NHS
Humber Teaching
NHS Foundation Trust

Trust Board Meeting 30 September 2026
Agenda - Public Meeting

For a meeting to be held at 10.00am Wednesday 30 September 2026, via Microsoft Teams

Quorum for business to be transacted – at least one third of the whole number of the Chair and Board members (including at least one Executive Director and one Non-Executive Director).

The role of the Board is described in the terms of reference and includes:

- Setting and overseeing the strategic direction of the Trust, having taken account of the views of the Trust's members and public at large
- Ensuring accountability by holding the Trust to account for the delivery of the strategy; and through seeking assurance that systems of control are robust and reliable
- Ensuring compliance with statutory requirements of the Trust (including the Provider License conditions and the Care Quality Commission registration)
- Shaping a positive culture for the organisation
- Monitoring the work of the Executive Directors
- Taking those decisions that it has reserved to itself

- Consider whether any items on this agenda will pose a risk to achievement of the strategic objectives as identified in the Board Assurance Framework

The patient story will be held in private from 9:30am.
The Public Board will commence and be live streamed from 10:00am.

		Lead	Action	Report Format
	Standing Items			
1.	Apologies for Absence	CF	Note	verbal
2.	Declarations of Interest	CF	Note	√
3.	Minutes of the Meeting held on 29 July 2026	CF	Approve	√
4.	Action Log, Matters Arising and Work Plan	CF	Discuss	√
5.	Chair's Report	CF	Note	√
6.	Chief Executives Report • Including policies to ratify	MM	Discuss/Ratify	√
7.	Publications and Highlights Report	MM	Note	√
8.	Board Assurance Framework Update	MM	Note	√

	Patient Safety and Quality			
9.	Safer Staffing Six Monthly Report	SS	Ratify	√
10.	Patient & Carer Experience (incl Complaints and PALs) Annual Report	KF	Ratify	√
11.	Infection Prevention Control Annual Report	SS	Approve	√
12.	Safeguarding Annual Report	SS	Approve	√
13.	Winter Plan	CJ	Approve	√
14.	Health Inequalities Six Monthly Update	KF	Note	√
15.	Care Quality Commission Assurance Report	SS	Assurance	√
	Building a Shared Purpose and Vision			
16.	Model Hospital – Productivity and Efficiency	PB	Note	√
	Investing in People and Culture			
17.	Guardian of Safeworking Annual Report	KF	Approve	√
18.	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D – Annual Board Report and Statement of Compliance	KF	Approve	√
19.	Staff Survey Progress Report	KP	Discuss	√
20.	Equality Delivery System (EDS22) 2026	KP	Approve	√
	Developing Leadership Behaviours			
21.	NHS Leadership and Management Framework	KP	Approve	√
22.	NHS Staff Standards	KP	Note	√
	Embedding Improvement into Management Systems and Processes			
23.	Digital Update • Cyber Security Arrangements • Ambient Voice Technology	PB	Approve	√

24.	Finance Report	PB	Note	√
25.	Performance Report	PB	Discuss	√
26.	High Level Risk Register	SS	Note	√
	Assurance Committee Reports			
27.	People & Organisational Development Committee Assurance Report	CW	Assurance	√
28.	Quality Committee Assurance Report	PE	Assurance	√
29.	Mental Health Legislation Committee Assurance Report	SP	Assurance	√
30.	Audit Committee Assurance Report	KS	Assurance	√
31.	NHSE Board Development Programme in place of Board Strategic Development Meeting – October 2026	CF	Note	Verbal
32.	Items to Escalate including Matters for the High-Level Risk Register, Board Assurance Framework, Provider Capability Assessment and Communications	CF	Note	Verbal
33.	Any Other Urgent Business	CF	Note	Verbal
34.	Review of Meeting – Being Humber • Has the Board focused on the right areas? • Did the quality of the papers enable Board members to perform their role effectively – did they enable the right level of discussion to occur? • Was debate allowed to flow and were all Board members encouraged to contribute? • Has the meeting been conducted in accordance with the Trust's cultural and behavioural standards framework (Being Humber)	CF	Discuss	Verbal
35.	**Exclusion of Members of the Public from the Part II Meeting**			

36.	**Date, Time and Venue of Next Meeting** Wednesday 25 November 2026, 9.30am via Microsoft Teams	

Humber Teaching NHS Foundation Trust

Agenda Item 02

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Declarations of Interest
Author/s:	Rt Hon Caroline Flint Trust Chair
Recommendation:	

To approve		To discuss	
To note	✓	To ratify	
For assurance			

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	The report provides the Board with a list of current Executive Directors and Non-Executive Directors interests. Changes have been made to the following declarations: • Removal from Kwame Fofie • Addition of Claire Jenkinson

Key issues:

Positive Assurances to Provide: • Updated declarations	**Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):** • N/A
Key Risks/Areas of Focus: • No issues to note	**Decisions Made:** • N/A

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)

Hospital to Community	Whilst this report is primarily a governance and statutory compliance document, it supports delivery of the Three Shifts by promoting transparency, effective management of conflicts of interest, and strong partnership working across health, care and community organisations, providing assurance that strategic decisions are made openly and in the best interests of patients and the public.
Analogue to Digital	As above
Sickness to Prevention	As above

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail) Monthly Board report	✓ 29.07.26

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	✓
Enhancing prevention, wellbeing and recovery	
Fostering integration, partnership and alliances	✓
Developing an effective and empowered workforce	
Maximising an efficient and sustainable organisation	
Promoting people, communities and social values	✓

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	

Public Exemption:

Is the report exempt from public disclosure	No

Directors' Declaration of Interests

Name	Declaration of Interest
Executive / Directors	
Ms Michele Moran Chief Executive (Voting Member)	• IMAS partner • Humber and North Yorkshire ICB Board Member (voting) • Co-opted Parish Councillor – Bamford with Thornhill • Member of the Charitable Funds Corporate body
Mr Peter Beckwith, Executive Director of Finance (Voting Member)	• Trustee of Heath Stars, and Executive Lead for Humber Teaching NHS Foundation Trust • Son is a Resident Doctor at University Hospitals Sussex NHS Foundation Trust • Daughter is employee of the Trust • Member of the Charitable Funds Corporate body
Dr Kwame Opoku-Fofie, Executive Medical Director (Voting member)	• Director of Bluewaters Healthcare Limited • Spouse is Director of Bluewaters Healthcare Limited • Spouse is the Deputy Chief Pharmacist of Humber Teaching NHS Foundation Trust • Executive Lead for The Trust Research Department – which receives grant and funding to the department • Member of the Charitable Funds Corporate body
Mrs Claire Jenkinson, Interim Chief Operating Officer (Voting Member)	• No interests declared
Mrs Lynn Parkinson, Chief Operating Officer (Voting Member)	• Son works for Labour MP as Communications Lead • Son works for Department of Health and Social Care • Member of the Charitable Funds Corporate body
Mrs Karen Phillips, Executive Director of People and Organisational Development	• Member of the NHS Professionals Strategic Advisory Board • Member of the Charitable Funds Corporate body
Mrs Sarah Smyth, Executive Director of Nursing, Allied Health and Social Care Professionals (Voting Member)	• Member of the Charitable Funds Corporate body
Non Executive Directors	
Rt Hon Caroline Flint – Chair (Voting Member)	• Chair of the Committee on Fuel Poverty which is an advisory non-departmental public body sponsored

	by the Department for Energy Security and Net Zero (DESNZ) • Member of the Charitable Funds Corporate body
Mr Andrew Brown, Non-Executive Director (Voting Member)	• Chairman of Welcome to Whiby CIC • Director of Nanotime LTD • Daughter is partner in Brown and Asquith Therapies, which provides Mental Health Support Services • Daughter is Associate for Aspire Psychological Services, based in Darlington • Daughter is senior lecturer in Social Work for Tees University. • Friend is a Director and Shareholder in the Ethos Partnership which provides consultancy services to some NHS trusts • Member of the Charitable Funds Corporate body
Dr Phillip Earnshaw, Non-Executive Director (Voting Member)	• Director of Conexus GP Federation • Owner of Phillip Earnshaw Ltd • Trustee of Prince of Wales Hospice • Five Towns PCN Clinical Director • Board Member of Wakefield District Health & Care Partnership • Chair and Trustee Smawthorne Community Project is a local charity in Castleford • Member of the Charitable Funds Corporate body
Mr Keith Nurcombe, Non-Executive Director (Voting Member)	• Director of Dietary Assessments LTD • Director of WMSG (Part of West Midlands Combined Authority • Crown representative – Cabinet Office – UK Government • Chair of the Avalon Group • Chair of Derbyshire Health United (CIC) • Member of the Charitable Funds Corporate body
Ms Stephanie Poole, Non-Executive Director (Voting Member)	• Husband is a Trustee of Yorkshire Coast Sight Support (YCSS), a registered charity • Member of the Charitable Funds Corporate body
Ms Kathryn Smart, Non-Executive Director (Voting Member)	• Doncaster & Bassetlaw NHS FT – Non-Executive Director / Deputy Chair and Audit Chair • Incommunities Ltd, Bradford – Non-Executive Director / Audit Chair • St Leger Homes, Doncaster – Co-opted Board member • Associate Hospital Manager – Rotherham Doncaster and South Humber NHS Foundation Trust • Member of the Charitable Funds Corporate body

Ms Caroline Wollerton, Non-Executive Director (Voting Member)	• Non-Executive Director at Locala CIC • Daughter is a Clinical Nurse Specialist at Tees, Esk and Wear Valleys NHS Foundation Trust • Daughter is the owner of the Yorkshire ADHD Assessment Clinic • Member of the Charitable Funds Corporate body

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Trust Board Meeting

Minutes of the Public Trust Board Meeting

held on Wednesday 29 July 2026
09:30am – 12:30pm via Microsoft Teams

Present:

Ms Stephanie Poole, Non-Executive Director, (Chair of the meeting)
Mrs Michele Moran, Chief Executive
Mrs Vickie Murray, Deputy Director of People and Organisational Development (on behalf of Mrs Karen Phillips)
Dr Kwame Fofie, Executive Medical Director
Mrs Claire Jenkinson, Interim Chief Operating Officer
Mr Peter Beckwith, Executive Director of Finance, Resources, Estates and Digital
Mrs Sarah Smyth, Executive Director of Nursing, Quality and Professions
Mr Andrew Brown, Non-Executive Director
Mrs Caroline Wollerton, Non-Executive Director
Mrs Kathryn Smart, Non-Executive Director
Mr Keith Nurcombe, Non-Executive Director
Dr Phillip Earnshaw, Non-Executive Director

In Attendance:

Mrs Stella Jackson, Head of Corporate Affairs (Minutes)
Mrs Justine Rooke, Children's and Learning Disability General Manager (for agenda item 5 `Service Story')
Ms Karen Warwick, Service Manager - Inspire Multi-Disciplinary (for agenda item 5 `Service Story')
Ms Alison Flack, Transformation Programme Director (for agenda item 9 `Freedom to Speak Up Annual Report and Six Month Update')
Mr Lee Rickles, Chief Information Officer (for agenda items 10 `Digital Governance' and 11 `Digital Enabling Strategy')
Mr John Duncan, Equality, Diversity and Inclusion Partner (for agenda items 14 `Gender Pay Gap', 15 `WDES Report and 16 `WRES Report')

The Board papers were available on the website and an opportunity provided for members of the public to ask questions via email. Members of the public were also able to access the meeting through a live stream on YouTube.

