review, the Boards-in-Common agreed on 10 September 2026 that HUTH and NLAG should move away from the existing Group arrangements and operate as two separate organisations, each with its own leadership and governance arrangements. This decision recognised that meaningful and sustainable improvement required more than strengthening existing processes: it required fundamental changes to an organisational model that had itself become an impediment to progress.

4.6 The decision does not mean an end to clinical collaboration across the Humber. The organisational separation is intended to strengthen local accountability while preserving the benefits of shared clinical services, specialist expertise and patient pathways. Existing relevant cross-Humber service arrangements will continue, with appropriate commissioning and contractual arrangements developed where necessary to secure their long-term clinical and financial sustainability.

4.7 The timing and findings of the independent review provide important context for both Trusts' ongoing regulatory improvement. The need to address underlying organisational and structural challenges had already been recognised, with the independent review commencing before the CQC inspections in June. By September, the Boards had agreed fundamental organisational change in response to the structural barriers identified through the review. In parallel, the IIP continues to address the specific quality, safety and governance improvements required. Together, these programmes provide a stronger foundation for sustained improvement and must remain closely aligned through transition to maintain delivery momentum, strengthen regulatory assurance and ensure both Trusts continue to meet their regulatory requirements.

5. Summary

5.1 The report demonstrates that, while significant challenges remain, progress is being made in improving the quality and safety of care across the Partnership. Recent CQC assessments have recognised improvements in several clinical services, while the IIP is beginning to deliver progress in addressing longstanding weaknesses in governance, patient safety, complaints handling and organisational learning. These improvements are encouraging, although further work is required to embed and sustain them.

5.2 Importantly, the independent organisational review established that the challenges facing the Trusts could not be addressed through operational improvements alone. Fundamental weaknesses in the way the Group was originally conceived and established had introduced additional complexity and created barriers to effective improvement. The Boards' decision in September to move to two separate Trusts therefore represents a necessary step towards addressing these underlying structural problems.

5.3 The Trusts' CQC Well-Led inspections took place in June 2026, while the independent organisational review was in progress. The forthcoming inspection outcomes are therefore expected to reflect the consequences of fundamental weaknesses in the original design of the Group, which the independent review subsequently identified as having created structural barriers to effective improvement from the outset. The Boards' decision in September to dissolve the Group arrangements, and the transition to two separate Trusts now underway, represent a fundamental response to those underlying problems.

5.4 The combination of the IIP and the fundamental organisational changes already agreed provides a clearer and more sustainable basis for improvement. The priority now is to maintain momentum in addressing the CQC's requirements, strengthen leadership and accountability within each Trust and ensure that organisational transition supports rather than disrupts improvements in patient care. This will be achieved while preserving the clinical collaboration and specialist services that benefit patients across the Humber.

6. Recommendations

The Trust Boards-in-Common are invited to:

- **Note** the improvements through recent CQC assessments.
- **Receive** assurance on progress against the wider range of CQC recommendations inclusive of section 29A Warning Notices.
- **Recognise** that further work is required to embed and sustain improvements.
- **Note** the planned further CQC assessment in Q1 of 2027/28 and the need to maintain momentum during the transition to two sovereign Trusts.
- **Support** continuous oversight of the remaining regulatory actions, risks and delivery trajectories via the IIP Oversight Group.

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)309

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 November 2026
Director Lead	Keith Haynes, Interim Board Secretary
Contact Officer / Author	Keith Haynes, Interim Board Secretary
Title of Report	**Governance Arrangements in Transition and Leading to Dissolution of the Humber Health Partnership**
Executive Summary	The Transition Plan requires consideration of the status and decision-making rights of the respective organisations and the two Chief Executive Officers during transition. This paper describes the governance arrangements in transition and a probable roadmap for dissolving the Group and Partnership arrangement, seeking Trust Boards-in-Common approval for both. It draws on advice from Capsticks LLP Solicitors. It also takes into account the content and discussion of the Boards-in-Common workshop facilitated by Carnall Farrar held on 4th November 2026. The report deals with Accountable Officer status and decision-making rights during transition. It also proposes an indicative target date for dissolution of the Group of 31 March 2027 subject to the "safe landing conditions" being met, and a backstop date of 31 May 2027 in the event that they are not. Finally, it proposes a variation to the existing Memorandum of Understanding to enable the MOU to be terminated with a date specified in the termination notice.
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 ☐ Assurance ☐ Other – please detail below:

Governance Arrangements in Transition and Leading to Dissolution of the Humber Health Partnership

1. Purpose of this paper

The Transition Plan requires consideration of the status and decision-making rights of the respective organisations and the two Chief Executive Officers during transition. This paper describes the governance arrangements in transition and a probable roadmap for dissolving the Group and Partnership arrangement, seeking Trust Boards-in-Common approval for both. It draws on advice from Capsticks LLP Solicitors. It also takes into account the content and discussion of the Boards-in-Common workshop facilitated by Carnall Farrar held on 4th November 2026.