89/26	**Apologies** Apologies were received from Caroline Flint, Karen Phillips and Lynn Parkinson	

90/26	**Declarations of Interest** The declarations were noted. Board members have been made aware that any changes to declarations should be notified to the Head of Corporate Affairs. If any items on the agenda present a potential conflict of interest, the person should declare the interest and remove themselves from the meeting for that item.	
91/26	**Minutes of the Meeting held on 27 May 2026** The minutes of the meeting held on 27 May 2026 were considered. **<u>Resolved</u>: The minutes of the meeting held on 27 May 2026 were approved as a true and accurate record of the meeting.**	
92/26	**Action Log, Matters Arising and Workplan 2025/26** There were no matters arising from the minutes of the meeting held on 25 March 2026. The workplan for 2025/26 was **noted.** Updates to the action log were **noted.**	
93/26	**Service Story – Child and Adolescent Mental Health Pathway Redesign and the Thrive approach** Justine Rooke and Karen Warwick delivered a presentation on the ongoing transformation of the Child and Adolescent Mental Health Services (CAMHS) pathway. The presentation provided an overview of the implementation of the Thrive framework, revised CAMHS pathway arrangements, and work to improve access to early intervention and support. It also covered pathways into specialist services, the redesign of the Nova service, and the clinical models underpinning the transformation programme. In addition, the presenters highlighted the positive outcomes achieved since the introduction of the new pathway. Caroline Wollerton sought an update on the progress of neighbourhood working arrangements. Justine advised that the service had established strong collaborative relationships with a number of partner organisations and that development of the neighbourhood model was continuing. Sarah Smyth welcomed the Think Family approach, noting its alignment with safeguarding statutory guidance and commenting that it provided assurance that related workstreams and agendas were being effectively integrated. She commended the service on the positive outcomes achieved to date and asked whether digital solutions were being used to support referral processes. In response, Justine explained that a specific digital platform was not currently being used for this purpose but agreed to explore whether this could be developed. Kath Smart asked what feedback had been received from families regarding the new pathway arrangements. Justine reported that feedback	

	from both families and schools had been positive. She added that young people were regularly asked about their experiences of the service and that formal evaluations were undertaken to inform service development. Board members referred to the slide outlining the positive outcomes achieved and requested the underlying figures supporting those outcomes. **Action: Justine to circulate the data underpinning the reported outcome measures to Board members.** Michele Moran highlighted the importance of sharing the success of the transformation programme more widely across the Trust's operational teams. Kwame Fofie informed Board members that the national Getting It Right First Time (GIRFT) team had contacted the Trust to learn more about the work and explore whether the approach could be replicated in other trusts across the country. **Resolved: Board members thanked Justine Rooke and Karen Warwick for their presentation and asked that their appreciation be conveyed to the wider CAMHS team in recognition of their work in delivering and embedding the service transformation programme.**	**JR**
94/26	**Chair's Report** Stephanie Poole introduced the Trust Chair report which provided updates on the Chair, Non-Executive Directors (NEDs) and Governor activities since the last Public Board meeting. Steph paid particular attention to the sections of the report regarding preparations underway for a CQC Well-Led inspection; Associate Non-Executive Director recruitment arrangements; the future Strategic Roadmap and recent discussions regarding the future statutory role of governors. **Resolved: The Chair's report was noted**	
95/26	**Chief Executive's Report** Stephanie Poole asked the Board to review the Leave, Redeployment and Accommodation Policies and the appointment of the Associate Hospital Manager. These were subsequently ratified. Michele Moran introduced the Chief Executive's Report and highlighted the following: • A Critical Incident had been declared following the fire at Malton Hospital. Patients were transferred to Bridlington Hospital and had since returned, although the ward remained under capacity. Michele thanked staff and partner organisations for their support in maintaining patient safety and continuity of care, and noted that health and wellbeing support had been made available to staff. Feedback from patients during the relocation had been highly positive. • The Trust's Crisis Service had been inspected by the Care Quality Commission and rated Good.	

	• The Executive Director of Finance's title had changed to Executive Director of Finance, Resources, Estates and Digital, reflecting his responsibilities. • A Partnership Group of system Chief Executives had been established to consider opportunities for greater service delivery collaboration across organisations, with the Trust leading this work. • New national and ministerial appointments had been announced within the Department of Health and Social Care. • The Trust had hosted visits from the ICB and NHS Alliance. • National mental health stretch targets had been agreed by the national Chief Executive Group, with work underway to determine monitoring arrangements. • North Yorkshire Community Services had been ranked first nationally, out of 38 providers, for Urgent Community Response performance. Claire Jenkinson advised that winter planning and wider service planning activities were underway. Kwame Fofie reported that a recent Supreme Court judgment had revised the definition of deprivation of liberty with immediate effect across the UK. The Executive Management Team had reviewed the implications and a report would be submitted to the Mental Health Legislation Committee. Andy Brown requested further information on learning from security incidents within the Forensic division, particularly the related data. Michele Moran and Pete Beckwith outlined the governance arrangements in place to oversee, monitor and respond to incidents. Phillip Earnshaw referred to a recently published report on mixed-sex accommodation and asked whether female PICU patients had been relocated to Townend Court. Pete Beckwith advised that the move would take place once refurbishment of alternative accommodation had been completed. Kwame Fofie confirmed that the Trust complied with national standards for mixed-sex accommodation, and Sarah Smyth noted that no mixed-sex accommodation breaches had been reported by the Trust. Stephanie Poole congratulated Michele Moran on completing the Chief Executive Challenge in support of Health Stars. **Resolved: The Trust Board ratified the Leave, Redeployment and Accommodation Policies and the appointment of Amy Dibb as Associate Hospital Manager, and noted the Chief Executive's Report.**	
96/26	**Publications and Highlights Report** The Publications and Highlights report was taken as read. **Resolved: The Publications and Highlights Report was noted.**	
97/26	**Freedom to Speak Up Annual Report and Six Month Update** Alison Flack introduced the Freedom to Speak Up (FTSU) Annual Report 2025/26 and highlighted the following key points:	

	• The National Guardian's Office closed at the end of June 2025, with oversight responsibilities transferring to Integrated Care Boards (ICBs). • Compliance with mandatory Freedom to Speak Up training remained high at just over 97%. • There had been an increase in the number of concerns raised during the reporting period, which was viewed positively as evidence of staff confidence in speaking up. • Work continued to recruit and support FTSU Ambassadors and to further raise the profile of the Freedom to Speak Up service across the Trust. Carrie Wollerton, Non-Executive Director Freedom to Speak Up Champion, welcomed the Internal Audit review and noted the Significant Assurance opinion received in respect of the Trust's Freedom to Speak Up arrangements. Pete Beckwith advised that Raising Concerns forms part of the national oversight framework and reported that the Trust was currently performing within the upper quartile nationally. Kath Smart requested that future reports include greater information regarding the impact of activities undertaken. Michele Moran supported this request and emphasised the importance of providing evidence of the outcomes achieved through Freedom to Speak Up interventions. **Resolved: Trust Board approved the Freedom to Speak Up Annual Report 2025/26**	
98/26	**Digital Governance** Pete Beckwith and Lee Rickles introduced the report, drawing attention to: • The Audit Yorkshire review of Digital Governance and the associated management responses, which had previously been reported to the Executive Management Team (EMT) in May. • Progress made against the review recommendations, as set out in Appendix A. • Proposed amendments to the Finance, Productivity and Digital Committee Terms of Reference, detailed in Appendix B. Keith Nurcombe advised that the report had been considered by the Finance, Productivity and Digital Committee and noted that the Terms of Reference would remain under review as the Trust's digital governance arrangements continued to develop. Kath Smart queried whether the Audit Yorkshire recommendations would also be considered by the Audit Committee. In response, Michele Moran clarified that, whilst the review had been undertaken by Audit Yorkshire, it was not an internal audit report. Oversight of the review and implementation of its recommendations therefore sat with the Finance, Productivity and Digital Committee. Phillip Earnshaw sought clarification regarding the types of digital decisions that would be escalated through the committee structure. Pete Beckwith outlined the digital governance reporting framework and noted	

	that the effectiveness of the arrangements would be considered as part of the annual committee effectiveness review. Pete Beckwith further advised that his revised job title would be reflected in the updated Terms of Reference. **Resolved: The Trust Board noted the findings of the Digital Governance Review and progress against the associated recommendations. The Board approved the revised Terms of Reference for the Finance, Productivity and Digital Committee, noting that a further amendment would be made to reflect the change in title from Executive Director of Finance to Executive Director of Finance, Resource, Estates and Digital.**	
99/26	**Digital Enabling Strategy** Pete Beckwith and Lee Rickles presented the Trust's Digital Plan and Digital Enabling Strategy, noting that both documents had been subject to a comprehensive governance and assurance process prior to submission to the Board. The Digital Plan set out the Trust's priorities over the next two years, focusing on strengthening clinical systems, data and analytics capabilities, virtual care, productivity and automation technologies, digital safety, digital inclusion, and support for operational delivery. The Digital Enabling Strategy outlined the Trust's longer-term digital ambitions for the period 2026–2030. As an enabling strategy, it provided an ambitious roadmap for harnessing digital technology to support delivery of the Trust's overarching strategic objectives and improve outcomes for patients, staff and the organisation. Pete Beckwith thanked Lee Rickles for his leadership and contribution in developing the two documents. Phillip Earnshaw sought clarification regarding the slight decline in the Trust's Digital Assurance Assessment rating in 2025. In response, Lee Rickles explained that the transition from Lorenzo to SystmOne, together with changes to the assessment criteria, had affected the Trust's score. He noted, however, that significant progress and improvements had been made since that assessment. Phillip Earnshaw also expressed an interest in understanding in more detail how the Plan would support and empower people to engage with and utilise digital technologies. Pete Beckwith and Lee Rickles agreed to discuss this further with him outside the meeting. Kwame Fofie and Lee Rickles highlighted the importance of addressing digital exclusion and ensuring appropriate reasonable adjustments for patients with limited access to digital services. Board members were advised that the Trust was preparing for implementation of the national reasonable adjustments digital flag and was working closely with NHS England and social care partners to support this development. Pete Beckwith reported that delivery of the Digital Plan and Digital Enabling Strategy would be monitored through the Trust's established governance	

	arrangements, with regular progress reports provided through the Finance, Productivity and Digital Committee. Michele Moran thanked all colleagues who had contributed to the development of the documents and recognised the significant work undertaken to produce these **Resolved: The Trust Board approved the Digital Plan and the Digital Enabling Strategy**	
100/26	**Learning from Deaths – Mortality Report** Kwame Fofie introduced the Learning from Deaths – Mortality Report covering the period July 2025 to December 2025. He advised that the Trust had established processes in place to identify, review and learn from deaths and serious incidents on an ongoing basis. He further noted that the Quality Committee would receive Learning from Deaths reports on a six-monthly basis, with an annual report presented to the Board. Board members noted the work undertaken to involve families and carers in the learning from deaths process and the Trust's continued commitment to ensuring that learning informs service improvement. Phillip Earnshaw informed Board members that the Quality Committee had reviewed the report prior to its submission to the Board and commented that the reporting arrangements and associated learning would continue to evolve over time as the process matured. Kath Smart sought assurance regarding the Trust's ability to benchmark its performance and learning from deaths arrangements against other organisations. Kwame Fofie reported that this issue had been raised at a national level, although opportunities for meaningful benchmarking remained limited. Kath Smart noted that the report identified no consistent themes relating to physical health; however, the report cover sheet referenced a continued focus on physical health monitoring and escalation. Kwame Fofie explained that physical health remained a key priority both locally and nationally and, as such, continued to be an area of focus for the Trust. He confirmed that no specific concerns had been identified from the reviews undertaken during the reporting period. Kath Smart also queried where the audit of Learning from Deaths processes and procedures would be reported. Kwame Fofie advised that relevant data was being collected and would be subject to audit and assurance processes as appropriate. In response to a further question from Kath Smart regarding Prevention of Future Deaths reports issued under Regulation 28, Kwame Fofie confirmed that the Trust had no outstanding Regulation 28 reports. He noted that the Trust maintained constructive and proactive relationships with the Coroner's Office and regularly shared cases for learning and improvement purposes where appropriate. . **Resolved: Trust Board noted the Learning from Deaths – Mortality Report (July 2025 to December 2025).**	

101/26	**Multi-Professional Strategy** Sarah Smyth introduced the Multi-Professional Strategy which supported delivery of the Trust Strategy, People Strategy and national workforce priorities. It provided a clear framework to strengthen professional leadership, workforce development, innovation and community-focused care across all health and care professions. The Strategy had been developed through extensive staff and service user engagement, and structured around four strategic promises: professional, workforce, care and innovation, and people and community. The Strategy included outcome metrics and a governance framework and, once approved, the delivery plan and framework would be produced. Carrie Wollerton praised the report and reported she was supportive of the document. **Resolved: Trust Board approved the Multi-Professional Strategy 2026-2030**	
102/26	**Gender Pay Gap Report** John Duncan introduced the Gender Pay Gap report which had been reviewed and considered by the People and Organisation Development Committee. John reported an increase in the mean gender pay gap to 11.8%, with recent data showing a reduction to 10.7%. The Trust remained ahead of sector and national averages, and actions to address the gap were outlined in the report. **Resolved: Trust Board approved the Gender Pay Gap report for publication.**	
103/26	**WDES Report** John Duncan introduced the Workforce Disability Equality Standard **(**WDES) Report, which had been reviewed by the People and Organisation Development Committee. He advised that the Trust had demonstrated improvement in seven of the ten WDES metrics, including a reduction in the number of disabled staff reporting experiences of bullying and harassment. John noted a slight decline in the proportion of staff reporting that reasonable adjustments had been put in place and confirmed that this would be explored further to understand the underlying causes. Kath Smart asked about the effectiveness and engagement levels of the Disability Staff Network. In response, John explained that attendance at Network meetings varied, which was consistent with experience across other NHS trusts. Pete Beckwith added that the Network had successfully influenced improvements, including adjustments to workstations and desks, and highlighted that the recently appointed Network Chair was committed to increasing participation and engagement. Carrie Wollerton noted that similar concerns regarding attendance had also been raised through the Anti-Racist Staff Network. She reported that the Network Chair believed low attendance was, in part, attributable to staff having limited control over their diaries and working patterns, which could affect their ability to participate in meetings.	