2. Accountable Officer status and decision-making rights during transition

A "Group" model allows only one Accountable Officer. Clause 6.1 of the Memorandum of Understanding (dated June 2024) for Humber Health Partnership confirms that a single executive leadership team, led by the Group Chief Executive Officer, manages the Group. The Group Chief Executive Officer acts as Accountable Officer for both Trusts.

However, as the "Group" transitions towards dissolution different considerations have emerged. Specifically, NLaG has appointed an Interim Chief Executive Officer. By the NHS Act 2006 (Schedule 7), the formal appointment of a Chief Executive Officer to an independent Foundation Trust automatically and immediately triggers their status as the legal Accounting Officer for that specific legal entity.

While Clause 6.1 of the Memorandum of Understanding historically consolidated executive authority under a single Group Accountable Officer, the governance framework should now adapt to recognise two Accountable Officers. The Group Chief Executive Officer remains Accountable Officer for HUTH and continues to have responsibility for the dissolution arrangements. The Interim Chief Executive Officer for NLaG has assumed full statutory accountability for her entity. To confirm this, it is proposed to amend Clause 6.1 of the MOU in the following terms:

"*At Executive level, the Group in transition to dissolution will comprise a Group Chief Executive Officer who will be Accountable Officer for HUTH and will have responsibility for implementing the Group's dissolution arrangements, and an Interim Chief Executive Officer for NLaG who will be its Accountable Officer."*

As part of the transition arrangements, the decision-making rights of the Interim Chief Executive Officer need to be confirmed. The proposal is to use the decision-making rights in the current Scheme of Delegation. The Interim CEO would have delegated authority up to and including CEO level. Decisions above that level would follow the existing Group approval arrangements.

3. Agreeing a target date for dissolution and revising the MOU termination clause

The proposed Transition Plan sets 31 March 2027 as the indicative target date for dissolution, with a backstop dissolution date of 31 May 2027 should the "safe landing conditions" not have been met to enable dissolution by 31 March 2027. Both of these indicative target dissolution dates are predicated on the basis that the "safe landing conditions" are met, which aim to ensure clinical continuity and patient safety (SL1-3), regulatory, corporate and financial continuity (SL4-7) and leadership and workforce (SL8-10).

On the basis that the 31 March 2027 dissolution date is achieved, the MOU would terminate and the Boards-in-Common would stand down, ending the Group/Partnership. In the transition period, new Boards will need to be established. Until then, the Trust Boards-in-Common and their Committees-in-Common should continue to meet as the decision-making bodies. Consideration will now also need to be given to the form in which business is transacted at the Trust Boards-in-Common in order to reflect the reality of the governance arrangements in transition.

After 1 April 2027, both Trust Boards may still meet jointly to consider and agree matters of mutual interest, particularly any ongoing transition arrangements.

Similar arrangements with different dates would apply if the backstop dissolution date had to be engaged.

Clause 9.1 of the MOU allows termination at the financial year end with at least six months' notice. To provide greater flexibility, the following revision is proposed to enable the Trust Boards to terminate the MOU at a date specified in a written notice:

"Following review and approval by the Trust Boards, if both Trusts agree in writing to terminate the Agreement, termination will take effect on the date specified in the written notice."

4. Proposed Actions

The Trust Boards-in-Common are asked to:

- Note the Accountable Officer status of both Group Chief Executive Officer and the Interim Chief Executive for NLaG and agree the proposed amendment to Clause 6.1 of the Memorandum of Understanding.

- Agree the decision-making rights of NLaG's Interim Chief Executive Officer based on the existing Scheme of Delegation.

- Agree the amendment of the MOU termination clause as proposed above.

- Agree 31 March 2027 as the proposed indicative target date for dissolving the Humber Health Partnership, subject to the agreed "safe landing conditions" being satisfied and, in the event that it should be necessary, a backstop dissolution date of 31 May2027.

Keith Haynes
Interim Board Secretary
7th November 2026