	Resolved: Trust Board approved the Workforce Disability Equality Standard report and associated actions to address the gaps.	
104/26	**WRES Report** John Duncan introduced the Workforce Race Equality Standard (WRES) Report, which had been reviewed by the People and Organisation Development Committee. He advised that the Trust had demonstrated improvement across the majority of indicators and highlighted the continued focus on addressing racial discrimination experienced from patients and service users, as well as strengthening staff confidence and capability in challenging and reporting racist behaviours. Claire Jenkinson thanked John for the quality improvement work undertaken within the Psychiatric Intensive Care Unit (PICU) to reduce incidents of racial harassment and acknowledged the positive impact this had made. **Resolved**: **Trust Board approved the Trust's annual Workforce Race Equality Standard Report 2026 and associated actions to address gaps.**	
105/26	**Social Values Report** Kwame Fofie introduced the Social Value Report 2025/26, highlighting the impact of the Trust's work across the key areas of prevention, reducing inequalities, workforce development, partnerships, and community engagement. Phillip Earnshaw reported that he had recently visited the East Riding 0-19 Service and had heard about the positive work being undertaken to increase breastfeeding rates. He welcomed the examples of impact provided within the report but commented that it was difficult to assess whether performance in areas such as social prescribing and volunteering was meeting expectations. In response, Kwame explained that the Trust's ambition was to increase the number of volunteers year on year. Steph Poole suggested that future reports could provide a clearer indication of performance trends, direction of travel, and the actions planned to drive further improvement. Kath Smart queried whether examples of successful practice highlighted within the report could be scaled and applied more widely across the Trust. Michele Moran acknowledged that while some services were effective at sharing and adopting good practice, there was scope for greater consistency across the organisation. She advised that work was underway to transform services at system level and noted that there were opportunities to strengthen the sharing and implementation of learning at Trust level. Michele suggested that Board committees consider this aspect when reviewing future reports. Michele further advised that the Social Values Report, although not a statutory requirement, would be professionally designed and formally launched at the Annual Members' Meeting/Annual General Meeting. She concluded by thanking Kwame and all colleagues involved in producing the report.	

	Resolved: **Trust Board approved the Social Values Report 2025-26**	
106/26	**Front Line Managers – Developing our People** Vickie Murray introduced the Front Line Managers – Developing our People report which provided an overview of the key themes emerging from the 2025 NHS Staff Survey and subsequent Trust-wide management listening exercise relating to leadership and management capability. The report outlined progress made to date; the strategic response being implemented and the next phase of work to establish a consistent management standard and scalable leadership and management development offer across the Trust. Kath Smart expressed her support of the programme of work and believed the 2026 Staff Survey would assist with measuring the effectiveness of the work. She queried whether an interim assessment would be undertaken. In response, Vickie reported the work of each cohort would be evaluated as would the impact. **Resolved**: **Trust Board noted and supported the work underway to develop Front Line Managers.**	
107/26	**Finance Report** Pete Beckwith introduced the Finance Report, providing an overview of the Trust's financial position as at 30 June 2026 (Month 3). He reported that the Trust had achieved a break-even position for the period, in line with the NHS England regional planning target, and continued to forecast a break-even position at year end. Pete advised that the Trust's cash balance stood at £18.951 million at Month 3, providing assurance regarding the organisation's liquidity position. He also noted the requirement within the NHS Long Term Plan for trusts to report any resident doctor pay errors and confirmed that no such errors had been identified during the reporting period. **Resolved: The Trust Board noted the Finance Report as at 30 June 2026 (Month 3).**	
108/26	**Performance Report** Pete Beckwith introduced the Performance Report, which outlined the Trust's performance position as at 30 June 2026. He advised that the format of the report had been refreshed in response to feedback received from Board members. Pete reported that the Trust had maintained a strong position within the NHS Oversight Framework, achieving a Trust Segment Score of 1. He highlighted sickness absence as an ongoing area of focus and noted that compliance with the Talking Therapies 18-week waiting time standard had not been achieved in June, reflecting increased case complexity and changes to service acceptance criteria. Phillip Earnshaw noted that the 18-week standard represented a backstop measure and that patients should ideally commence treatment within six weeks. He queried whether a deeper review of performance in this area would be beneficial. In response, Claire Jenkinson explained that the	

	amalgamation of the pathway had created additional pressures for the service and that options for service reconfiguration were currently being explored. Michele Moran suggested that a paper outlining the national and regional position in relation to Talking Therapies be presented to the Quality Committee to provide further context and assurance. ***Action: Claire Jenkinson to arrange for a paper on the national and regional Talking Therapies position to be presented to the Quality Committee.*** Phillip Earnshaw also observed that Virtual Ward admissions had reduced and asked whether there was an identifiable reason for the decline. Claire advised that, despite continued promotion of the service, referral rates had decreased during the reporting period. Phillip further noted an emerging increase in out-of-area placements and sought clarification on the reasons for this trend. Claire reported that reducing older adult out-of-area placements remained a key area of focus. She highlighted that a Social Worker had recently joined the service to support more timely discharges for patients requiring social care packages. In addition, the Executive Management Team had approved measures to increase local capacity through the introduction of additional step-up beds. **Resolved**: **Trust Board noted the Performance Report.**	**CJ**
109/26	**Specialised Provider Collaborative Committee Terms of Reference** Stella Jackson introduced a paper proposing minor changes to the Specialised Provider Collaborative Committee Terms of Reference. **Resolved: Trust Board approved the proposed changes.**	
110/26	**Finance Committee Assurance Report** Keith Nurcombe provided a verbal update on the Finance Committee meeting held on 21 July 2026. The Committee received assurance that robust financial grip and control arrangements remained in place. The Trust was delivering against its planned budget at Month 3 and continued to maintain a positive cash position. It was noted that the Trust was currently the only organisation within the wider system achieving its financial plan, whilst financial performance continued to present challenges at system level. Keith advised that a meeting of Finance Committee Chairs from across the North East region would be convened to consider approaches to strengthening financial management and collaboration across the wider system. The Committee also received assurance regarding productivity and efficiency performance. It was noted that the Trust's National Oversight Framework position reflected the significant progress and sustained effort being made across the organisation. Committee members considered a deep dive review of bank and agency expenditure and were assured regarding the management and oversight of the consultant workforce. The Committee had also reviewed the Digital papers presented earlier on the Board agenda.	

	Resolved: **Trust Board noted the Finance Committee Assurance report.**	
111/26	**People & Organisational Development Committee Assurance Report** Carrie Wollerton introduced the People and Organisational Development Assurance Report. The Committee had considered four key reports, three of which had been presented to the Board for approval. Committee members reviewed the Workforce Plan, including workforce challenges, vacancy rates, turnover and the demographic profile of the workforce, noting that 22% of staff were approaching retirement age. The Committee also discussed opportunities for wider benchmarking beyond NHS organisations. The Committee was assured that good progress was being made across its key areas of focus. **Resolved**: **Trust Board noted the People and Organisational Development Committee Assurance Report.**	
112/26	**Specialised Provider Collaborative Committee Assurance Report** Stephanie Poole introduced the Specialised Provider Collaborative Committee Assurance report. The Committee noted the significant reduction in the use of naso-gastric tube (NGT) feeding within young people's inpatient services, from 458 episodes in 2024 to three in 2026. This achievement reflected the Trust's continued focus on placing patient needs at the centre of care, together with the benefits delivered through collaborative working. The Committee approved its 2026 workstream priorities and received positive feedback from NHS England on the approach taken to develop alternative-to-admission services across Humber and North Yorkshire. The Collaborative remained in a positive financial position. **Resolved**: **Trust Board noted the Collaborative Committee Assurance Report.**	
113/26	**Quality Committee Assurance Report** Phillip Earnshaw introduced the Quality Committee Assurance report. The Committee noted the increasing number of recommendations arising from national inquiries relating to leadership, governance and Board oversight. These recommendations would be reviewed by the Executive Management Team to assess their relevance and application to the Trust. Phillip advised that the Committee had approved the Quality Account, in line with the authority delegated to it by the Board. The Committee had also received updates on falls prevention and pressure ulcer prevention, and was assured regarding progress in both areas. Looking ahead, the Committee's next meeting would include a detailed review of the Board Assurance Framework and a focus on enhanced wellbeing and recovery services. **Resolved**: **Trust Board noted the Quality Committee Assurance report.**	

114/26	**August Board Strategic Development Meeting Agenda** The August Board Strategic Development Meeting agenda was **noted.**	
115/26	**a) Items to Escalate including to the High Level Risk Register and for Communication.** The Board did not identify any items to escalate or for communication. **b) Has anything on the agenda contributed to or improved the Board Assurance Framework position?** The Board did not consider anything on the agenda had contributed to or improve the Board Assurance Framework position.	
116/26	**Any Other Business** There were no other items of business.	
117/26	**Review of the meeting – Being Humber** The Board agreed there had been focused and relevant/interesting topics for discussion. The meeting had been conducted in accordance with the Trust's Being Humber behavioural framework. The meeting concluded at 12.26 pm.	
118/26	**Exclusion of Members of the Public from the Part II Meeting** It was resolved that members of the public would be excluded from the second part of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.	
119/26	**Date, Time and Venue of Next Meeting** 30 September 2026, 9.30am via Microsoft Teams	

Signed …… Date ……

Chair

Humber Teaching NHS Foundation Trust

Agenda Item 4

Action Log:
Actions Arising from Public Trust Board Meetings

Summary of actions from July 2026 Board meeting and update report on earlier actions due for delivery in September 2026 *Rows greyed out indicate action closed and update provided here*						
Date of Board	**Minute No**	**Agenda Item**	**Action**	**Lead**	**Timescale**	**Update Report**
29.07.2026	108/26	Performance Report	Claire Jenkinson to arrange for a paper on the national and regional Talking Therapies position to be presented to the Quality Committee.	CJ	September 2026	Report is being taken to the September 2026 Quality Committee.
29.07.2026	93/26	Service Story – Child and Adolescent Mental Health Pathway Redesign and the Thrive approach	Justine to circulate the data underpinning the reported outcome measures to Board members.	JR	August 2026	Information circuclated to the Board – 25/9/26.
25.03.2026	31/26 30/26	Chief Executives Report Chairs Report	Review Systm1 task policy information when received. Quality Committee Chair to undertake planned visit to Townend Court (following the CQC inspection)	PE PE	June 2026 July 2026	Board has approved the Policy and it has been widely circulated alongside SOPs. Due to be presented at Clinical Oversight Group on 22nd July 2026 and an update will be provided to the Quality Committee on 20th August 2026. Visit rescheduled for 16th September 2026.

Outstanding Actions Arising from Previous Board meetings for feedback to a later Board meeting						
Date of Board	**Minute No**	**Agenda Item**	**Action**	**Lead**	**Timescale**	**Update Report**
A copy of the full action log recording actions reported back to Board and confirmed as completed/closed is available from the Head of Corporate Affairs						

Humber Teaching NHS Foundation Trust

Board Public Workplan April 2026/March 2027 *(v12)*

Chair of Board: **Caroline Flint**
Executive Lead: **Michele Moran**

Board Dates:- / Reports:	Strategic Headings	LEAD	27 May 2026	29 Jul 2026	30 Sep 2026	25 Nov 2026	27 Jan 2027	31 Mar 2027
Standing Items - monthly								
Minutes of the Last Meeting	Corporate	CF	x	x	x	x	x	x
Actions Log	Corporate	CF	x	x	x	x	x	x
Workplan	Corporate	CF	x	x	x	x	x	x
Chair's Report	Corporate	CF	x	x	x	x	x	x
Chief Executives Report includes:- Policy ratification, Comms Update, Health Stars Update, Directors Updates	Corporate	MM	x	x	x	x	x	x
Publications and Highlights Report	Corporate	MM	x	x	x	x	x	x
Performance Report	Perf & Fin	PB	x	x	x	x	x	x
Finance Report	Perf & Fin	PB	x	x	x	x	x	x
Board Assurance Framework	Corporate	MM	x		x	x		x
Quarterly Items								
Finance Committee Assurance Report	Assur Comm	KN	x	x	x	x	x	x
People & Organisational Development Committee	Assur Comm	CW	x	x	x	x	x	x
Quality Committee Assurance Report	Assur Comm	PE	x		x	x	x	x
Mental Health Legislation Committee Assurance Report	Assur Comm	SP	x		x	x	x	x
Audit Committee Assurance Report	Assur Comm	KS	x	x	x	x	x	x
Collaborative Committee Report	Assur Comm	SP		x	x	x	x	x
High Level Risk Register (March, May, September, November)	Corporate	SS	x		x	x		x
Communications Plan Quarterly Update – Included in CEO Report) (January, May July and November)	Corporate	RK/MM	x (from 2026)	x		x	x	
Six Monthly and Annual Agenda Items								
MAPPA Strategic Management Board Report (inc in CE report)	Strategy	LP			x			x
Safer Staffing 6 Monthly Report (March, September from 2026)	Corporate	SS			X			x
Suicide and Self-harm Strategic Plan (next due September 2025 – moved to November)	Strategy	KF			~~X~~	x		
Recovery Framework Update (from 2026)	Strategy	LP						
Patient and Carer Experience Forward Plan (2023 to 2028 – next due September 2028)	Strategy	KF						

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Board Dates:- Reports:	Strategic Headings	LEAD	27 May 2026	29 Jul 2026	30 Sep 2026	25 Nov 2026	27 Jan 2027	31 Mar 2027
Presentation of Annual Community Survey Results	Corporate	KF		~~x~~				
Guardian of Safeworking Annual Report	Corporate	KF			x			
Patient & Carer Experience (incl Complaints and PALs) Annual Report	Corporate	KF			x			
Infection Control (Enabling) Plan (five yearly – next due in Sept 2028)	Strategy	SS						
Infection Prevention Control Annual Report	Quality	SS			x			
Safeguarding Annual Report	Quality	SS			x			
People Enabling Strategy	Strategy	KP						x
Going Concern Assessment	Corporate	PB	x					
Annual EPRR Assurance Report	Quality	LP	x					
EPRR Core Standards	Corporate	LP				x		
Patient Led Assessment of the Care Environment (PLACE) Update	Quality	PB						x
NHS England - Annual Self-Assessment for Placement Providers	Quality	KF			~~x~~	x		
Annual Operating Plan	Strategy	PB						x
Freedom to Speak Up Annual Report (and Six Month Update)	Corporate	MM		x			6 month update	
Risk Management Enabling Strategy Annual Report	Quality	SS	x	~~x~~				
Report on the Use of the Trust Seal	Corporate	MM	x					
Review of Standing Orders, Scheme of Delegation and Standing Financial Instructions	Corporate	SJ	x					
Charitable Funds Annual Accounts	Corporate	PB					X Separate meeting of Trustees	
A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D – Annual Board Report and Statement of Compliance	Corporate	KF			x			
Gender Pay Gap	Corporate	KP		x				
WDES Report — reports into Workforce & Organisational Development Committee, but separate report to the Board (via Committee Chair report)	Corporate	KP		x				
WRES Report - reports into Workforce Committee with report to Board (via Committee Chair report)	Corporate	KP		x				
Board Effectiveness and Terms of Reference Review	Corporate	CF	x					

Board Dates:- Reports:	Strategic Headings	LEAD	27 May 2026	29 Jul 2026	30 Sep 2026	25 Nov 2026	27 Jan 2027	31 Mar 2027
Annual Committee Effectiveness Reviews & Terms of Reference (one paper)	Corporate	SJ	x					
Reaffirmation of Slavery and Human Trafficking Policy Statement in Chief Executive report	Corporate	MM					x	
Fit and Proper Person Compliance	Corporate	CF	x					
Winter Plan	Corporate	LP			x			
Compliance with the New Provider License	Corporate	SJ	x					
Staff Survey Presentation to Board (IQVIA attending)	Corporate	KP	x					
Staff Survey Progress Report	Corporate	KP			x			
Review of the Constitution	Corporate	SJ	x	~~x~~				
EDS22 Report (for approval)	Corporate	KP			x			
Auditors Letter	Corporate	PB				x		
Annual Members Meeting Minutes	Corporate	CF				x		
Risk Management Enabling Strategy Annual Report	Corporate	SS	x					x
Health Inequalities Six Monthly Update (March and September)	Corporate	KF			x			x
Strategic Board Development Agenda	Corporate	CF	x	x	x	x	x	x
Annual Operating Plan	Corporate	PB					x	
Multi-Professional Enabling Strategy	Quality	SS	x					
Digital Enabling Strategy	Corporate	PB		x			6-monthly update	
Digital Governance	Corporate	PB		x				
Annual Learning from Deaths/Mortality Report (September each year from 2027)	Quality	KF		x				
Six Monthly Model Health Systems Report (agreed at July Finance Committee to forward the report to Board – March and September).	Corporate	PB			x			x
Adhoc/future Items								
Freedom to Speak Up Strategy 2024-2027 (next due May 2027)	Corporate	MM						
Review of Committee Membership and NED Champions (part of Chair report)	Corporate	CF			x			
Insightful Board Update	Corporate	SS/SJ	x					
Mental Health Inpatient Redesign and Granville Court Development Progress Update (requested at the April Strategic Board Development meeting)	Corporate	PB				x		

Board Dates:- Reports:	Strategic Headings	LEAD	27 May 2026	29 Jul 2026	30 Sep 2026	25 Nov 2026	27 Jan 2027	31 Mar 2027
Antimicrobial Resistance (performance against national AMC targets, benchmarking for Antimicrobial utilisation and resistance and key concerns/immediate actions)	Quality	KF	x					
Resident Doctors Ten Point Plan Update, Board Assurance Framework and Next Steps	Corporate	KF	x					
EPR Optimisation Benefits	Corporate	LP			x			
NHS Staff Standards	Corporate	KP			x			
NHS Leadership and Management Framework	Corporate	KP			x			
Learning from visits to other industries report back	Strategy	CJ			~~x~~	x		
Learning from Deaths – Mortality Report	Quality	KF		x				
Cyber Security Arrangements	Corporate	PB			x			
90-Day Service-Level Planning Challenge and Service-Level Activity	Quality	KF				x		
Deleted /Removed Items								

Humber Teaching NHS Foundation Trust

Agenda Item 05

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Trust Chair's Report
Author/s:	Rt Hon Caroline Flint - Trust Chair
Recommendation:	

To approve		To discuss	√
To note	√	To ratify	
For assurance	√		

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	To provide updates on the Chair, Non-Executive Directors (NED) and Governor activities since the last Council of Governors' Meeting.

Key issues:

Positive Assurances to Provide:

- The ATC discussed Succession Planning and Terms of Office for NEDs at the meeting on 15.09.26 with recommendations going to Council of Governors (CoG) Part II on 15 October 2026.
- The Chair and Lead Governor have developed Terms of Reference for a Governor Task and Finish group on Future Engagement and Governor Transition Task and Finish Group to be considered at the Engaging Members Group meeting on 24 September.
- Humber Board is taking part in the first cohort of Trust Providers for NHS England's Board Development Programme.
- Humber Board has been increasing preparation for a Well Led Review in 2027, undertaking mock interviews by an external facilitator and CQC Bitesize briefings provided internally. Governors will be briefed on their role and participation.
- High level engagement Regional and System level with NHS NEY, HNY ICB

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Recruitment campaign planning underway for ANED and inclusion of a NED on approval to be factored in. The ATC agreed the NED Specification should include strategic digital knowledge and skills.
- Continuing development of the Trust's Strategic Roadmap and preparations for a Humber Strategy refresh.
- Future Statutory role of Governors – supported by Governor Task and Finish Group and enabling co-opting of Governors whose term expires in January 2027.
- Board Preparations for a CQC inspection and Well Led Review.

and Humber East Riding Combined Authority.	
Key Risks/Areas of Focus: • CQC Preparation and System Engagement	**Decisions Made:** • N/A

Alignment with the Three Shifts in the Long-Term Plan (*If not applicable please state*)	
Hospital to Community	Engaging with local and regional partners
Analogue to Digital	Ensuring Board has digital knowledge and Skills
Sickness to Prevention	Engaging with local and regional partners and Board oversight

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Appointments, Terms & Conditions Committee	150926	Engaging with Members Group	
Finance, Audit, Strategy and Quality Governor Group		Other (please detail) Quarterly Report to Council of Governors	
Trust Board			

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	
Enhancing prevention, wellbeing and recovery	
Fostering integration, partnership and alliances	√
Developing an effective and empowered workforce	
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	√

Areas to include within the report:	
Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	√
Public Exemption:	
Is the report exempt from public disclosure	No

Trust Chair's Board Report 30 September 2026

Governors Marilyn Foster and Julian Barnard have resigned. Marilyn stepped down as Lead Governor earlier this year but continued in her responsibilities as Appointments, Terms and Conditions Chair, as a PACE Governor and volunteer involved in other Humber activities. She has decided to reduce her volunteering workload but will continue to be active within the Market Weighton Practice and community. It has been a pleasure to work with Marilyn over some years now and on behalf of the Board and governors, we have sent her a bouquet and card.

Julian has been with us a shorter time but engaged with both formal CoG, development sessions, and the PLACE visits, for which he did the most visits of any other governor. His resignation was for personal reasons, and I will write to him expressing our thanks for his service.

Congratulations to Keith Nurcombe who has been offered the role Of Chair at Mid Yorkshire Teaching NHS Trust. Keith has made a positive impact to our Board, and our loss is Mid Yorkshire's gain. The Appointment and Terms and Conditions have recommended a NED with digital knowledge and skills be included in the recruitment campaign for an Associate Non-Executive Director

Trust Board Strategic Development Meeting 26 August 2026

The agenda covered:

- The Annual Review of Risk Appetite
- Implementing Outcome Measures at the Trust (Patient Related Outcome Measures (PROMS) and Clinical Related Outcome Measures (CROM)
- The Provider Capability Process
- Well Led Bitesize Briefing on Organisational Culture

1.Chair's Activities Round Up

Since returning from my leave at the end of August I have worked with the Lead Governor to establish the draft terms of reference for the Future Engagement and Governor Transition Task and Finish Group for consideration by the Engaging with Members Group (EWMG). This action was agreed at the Council of Governors Meeting in July regarding the Health Bill proceeding through Parliament and Humber's PACE Review. At time of writing the EWMG is due to meet on the 24 September where the terms of reference are to be agreed as well as receiving a presentation on the current Humber Review of PACE activities. We also discussed whilst we have not proceeded with governor elections this Autumn, Humber would still like to co-opt governors ending their term in January who wish to maintain a role at Humber as we respect and value their contribution.

NHS England (NHSE) invited Humber to be in the first cohort of their new Board Development Programme for which they have established a consortium of facilitators led by Deloitte. Both Michele and I saw this as a positive opportunity for Board development and have met twice with Stephen Picken from Deloitte who will design our programme informed by a survey of Board members. This NHSE initiative is aimed at both supporting Boards but also to ensure that Boards can meet their obligations under the NHS 10-year plan to increase and sustain impact through continuous improvement and lead organisation-wide transformational state change with stewardship, oversight and accountability. The first Board Day for the programme is on 28 October and over the course of the next 12 months will be the mainstay of our Board Development Plan.

NHS Northeast and Yorkshire Region (NEY) continue to run their Regional Roadshows for Provider CEOs and Chairs, and the next will take place on 8 October. These events are an opportunity to receive high level presentations on what's happening regionally and nationally backed by high level data as well as networking with system colleagues.

Preparations are underway for the Annual Members Meeting and Annual General Meeting on 1 October.

Internal meetings also included:
Complaints Catch Up with David Napier 4 August
Mental Health Legislation Committee 6 August
Appointments, Terms and Conditions Committee 15 September
Quality Committee 29 September

External meetings also included:

NHS Alliance Mental Health Chairs Network 2 September

Board Unannounced Visits

Steph Poole & Pete Beckwith	08/09/26	Maister Court
Phil Earnshaw & Pete Beckwith	22/09/26	Townend Court

2. Governor Activities Round Up

Appointments, Terms and Conditions Committee (ATC) 15 September met to review NEDs succession planning and terms of office.

Engaging with Members Group met on 24 September to discuss the establishment of a Future Engagement and Governor Transition Task and Finish Group.

Governor Development and Information:

Governor Briefings

30 July	How we manage risk and the Board Assurance Framework (BAF)
24 September	The Role of the Humber Youth Action Group

The next **Governor Briefing on 29 October** will receive a presentation on how Humber manages patient flow and demand.

Governor Development Session (GDS)

The next GDS on 12 November will focus on the new version of the performance Report and Patient Outcome Measures.

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Agenda Item 06

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Chief Executive's Report
Author/s:	Michele Moran Chief Executive
Recommendation:	

To approve		To discuss	✓
To note		To ratify	✓
For assurance			

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	To provide the Board with an update on local, regional and national issues. Areas of note include: Ratification of policies for: • Waste Management Policy

Key issues:

Positive Assurances to Provide: • Work contained within the report	**Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):** • Contained within the paper
Key Risks/Areas of Focus: • Nothing to escalate	**Decisions Made:** • Ratification of Policies • The Board notes the findings of the Thirlwall Inquiry, acknowledges the relevance of its recommendations to all healthcare settings, and commits to undertaking a Trust-wide review of safeguarding, patient safety, organisational culture, and speaking-up arrangements. The Board requests a detailed assurance and action plan to be presented through the Quality Committee and reported back within six months.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	The report demonstrates strong alignment with the shift from hospital-based care to community-based care through investment in intermediate care, community mental health services, substance misuse services, admission avoidance initiatives and alternatives to inpatient care.
Analogue to Digital	The report supports the shift from treatment to prevention through public health initiatives, workforce wellbeing programmes, vaccination campaigns, substance misuse prevention activity, and projects focused on reducing health inequalities and improving population health.
Sickness to Prevention	The report aligns with the shift from analogue to digital through investment in digital transformation programmes, shared care records, data analytics, workforce digital systems, artificial intelligence governance and technology-enabled patient engagement

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		**Date**
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	✓
Enhancing prevention, wellbeing and recovery	✓
Fostering integration, partnership and alliances	✓
Developing an effective and empowered workforce	✓
Maximising an efficient and sustainable organisation	✓
Promoting people, communities and social values	✓

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	✓

Public Exemption:

Is the report exempt from public disclosure	No

Chief Executive's Report

This report provides an overview of key developments, highlights of organisational achievements, developments across the wider health system, and national policy updates with potential implications for the Trust.

1 Policies for Approval

Trust Policies

The policies in the table below were approved by the Executive Management Team. Assurance was provided to the Executive Management Team (EMT) as the approving body for policies that the correct procedure has been followed and that the policies conform to the required expectations and standards in order for the Board to ratify these.

Policy Name	Date Approved	Lead Director	Key Changes to the Policy
Waste Management	8/9/2026	Executive Director of Finance, Resources, Estates and Digital	A number of changes have been made to the policy to introduce a more strategic, compliant and sustainable approach to waste management aligned with HTM 07-01, NHS Clinical Waste Strategy and the Trust Estates Strategy.

2. Leadership Visibility

Staff and Service Visits

During the reporting period, I have continued my programme of engagement visits across the Trust, visiting our:

- Addictions Services
- Children and Young People's Services
- School Nursing Teams
- Pharmacy Services
- Maples

These visits continue to provide valuable opportunities to hear directly from colleagues about their experiences and the challenges and successes within their services. Staff remain highly supportive and committed to the organisation and to delivering high-quality care for our communities.

A recurring issue raised during recent visits has been the impact of the prolonged hot weather and elevated room temperatures in some of our facilities. This has affected both staff and service users, and work is ongoing to explore potential mitigations and longer-term solutions.

Our staff engagement initiatives, including Meet Michele and Ask the Execs, continue to be well attended and provide important forums for open dialogue, feedback and organisational learning.

2.1 Around the Trust

Veteran Aware Reaccreditation

I am delighted to report that the Veterans Covenant Healthcare Alliance (VCHA) Steering Group has approved Humber Teaching NHS Foundation Trust's application for reaccreditation of its Veteran Aware Status.

This achievement reflects the Trust's ongoing commitment to supporting veterans, reservists and military families, ensuring that they receive appropriate recognition and access to services that meet their specific needs.

My thanks go to all colleagues involved in securing this important reaccreditation.

GMC National Training Survey 2026

The results of the General Medical Council (GMC) National Training Survey 2026 have been released and demonstrate exceptional performance by the Trust.

Key highlights include:

- Ranked 25th out of 224 UK trusts for resident doctor training, placing Humber in the top 11% nationally.
- Overall resident doctor satisfaction score of 85%, compared to a national average of 78.7%.
- No red outliers identified across any assessed domains.
- Ranked 1st nationally out of 220 UK trusts for trainer satisfaction.

These results represent a significant endorsement of the quality of education, supervision and support provided across the Trust and demonstrate the strength of our learning culture.

I would like to thank all colleagues involved in medical education, training and supervision for this outstanding achievement.

UNICEF Baby Friendly Recognition

I am pleased to report that the Hull 0-19 Integrated Public Health Nursing Service (IPHNS) has been named a finalist in the Institute of Health Visiting (IHV) Health Visiting Team of the Year Awards.

The nomination recognises the team's outstanding work to increase and normalise breastfeeding across Hull and reflects the positive impact being made through collaborative public health initiatives.

This recognition is a further example of the high-quality work taking place across our services and the positive outcomes being achieved for children and families.

Occupational Health Accreditation

The Trust's Occupational Health Service has successfully renewed its Safe Effective Quality Occupational Health Service (SEQOHS) accreditation.

The accreditation has been confirmed until 12 August 2027 and represents national recognition of the quality and effectiveness of the service provided to our workforce.

This achievement demonstrates the team's ongoing commitment to maintaining high standards, delivering effective services and supporting the health, wellbeing and attendance of our staff.

I would like to congratulate the Occupational Health team on this important accomplishment.

National Recognition of Humber's Workforce Health Improvement Programme

The Trust's workforce health improvement work has received significant national recognition following the invitation for Karen Phillips, Executive Director of People & OD, to participate as both a presenter and panellist at a national NHS workforce webinar hosted by the NHS Alliance on 10 September 2026. The invitation was extended in recognition of Humber's innovative and evidence-based approach to improving workforce health, wellbeing and attendance through the Towards a Healthier Workforce programme.

The programme has attracted considerable interest from NHS organisations nationally due to its strong outcomes and distinctive approach, combining workforce analytics with a sustained focus on culture, compassionate leadership, manager capability, wellbeing and early intervention. Humber's work has been highlighted as an exemplar of how organisations can move beyond traditional sickness absence management and instead address the wider factors that influence workforce health and attendance.

The national webinar generated substantial positive feedback, with the Trust's approach receiving praise for the way it integrates workforce intelligence, cultural improvement and leadership accountability to deliver sustainable change. The session has subsequently resulted in a number of follow-up discussions with NHS organisations seeking to learn from Humber's methodology and explore how elements of the programme could be adapted within their own organisations.
This national recognition reinforces Humber's position as a leading organisation in workforce improvement and reflects the impact of the Trust's commitment to creating a healthy, supportive and high-performing culture for colleagues. It also provides an important opportunity to continue sharing learning across the NHS while showcasing the achievements of teams and leaders across the organisation.

3. Around the System

Humber Health Partnership

The organisational review of the Humber Health Partnership, involving Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG), has now concluded.

Since autumn 2025, the Partnership has undertaken a clinically led programme of work to understand and address the longstanding challenges facing both organisations. This culminated in the publication of a clinically led Improvement Plan earlier this year.

Supported by NHS England's Intensive Recovery Programme and independent review by Carnall Farrar, the organisational review considered whether a more integrated model or separate organisational arrangements would best support patients, staff and long-term sustainability.

The review concluded that the existing Group model should cease, with arrangements developed to re-establish a two-organisation model.

The outcome marks a significant development within the provider landscape across the Humber region and will require ongoing monitoring to understand any implications for partnership working and system-wide service delivery.

Tees, Esk and Wear Valleys NHS Foundation Trust

It has been confirmed that Judge John Potter will lead the independent inquiry into the deaths of three teenagers:

- Christine Harnett
- Nadia Shariff
- Emily Moore

All three young people died by suicide whilst under the care of Tees, Esk and Wear Valleys NHS Foundation Trust during 2019 and 2020.

The inquiry will examine the circumstances surrounding these deaths and the care provided, with findings expected to contribute to wider learning across mental health services nationally.

As a mental health provider, the Trust will continue to monitor developments and consider any lessons emerging from the inquiry that may strengthen our own services and approaches to patient safety.

4. National Update

Thirlwall Inquiry Report – September 26

The publication of the Thirlwall Inquiry is a significant moment for the NHS and reinforces the fundamental responsibilities of Boards in relation to patient safety, safeguarding, organisational culture, and speaking up. The report concludes that failures to act on concerns, insufficient curiosity, weak escalation processes, and poor organisational culture contributed to devastating harm. NHS England has made clear that the lessons extend beyond neonatal services and are relevant to every NHS provider and Integrated Care Board. NHS England has requested that all Trust and ICB Boards review the findings at a public Board meeting and seek assurance that similar failures could not occur within their own organisations. Boards are expected to consider whether current governance, safety, safeguarding, and

speaking-up arrangements provide sufficient protection to patients and support for staff.

For a Mental Health and Community Trust, the report has particular relevance to:

- Strengthening safeguarding arrangements for children, young people, and vulnerable adults.
- Ensuring staff feel empowered and psychologically safe to raise concerns.
- Maintaining robust escalation, incident reporting, and learning systems.
- Board visibility and assurance regarding patient safety risks.
- Fostering a culture of openness, challenge, professional curiosity, and accountability.
- Supporting staff wellbeing, particularly in services caring for people with complex needs and significant vulnerability.

The Board notes the findings of the Thirlwall Inquiry, acknowledges the relevance of its recommendations to all healthcare settings, and commits to undertaking a Trust-wide review of safeguarding, patient safety, organisational culture, and speaking-up arrangements. The Board requests a detailed assurance and action plan to be presented through the Quality Committee and reported back within six months.

Government Devolution Agenda

The Government has published its "Rewiring the State" Cabinet Statement, setting out a significant programme of public sector reform centred on greater devolution of powers, funding and accountability from central government to local and regional leaders.

The proposed reforms aim to:

- Strengthen local institutions.
- Increase fiscal devolution.
- Improve integration of public services.
- Support economic growth.
- Enable more place-based approaches to improving population outcomes.

The statement signals a future operating environment in which local authorities, mayors and strategic authorities are expected to exercise greater influence over a range of public services, including health-related determinants such as housing, employment, transport, skills and prevention.

Of particular relevance to the NHS is the Government's stated intention to align key public service boundaries, including those of Integrated Care Boards (ICBs), with strategic authority boundaries before the end of the current Parliament.

For Humber and North Yorkshire ICB, this development reinforces the importance of ongoing boundary alignment discussions and may have implications for:

- Governance arrangements.
- Commissioning responsibilities.
- Strategic planning.
- Place-based partnerships.
- Relationships between providers, local authorities and strategic authorities.

The Government has also reiterated its ambition for increasingly integrated public services, with stronger collaboration across health, social care, education, policing, employment and voluntary sector partners.

These developments align closely with the direction of travel for neighbourhood health, prevention, reducing health inequalities and place-based partnership working.

Further detail is anticipated through:

- The forthcoming Devolution White Paper.
- Future Budget announcements.
- The Fiscal Devolution Roadmap.
- The Spending Review.

The Board will continue to receive updates as additional information becomes available and implications for the Trust become clearer.

The reporting period has seen several notable achievements for Humber Teaching NHS Foundation Trust, including significant national recognition for our education and training environment, reaccreditation of Veteran Aware status, Occupational Health accreditation renewal, and external recognition of our public health nursing services.

Alongside these successes, developments within the wider system and evolving national policy landscape continue to present both opportunities and challenges. The Trust remains well-positioned through its focus on quality, staff engagement, partnership working and continuous improvement to respond effectively to these changes and continue delivering excellent care for our communities.

5. Director Updates

5.1 Interim Chief Operating Officer Update
5.1.2 Leadership Visibility

The Deputy Chief Operating Officer has been appointed as Interim Chief Operating Officer in the absence of the Chief Operating Officer.

5.1.3 Operational Position, Winter Review, Industrial Action and Service Planning

This update provides an overview of the Trust's current operational position, progress against 26/27 winter planning and operational planning progress, and the ongoing arrangements in place both within the Trust and across partner organisations to manage operational pressures and support service delivery.

Operational pressures continue to be monitored through our daily OPEL (Operational Pressures Escalation Levels) and sitrep reporting processes, enabling the timely identification of emerging pressures across services and a coordinated response where required. This provides a clear understanding of operational risk, supports effective communication with system partners, and enables the provision or receipt

of mutual aid as appropriate. The Emergency Planning Team have a rolling programme of review of the triggers and action cards associated with each escalation level that are designed to prevent further escalation remain robust and effective. Escalation triggers remain in place to initiate a daily Executive Director level response when required. We continue to report daily through the national UECRAIDR system and are actively engaging with the Integrated Care Board (ICB) regarding proposed changes to the Opel reporting framework. The Trust is committed to fully supporting and engaging with the change process as it is developed and implemented by the ICB.

The Trust Winter Plan for 2026/27 has been approved at Executive Management Team and has been sent to the ICB and health system partners for feedback ahead of Trust Board submission at the end of September. A regional winter resilience exercise is taking place with all health system partners to work through plans and ensure a joined-up approach to planning and response during the winter period across all partners (through understanding of governance and escalation routes).

The annual operational planning process for 2027/28 has now moved into its second phase. During Quarter 1, a series of planning workshops were completed to review emerging service and system priorities and establish the approach to plan development. In Quarter 2, operational planning workshops are being undertaken across Divisions, bringing together clinical, operational and corporate colleagues to identify priorities, risks, opportunities and improvement ambitions for the year ahead.

The outputs from these workshops will form the objectives and key deliverables within divisional annual plans, ensuring alignment with Trust priorities, local service needs and wider system objectives. This collaborative approach supports the development of robust, deliverable plans informed by performance intelligence, workforce considerations and service improvement opportunities.

During Quarter 2, operational pressures across the Trust have remained moderate overall. The most significant challenge has been in relation to older adult bed availability, where sustained demand has created periods of increased operational pressure. Across Mental Health Services, escalation levels have predominantly remained at OPEL 3, reflecting ongoing system and capacity pressures, with occasional periods at OPEL 2 when demand and service capacity have been more balanced. Similarly, the Community Division has operated between OPEL 2 and OPEL 3 throughout the quarter, demonstrating a generally stable position whilst maintaining the flexibility to respond to fluctuations in demand.

Across the Humber and North Yorkshire system, there have been signs of improvement in overall pressure levels during Quarter 2. Acute hospital partners across all localities have continued to experience operational pressures; however, these have predominantly been reported at OPEL 3, with only occasional escalation to OPEL 4. Whilst system demand remains significant, this represents a more stable position than has been experienced during periods of sustained escalation, and system partners continue to work collaboratively to manage pressures and support patient flow across health and care services.

There have been no further periods of industrial action due to Resident Doctors accepting a pay deal. However, there is now a mandate in place for consultants to take industrial action, no dates or further information have been received at this time.

The Trust declared a business continuity incident and subsequently a critical incident on Wednesday 8th July 2026 due to the evacuation of Malton Community Hospital. The Trust activated their Incident Response Plan and associated command and control structures to support patients, staff and system partners during this period. All staff involved worked extremely hard during this period to ensure patient safety was upheld and work is still ongoing to ensure full bed capacity is obtained at Fitzwilliam ward.

Thank you to all staff involved and the continued support all command and control levels are providing at this time.

Whilst the Trust has continued to manage significant demand for inpatient mental health services during Quarter 2, a temporary increase in inappropriate out of area placements for working-age adults was experienced as a result of capacity pressures within older adult services. Delays in discharge and reduced bed availability within older adult wards resulted in some older adult patients being cared for in adult mental health beds, reducing capacity available for working-age adults. This consequently led to an increase in inappropriate out of area placements for adult patients during the quarter. Since the implementation of additional support from East Riding of Yorkshire Council to strengthen discharge planning and facilitate more timely transfers of care, patient flow within older adult services has begun to improve. As a result, delayed discharges are reducing, bed capacity is being released more effectively, and the number of out of area placements is now showing signs of improvement. To support sustained progress, agreement has been reached with East Riding of Yorkshire Council to enhance social work provision on older adult inpatient wards, strengthening multidisciplinary discharge planning and helping to reduce delays associated with onward care arrangements. In addition, the proposal for four step-up older adult beds, supported by the Older Adult Crisis Intervention Team and the Older People's Acute Community Service Team, has been approved. Work is now due to commence on the development of Hawthorn Court to accommodate this provision. The additional capacity will provide an alternative to inpatient admission where appropriate, improve patient flow across the system, support timely discharge from acute wards, and further reduce reliance on out of area placements for both older adult and working-age adult patients.

The overall staff absence position has remained static from end of July to August with sickness at 5.8%

The National NHS Oversight Framework outcome for Quarter 1 has now been published, incorporating a revised set of indicators, some of which were anticipated and others that represent new measures for Trust performance assessment. The Trust has been assigned a high Segment 2 rating. Whilst this reflects a positive overall position and compares favourably with a number of similar providers that have experienced a deterioration in their segmentation under the revised framework, improvement actions are underway to address key areas of focus and support a return to Segment 1. These actions build on the Trust's existing programmes to improve operational performance, productivity, patient access and flow, supported by transformation, digital optimisation and service improvement initiatives. Performance against the Oversight Framework indicators continues to be closely monitored through established governance arrangements, with targeted improvement plans in place where required.

A planned visit to NHS 111, previously postponed due to the declaration of a critical incident, has now successfully taken place. In addition, colleagues from the Trust participated in a joint visit with North Yorkshire Council to review digital systems, operational processes and ways of working, with a particular focus on identifying learning and best practice that could support service improvement within the Trust.

The Trust's Project Management Office and BeDigital team are now working collaboratively to develop a structured schedule of visits to organisations that benchmark highly for their systems and processes, as well as those that have successfully implemented proven digital solutions. This programme is intended to support the identification and adoption of best practice, innovation and opportunities for service transformation across the Trust. An update on the learning, opportunities and outcomes arising from these visits and the wider programme of benchmarking activity will be provided as the programme progresses.

5.1.4 Community Directorate overview

Investment in Intermediate Care to Support Admission Avoidance and Flow
Additional funding has been secured to expand Intermediate Care services across North Yorkshire. This will provide more clinical capacity, strengthen rehabilitation and reablement, and help people leave hospital sooner. The investment supports delivery of the Intermediate Care Strategy, enabling more people to recover and regain their independence closer to home while easing pressure on hospital services.

Pulmonary Rehabilitation Retains Green Accreditation Status
The Pulmonary Rehabilitation Service has retained its Green Status accreditation, demonstrating that it continues to provide high-quality, evidence-based care. This reflects the service's strong clinical outcomes, positive patient experience and compliance with national standards. It provides assurance that people living with chronic respiratory conditions are receiving effective support to improve their health, independence and quality of life.

5.1.5 Mental Health Service Update

Mental health discharge delays have remained elevated during Quarter 2, reflecting ongoing challenges in securing timely onward care arrangements and maintaining patient flow across inpatient services. However, performance has stabilised during the quarter, with the number of patients who are clinically ready for discharge, including those with no criteria to reside, no longer increasing at the rate seen previously. In contrast, community services have seen a marked improvement in discharge performance, driven by strengthened discharge processes, closer partnership working and a continued focus on reducing delays. During Quarter 2, the strengthened discharge arrangements implemented with East Riding of Yorkshire Council have begun to deliver tangible benefits, contributing to improved patient flow and more timely progression of care. Collaborative work with North Yorkshire Council has also continued, with a focus on reducing response times to discharge requirements and supporting more effective system-wide coordination. Building on these developments, the Trust is embedding revised discharge processes and escalation arrangements to sustain improvements and further reduce delays across inpatient and community services.

Multi-agency discharge meetings remain established and continue to take place on a weekly basis for mental health inpatient services and fortnightly for community rehabilitation beds, providing oversight of complex discharges and supporting collaborative action to address barriers to timely discharge.

Older People's Community Mental Health Team (CMHT**)** has delivered a significant improvement in access and service responsiveness, reducing average referral-to-assessment waits by 50% despite a 40% increase in referral demand since April. Assessment-to-treatment waits have also reduced by a further 50% following a programme of pathway redesign and the introduction of the Community Treatment Service (CTS).

The CTS represents an innovative workforce and delivery model, utilising newly developed Band 3 and 4 roles to provide group-based behavioural activation interventions within community settings. This approach supports earlier access to care, enhances patient experience through peer-supported and trauma-informed delivery, and maximises workforce productivity. Strategically, the model aims to improve patient flow, reduce time spent on caseloads, and optimise the deployment of registered practitioners, enabling specialist resource to be targeted towards individuals with more complex and acute needs.

The Memory Assessment Service has implemented a series of pathway improvements focused on demand and waiting list management, creating a more sustainable and responsive service model. Early indicators demonstrate a consistent week-on-week reduction in patients waiting over 38 weeks. In addition, proactive engagement has been introduced at the point of referral, ensuring patients are connected earlier with community and voluntary sector (VCSE) partners, supporting wellbeing during the waiting period and strengthening the wider system response to growing demand.

Hull Community Mental Health progress has continued against the CMHT Improvement Plan during Quarter 2, with a particular focus on caseload management, waiting list oversight, workforce recruitment, digital enablement and governance. Waiting list management arrangements have been strengthened, with weekly monitoring embedded, improved visibility of follow-up and medication review requirements, and an allocation trajectory now demonstrating the positive impact of additional resources and external support.

Leadership and governance arrangements have been enhanced through the establishment of regular improvement oversight meetings, appointment of a Waiting Well Coordinator and the development of dedicated digital and service management roles. Recruitment remains positive, with agency and substantive workforce plans progressing and additional external capacity due to commence in October. Digital developments continue to support improvement, including the implementation of business intelligence dashboards, enhanced reporting capability and the development of caseload and performance visualisation tools.

Early indicators suggest improvements in patient safety, performance management and organisational culture, supported by strengthened risk stratification processes, positive feedback from a mock CQC visit, reducing vacancy levels and continued focus on neighbourhood-based models of care.

5.1.6 Forensic Service Overview

Forensic Community: Introduction of a band 7 Speech and Language Therapy (SaLT) post across all forensic community - potential for innovation project in this regard.

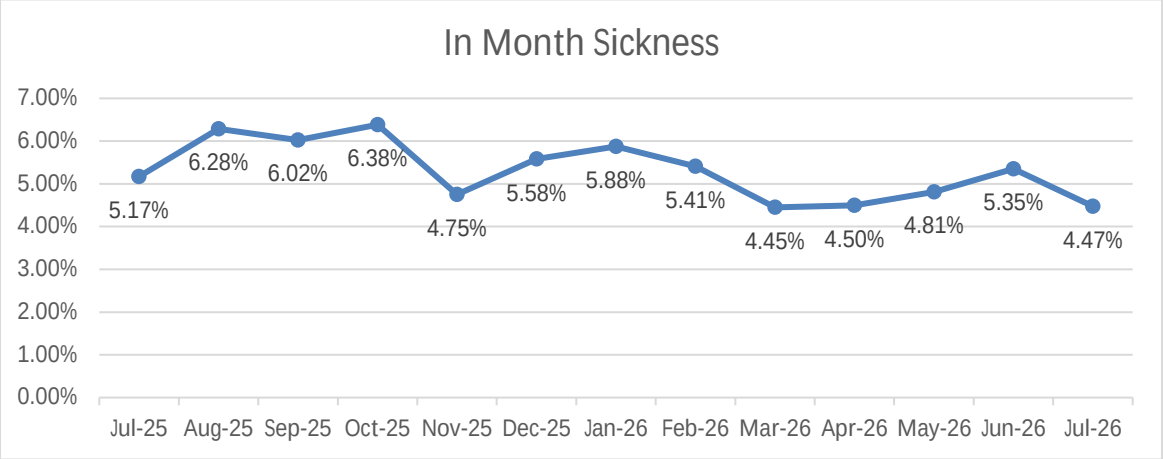
Our forensic community team have introduced a clinical role which spans all-ages of community forensic provision. We recognise the important of Speech and Language Therapy for both our youth and adult service users: over 60% of people in contact with the justice system have speech, language and communication needs (RCSLT, 2016), and we understand that improving the language, literacy and social skills for service users can have a significant impact on recidivism, improvements in independence, and quality of life.

The new post will work with the Youth Justice Services in East Riding, there has already been an SaLT pilot in this service which was able to demonstrate a positive impact. In our adult Community Forensic Service the SaLT role will bring a richness to the MDT offer, enabling service users to access treatment and therapy as well as providing specialist SaLT assessment and intervention.

We know from the recommendations in Phase One of the Southport Report that we are going to be looking at the needs and services delivered to young people up to the age of 25, having team members working across the age groups will improve our transition support, particularly for service users with support needs relating to neurodevelopment. The SaLT will work closely with our transition lead improving the experience of young adults who may be engaging independently with services for the first time. We are looking forward to reporting on the progress and impact of the post.

Forensic inpatient well-being:

Service Managers have been working closely with Ward Managers and HR to ensure that staff are appropriately supported to promote well-being. We have focussed on promoting a positive environment that supports health and well-being. We have also robustly managed absence to ensure a return to work from sickness/ absence when staff are fit to do so; we make referrals to appropriate services, including Occupational Health and the Wellbeing Team. Monthly sickness clinics, return-to-work interviews, reasonable adjustment, strengthened oversight and assurance (from a divisional sickness tracker) have all aided the improved performance, which we aim to maintain:



Forensic Division Admin:

The Forensic Division are scoping a review of their admin needs: The review will assess the structure, capacity and effectiveness of administrative support across Forensic Mental Health services, including inpatient and community services. It will identify gaps, duplication and inefficiencies, consider workload and role responsibilities, and explore opportunities to standardise processes and maximise the use of digital solutions, ensuring administrative resources are aligned to service needs and support the release of clinical time. We look forward to sharing the outcome at the end of the financial year.

Forensic Inpatient Event:

Our patients, involvement lead, professional groups and ward staff engaged together in a Humber's Got talent Event in August. Carers and corporate colleagues also attended to enjoy the show. We had excellent acts with comedy, music and even a 10-pin bowling show! The event was a huge success rounded off with burgers and hot dogs, veggie options and cake. Here's some feedback:

"…thank you and everyone involved for all your hard work in making Humber's Got Talent such a wonderful success. It was a real pleasure to attend the event. All the contestants were amazing. The event was so well organised, and seeing the participants' faces, their interactions and their enthusiasm was truly heart warming, and more than words can describe. It was also lovely to see staff supporting and interacting with patients in such a natural and relaxed way, while giving them the space and independence to enjoy themselves rather than being constantly on top of them. It would be wonderful to see something similar take place more often. Events like this can make such a positive difference to people and the wider community. Carer, August 26

"The performers were so brave to get up and do what they did, and to showcase different talents. But honestly the best part of it for me was how the patients supported each other throughout, the hugs and handshakes, everyone cheering - and when X got a strike and the room erupted, I could have cried!" Health Stars

"Mixing the wards was good, there was a great atmosphere!" Service user August 26

"I just wanted to say what an excellent event Humber's Got Talent was today. The passion, enthusiasm and courage on display from both patients and staff was truly

evident throughout the event. It was fantastic to see so much engagement and support for the participants, and the positive impact the event had on everyone involved." HR staff

5.1.7 Children's and Learning Disability Service Overview

Learning Disability services are delivering strong productivity with the most tangible success is within Learning Disability services, where several teams are performing above plan on NCCI productivity measures.

Waiting times for both children's and adult neurodiversity services continue to represent a significant area of operational pressure and challenge, with demand consistently exceeding commissioned capacity and there being no commissioned service for East Riding adult ADHD referrals. During the reporting period, the Integrated Care Board (ICB) issued a new service specification for an all-age neurodiversity service and identified funding to support its implementation. In response, the Neurodiversity Team has developed a comprehensive mobilisation plan and supporting activity plan aligned to the new specification. The plans set out a phased approach to implementation, reflecting the staged release of funding by the ICB and prioritising actions to improve access to assessment and treatment, reduce waiting times, and decrease reliance on Right to Choose referrals. The Division continues to work closely with the ICB to finalise delivery arrangements and ensure the service develops in line with commissioning expectations. A separate paper outlining the proposed model, mobilisation approach, and phased delivery plan will be presented to the Board. This represents a positive step towards establishing a more sustainable and equitable approach to meeting the growing demand for neurodiversity services across the region.

The Inspire Family Day Service is in the final stages of implementation and is scheduled to go live in September 2026. Good progress has been made across all project workstreams, including workforce, operational, digital, estates and governance elements, with the majority now complete or nearing completion.

Final preparations are underway to support a safe and effective launch, alongside continued stakeholder engagement and workforce development. The service will provide a day therapy alternative to inpatient admission for children, young people and families, improving outcomes and patient experience while reducing the need for inpatient care and associated costs.

5.1.8 – Multi-Agency Public Protection Arrangements (MAPPA) Assurance Update

The Mental Health Legislation Committee received the Trust's annual assurance report on compliance with Multi-Agency Public Protection Arrangements (MAPPA). MAPPA provides the framework through which criminal justice agencies and partner organisations work together to manage the risks posed by violent and sexual offenders and protect the public from serious harm. As a Duty to Cooperate agency, the Trust is required to identify individuals subject to MAPPA, share relevant information, and contribute to risk assessment and management processes. The Committee was assured that robust governance and operational arrangements remain in place to support the Trust in meeting these obligations.

The Trust continues to maintain a well-established MAPPA structure, led by the Forensic Division Clinical Lead acting as Operational Lead, supported by divisional MAPPA leads across services. Divisional leads attend Level 2 and Level 3 MAPPA meetings, provide oversight and quality assurance of referrals, and act as the link between MAPPA panels and clinical teams. Regular interface meetings between Trust representatives and the MAPPA Coordinator and Administrator continue to provide opportunities to review performance, discuss operational issues and ensure effective partnership working. The Trust remains actively engaged in the Strategic Management Board (SMB), Performance and Quality Assurance (PQA) Group, Criminal Justice Board and local MAPPA panels, with no concerns raised regarding attendance, engagement or compliance.

The Committee also noted a number of positive developments during the reporting period, including approval of a revised MAPPA Protocol, delivery of foundation-level MAPPA training in April 2026 attended by more than 80 staff, increased use of an automated electronic patient record (EPR) report to identify MAPPA patients, and continued communication through divisional networks and a dedicated intranet resource. The Trust has also contributed to the annual MAPPA report being produced by the Responsible Authority, including input on the implications of the Mental Health Act 2025 and its interface with the criminal justice system.

A re-audit undertaken in March and April 2026 reviewed 97 patients recorded as being subject to MAPPA across Mental Health, Forensic and Learning Disability Services. The audit demonstrated 100% compliance in the accurate recording of MAPPA status within the electronic patient record system and 100% compliance in maintaining current MAPPA alerts. Compliance was also high in relation to MAPPA reviews (95%), inclusion of MAPPA information within risk assessments (88%) and incorporation of MAPPA considerations within care plans, formulations and risk management plans (92%). This represented a significant improvement across all measures when compared with previous audit findings. Following the audit, all identified documentation gaps were addressed and patient records updated to ensure full compliance.

Further work is ongoing to strengthen assurance arrangements, including continued attendance at MAPPA governance meetings and a data validation exercise with partner agencies to reconcile Trust records with those held by the Responsible Authority. The Committee concluded that the Trust has effective governance, communication and partnership arrangements in place and received strong assurance that it continues to meet its responsibilities as a Duty to Cooperate agency. Feedback from both the MAPPA Coordinator and the Strategic Management Board remains positive, with no risks or concerns regarding the Trust's compliance with MAPPA processes currently identified.

5.2 Executive Director of Nursing, Quality and Professions / Caldicott Guardian

5.2.1 Leadership Visibility

Executive Director of Nursing, Quality and Professions Visit to East Riding Partnership – 12 August 26

On 12 August, the Executive Director of Nursing, Quality and Professions visited the East Riding Partnership, a collaboration between Humber Teaching NHS Foundation Trust, Alcohol and Drug Service (ADS) and Nacro. The partnership provides comprehensive, community-based substance misuse services across the East Riding of Yorkshire, delivering support for both adults and young people through hubs in Goole, Bridlington and Hull, alongside a range of satellite locations.

The visit provided an opportunity to meet with service leaders and members of the multidisciplinary team to gain a greater understanding of the breadth and impact of the service. Discussions highlighted the team's passion, commitment and expertise in supporting individuals affected by substance misuse, alongside the extensive range of programmes available to meet diverse needs.

The Executive Director met representatives from across the service, including nursing, social work, medical, healthcare support, recovery worker and peer mentor roles. The multidisciplinary nature of the workforce was identified as a key strength, enabling the delivery of personalised and holistic care.

The team outlined the range of interventions provided, including detoxification, stabilisation and maintenance therapies. The service's case management approach combines prescribed treatments with psychosocial interventions through individualised recovery plans designed to support long-term recovery and wellbeing.

Strong partnership working was evident throughout the service model. The team described close collaboration with primary care colleagues to broaden access to treatment and improve outcomes. This includes delivery of the Optimise Programme, which supports individuals to safely reduce or discontinue long-term prescribed medications where appropriate.

The visit also highlighted innovative programmes delivered by the partnership, including:

- Close working with the Criminal Justice Team to ensure continuity of care for individuals within, or transitioning from, the justice system.
- The Inclusion Health Team and Inclusion Health Bus, providing outreach services, health education, overdose prevention and needle exchange support to people experiencing homelessness and those recently released from prison.
- Parenting Under Pressure (PuP), which offers therapeutic support to parents experiencing substance misuse and associated challenges.

The Executive Director was particularly impressed by the service's proactive approach to horizon scanning and identifying emerging trends and risks associated with substance misuse. The team described how they monitor developments in drug use patterns and maintain links with local communities and settings where new risks may emerge, supporting early intervention and prevention.

During discussions, opportunities were identified to strengthen collaboration between mental health and substance misuse services, particularly for individuals with co-occurring mental health and substance use needs. Support was offered to explore opportunities for multidisciplinary case review meetings to enhance integrated care planning and improve patient outcomes.

The use of technology was also discussed, with potential opportunities identified to further improve accessibility through the exploration of enhanced translation and interpretation solutions.

A key theme throughout the visit was the team's commitment to recovery-focused practice. Staff described recovery as a highly individual journey, recognising that successful outcomes vary according to personal circumstances and goals. The service adopts a person-centred approach that supports individuals to improve wellbeing, reduce harm, build resilience and strengthen support networks, alongside supporting those whose aim is abstinence from drugs or alcohol.

The visit provided strong assurance regarding the quality, innovation and compassion evident within the East Riding Partnership. The Executive Director observed a highly motivated and committed workforce, with a clear focus on improving outcomes and supporting individuals to achieve meaningful and sustainable recovery. The dedication, enthusiasm and pride demonstrated by the team were evident throughout the visit.

Long Service Staff Awards

On 30 July 2026, the Trust held a special Long Service Awards celebration to recognise and honour colleagues who have demonstrated many years of dedicated service. The event was attended by the Executive Director of Nursing, Quality and Professions, alongside the Chief Executive who personally presented awards to staff in recognition of their commitment, professionalism and contribution to patient care and services across the organisation. The celebration provided an opportunity to acknowledge the significant achievements and lasting impact of long-serving colleagues, whose dedication has helped shape and strengthen the Trust over many years. It was a memorable and heartfelt occasion, reflecting the organisation's appreciation for the invaluable contribution of its workforce and celebrating the collective experience, expertise and commitment of staff.

5.2.2 Caldicott Guardian Update

IG Audits

A series of Information Governance audits have taken place across the Forensic Directorate. The audits are to assess the effectiveness of information governance processes and operational practices.

This audit provided a valuable opportunity to assess Information Governance (IG) knowledge and awareness across ward teams by engaging with staff in a range of clinical and non-supervisory roles, rather than focusing solely on ward managers. This approach enabled a broader understanding of how different staff groups perceive and apply IG principles and helped identify the most effective methods for communicating IG requirements across ward environments.

Good Information Governance practices were observed overall across all wards that were audited with area of notable good practice. Actions from the audits focus on broadening Information Governance knowledge beyond routine responsibilities, increasing awareness of recent developments and organisational guidance, and

building confidence in applying Information Governance principles to less familiar or more complex scenarios.

Data Security and Protection Toolkit (DSPT)

The CAF-aligned DSPT is how the Trust measures its information governance and cyber security compliance. The Trust has published its DSPT and has achieved a 'Standards Met.' DSPT. Eight of the DSPT Outcomes were raised above the national expected minimum. The evidence for 12 x DSPT Outcomes were submitted for a mandatory independent audit. The audit confirmed the Trust has a comprehensive, effective and established IG framework with information governance and cyber assurance activities embedded within a structured work cycle and a structured Board led framework and clear accountability and governance arrangements in place. There was one low risk action arising from the audit which has now been completed.

IG Annual Report

The IG Annual Report highlighted the achievements of the Team, and the work undertaken to support the Trust to maintain compliance with data protection legislation. The report set the objectives for the year ahead.

Stopping Unlawful Access to Records Guidance

NHS England has recently strengthened its guidance on preventing unlawful access to health and care records. The guidance has been reviewed against current Trust processes, the review provided assurance that robust systems, policies and processes are in place to protect confidential information, supported by clear staff responsibilities, monitoring arrangements and ongoing awareness activities. The review has provided the opportunity to look at how these arrangements can be strengthened, an action plan is in place, progress will be monitored by the Information Governance Group.

MetaCompliance Awareness Programme

The Trust continues to utilise the MetaCompliance platform to strengthen cyber security and information governance awareness across the workforce. Through the delivery of short, accessible learning resources and Nano Videos, the platform provides regular opportunities for staff to reinforce their understanding of key information governance, data protection and cyber security principles. This supports the Trust's commitment to maintaining a strong security culture and reducing risks associated with human error, which remains a significant factor in information security incidents.

To further enhance staff awareness, monthly communications are being distributed Trust-wide, providing access to targeted learning resources and key security messages. This approach supports the ongoing promotion of good information governance practice and helps ensure that cyber security remains a visible organisational priority.

Feedback indicates that staff value the practical and concise nature of the learning materials. However, awareness work has identified that some communications are not always being fully engaged with, partly due to unfamiliarity with the platform and, in some cases, because staff appropriately exercise caution when receiving unsolicited electronic communications. Whilst this reflects a positive security culture, ongoing work is being undertaken to improve recognition of approved learning resources and maximise participation in the programme.

The Executive Management Team has endorsed the continued use of MetaCompliance as part of the Trust's wider cyber security and information governance assurance framework. This support will help further strengthen staff engagement, promote good security behaviours and support the protection of patient, staff and organisational information

Anti-Racist Network Update

Demand for Anti-Racist Practice training continues to increase across the Trust, with sessions being requested and delivered within a number of services including Intensive Support, Forensics, Townend Court and PICU. The training focuses on increasing awareness of racism, promoting anti-racist practice, encouraging individual and team reflection, and supporting staff to have open and constructive conversations about race and inclusion. The Executive Director of Nursing, Quality and Professions continues to actively support this work and the ongoing delivery of Anti-Racist Practice training as part of the Trust's commitment to creating an inclusive culture and embedding anti-racist principles across all services.

As part of Black History Month, the Anti-Racist Network will host a face-to-face event on 7 October 2026, bringing together staff from across the Trust and partner organisations for networking, peer support and shared learning. The event will feature external speakers and discussions focused on advancing anti-racist practice and strengthening collective action to tackle racism within health and care settings. The Executive Director of Nursing, Quality and Professions will be attending the event in support of this important work and to reinforce the Trust's ongoing commitment to equality, diversity and inclusion.

5.2.3 Professional updates

Nursing

At the end of last month, the Chief Nursing Officer for England, brought together senior nursing and midwifery leaders from across the NHS, social care, the military, independent and voluntary sectors. These events are an important opportunity to come together as one leadership community, to focus on the priorities we share, have honest conversations about the challenges facing our professions, and identify where we can work collectively to improve care for the people and communities we serve.

The new Secretary of State for Health and Social Care, Yvette Cooper, was able to join us. Colleagues valued hearing directly from her about her priorities and her clear

support for nursing and midwifery, recognising the vital contribution you make every day in all settings.

During her speech, the Secretary of State reiterated the importance of social care reform and the need to build a system that works better for people, families and staff. The Big Conversation on Care has now been launched, asking people across the country what they want and expect from a future National Care Service. This is a significant opportunity for nursing colleagues, and the people we support, to help shape the future of care. Please do take part and encourage others to get involved. In July, the Department of Health and Social Care opened a call for evidence on the use of the title ‘nurse’. We know that patients and the public place enormous trust in registered nurses. By protecting the title of nurse, we can help maintain public confidence that care is being provided by professionals with the right education, skills and accountability, and this call for evidence is an opportunity to help shape how future protections for the title of nurse should work in practice. This has been shared across the nursing community within the Trust for views. We have begun some initial scoping work in preparation for any national recommendations.

In future we will need to increase planning for hotter summers as we do every year for winter. We are already looking ahead to and preparing for the winter months. Vaccination is one of the simplest and most effective ways we can help protect ourselves, our families, and our patients. As nursing professionals, we also play a vital role in promoting the importance of vaccination to our patients and local communities, and in protecting ourselves.

Social Work Update

Social Work services continue to make progress across a number of strategic and operational priorities. Joint work with Hull City Council has focused on securing a sustainable future model for Approved Mental Health Professional (AMHP) services, including proposals to address current workforce and funding pressures and support the delivery of safe and effective statutory services.

Social work performance and delivery continue to be monitored through developing joint dashboard arrangements, with a focus on strengthening oversight of statutory responsibilities and supporting improvements in Care Act review activity. Workforce development remains a key priority, with three staff successfully securing places on AMHP training programmes commencing in September and further work underway to expand practice education capacity, support social work apprenticeships and develop newly qualified social workers through the Assessed and Supported Year in Employment programme. The Trust has also continued to influence social work practice more widely, with its approach to developing social work services being shared with Humber and North Yorkshire ICB colleagues and ongoing partnership work with NHS England, the Department of Health and Social Care, and Lancashire and South Cumbria NHS Foundation Trust to advance interprofessional learning, leadership development and trauma-informed practice.

Allied Health Professionals 2025-2026

Achievements at a Glance

Workforce Growth & Development

2025 – 2026 saw a 4% increase across the AHP registered workforce

4 AHP Support Workers commenced the Level 6 Apprenticeship in March 2026

NHS Funding Bid granted – 5 AHP Support Workers accessing level 3 and 5 Apprenticeships

AHP first Communication Team led Recruitment Campaign

Achievement of increased compliance from 74% in 2024-2025to 96% across AHP e-job planning, demonstrating strong engagement and workforce alignment. Data shows direct clinical care, with over 80% of time dedicated to patient-facing activity and 19% of AHP time is dedicated to supporting professional activities, with a strong focus on training, supervision, and continuing professional development

Occupational Therapy and Physiotherapy have increased their student offers to Teesside University.

Provided long arm supervision for 6 Role Emerging AHP students in 2025-2026.

Speech and Language Therapy introduce student placements from York St John University

Innovative Practice & Integration

AHP LinkedIn site doubled connections from 214 to 462

Children's SLT waiting list reduced from 52 and aiming to achieve 18 weeks

Improved digital developments and innovations with 1 AHP attending "AI for Leaders" and 10 AHP staff attending "AI for workers" Training. AHP representation in National AI Ambassador Network and a Physiotherapist creating an AI video for patients as part of their Leadership Project.

Increased engagement across 24 Research initiatives, embedding a culture of evidence-based practice

Delivery of 39 AHP Quality Improvement Charters demonstrating a strong commitment to continuous improvement

Improved implementation of AHP Clinical Outcome Metrics (TOMs) across all Trust divisions, supported by the development of a TOMs BI dashboard to capture and analyse outcomes data

Implemented an AHP Clinical Pathway Audit, piloted across Mental Health OT services, identifying best practice and improvement areas and now available on InPhase for wider rollout

5.3 Executive Director of People & Organisational Development (OD) Updates

5.3.1 Leadership Visibility

Addictions Services Visit – August 2026
The Executive Director of People & OD visited the Trust's Addictions Services and met with Simon and Lisa to gain an overview of the service, its outcomes and current challenges. The discussion highlighted increasing demand, driven in part by greater awareness of services and reduced stigma around accessing support. The service provides harm reduction, treatment and recovery support, working closely with primary care, public health, criminal justice and other partner organisations.

Staff described supporting individuals with complex needs, including substance dependency and co-existing mental health conditions, through multidisciplinary assessment and recovery pathways. Strong partnership working, outreach provision and engagement with young people were highlighted as particular strengths.

A key focus of the visit was staff wellbeing. Whilst colleagues manage significant caseloads and emotionally demanding work, there was a clear emphasis on supporting staff through regular clinical supervision, strong leadership and a positive team culture. Staff spoke positively about the support available to them and the visibility of local leadership. Turnover remains relatively stable, and leaders continue to prioritise staff wellbeing and professional development.

Overall, I was impressed by the commitment and professionalism of the team. The visit demonstrated the significant impact the service has on supporting recovery and improving lives, underpinned by strong partnership working, effective leadership and a supportive culture.

5.3.2 NHS Staff Standards

NHS England's NHS Staff Standards, published on 6 July 2026, introduce a mandatory national framework to strengthen staff experience and improve consistency across NHS organisations. The Standards cover six priority areas: line management, health and wellbeing, violence prevention and reduction, sexual safety, tackling racism, and flexible working. Compliance and progress will be monitored through the NHS Oversight Framework, with performance assessed against NHS Staff Survey indicators and workforce metrics.

The Standards align closely with Humber's existing priorities within *Being Humber*, the People Strategy and established programmes focused on wellbeing, inclusion, flexible working, sexual safety, violence prevention and leadership development. As a result, the Trust is well positioned to respond to the new requirements.

A comprehensive assessment against the Standards has been completed and reviewed by EMT. Work is now underway to establish a reporting framework and implementation plan, ensuring robust oversight through EMT, People Committee and Board. This will enable targeted action where required, provide assurance on progress and support delivery of measurable improvements against the national framework.

Overall, the Standards reinforce the national emphasis on staff experience as a key determinant of organisational performance. Humber has strong foundations in place and appropriate governance arrangements to support effective implementation and ongoing assurance.

5.3.3 NHS Leadership and Management Framework

NHS England has launched the NHS Leadership and Management Framework, introducing a national code of practice, leadership standards and management competencies for leaders and managers at all levels across the NHS. The framework provides a consistent approach to leadership expectations, development and accountability, and is supported by a range of resources including a self assessment tool. Additional development resources, enhanced feedback tools and modular learning programmes are expected to follow later this year.

In response, Humber is launching its new **Leadership and Management Skills Hub**, which will act as a single point of access for national NHS leadership resources alongside the Trust's existing leadership, management and talent development offers. This approach supports the commitments previously outlined to EMT regarding strengthening leadership capability, enhancing talent management pathways and embedding the Being Humber culture programme.

Work is underway to align Humber's current leadership and management development programmes with both the NHS Leadership and Management Code and the new Framework. This will ensure that national and local development offers complement one another, providing a coherent and consistent leadership journey rather than competing initiatives.

By bringing these resources together through the Skills Hub, the Trust will provide greater clarity for leaders and managers about the standards expected of them, the development opportunities available and the support required to succeed. This reinforces Humber's commitment to investing in leadership capability and creating the conditions for leaders and managers to thrive in the modern NHS, whilst continuing to deliver compassionate, inclusive and effective services for patients and communities.

5.3.4 Future Workforce Solution – NHS People Portal

The NHS Future Workforce Solution project was created to identify a new solution to succeed the existing Electronic Staff Record (ESR). Earlier this year, Infosys were identified as the new provider to develop and roll out the new system, as well as complete the phasing out of ESR.

Recently, the project has received an update to its name and branding – the new solution will be titled the NHS People Portal and is described nationally as a major step forward for current systems, with a significantly broader and more integrated suite of capabilities.

The solution will aim to provide a shared workforce platform supporting common ways of working while also meeting local needs. Early adopter organisations are currently planned to go live by mid-2028, with a broader rollout of remaining

providers by 2030. It is estimated Humber will learn its place in the wider roll out around the end of the year.

To support the transition to the new solution, several internal readiness activities are underway, including a wider adoption of appraisal functionality in ESR during this year's appraisal window, an in-progress roll out of Manager Self-Service (see below) and a planned data quality and cleansing exercise of the existing system.

5.3.5 ESR Manager Self Service

A project to implement a higher level of ESR Manager Self Service functionality across the organisation is now underway. Currently in the planning stages, the project aims to support managers to complete staffing changes, hires and leavers in a timely manner directly in ESR, reducing the requirement to complete and submit forms outside of the core system.

In addition to providing a more efficient process, the functionality will also reduce the amount of central processing of forms, increase the data quality of staff assignment changes and provide both a cultural change and the infrastructure required to transition to the NHS People Portal at a later stage.

The planning of the project will continue to gather pace in the coming months, with services already identified to pilot the new functionality receiving full access to Manager Self Service later this year.

5.3.6 Flu Plan Summary 2026

The 2025/26 flu vaccination campaign delivered a strong performance, achieving 66% uptake among frontline staff, reaching the second highest national uptake position in November 2025 and contributing to a continued reduction in flu-related sickness absence. This reflects the effectiveness of a data-led approach and the peer vaccinator model.

Planning for the 2026/27 campaign is well advanced through the established Flu Working Group, with representation from Occupational Health, People Experience, Pharmacy, Communications and Workforce Systems. The focus is on increasing uptake, reducing variation across teams and further embedding vaccination as a routine workforce health intervention.

EMT has reaffirmed its support for the peer vaccinator model, including protected time for peer vaccinators where operationally feasible and approval of an additional half day of annual leave for peer vaccinators who achieve the 71% uptake target within their areas.

Key actions for 2026/27 include:

- Deployment of a weekly team-level dashboard to identify low-uptake areas and target interventions.
- Recruitment and training of additional peer vaccinators, with 33 registrants currently identified and a target of 50 trained vaccinators.
- Improved accessibility through local clinics, pop-up sessions and simplified processes.

- Targeted communications and engagement to address vaccine hesitancy.
- Alignment of vaccination and sickness absence data to prioritise higher-risk areas.
- Ongoing divisional accountability supported by robust governance, weekly reporting and targeted follow-up actions.

Overall, strong governance arrangements, enhanced data insight and continued investment in the peer vaccinator model provide assurance that the Trust is well positioned to increase uptake and strengthen workforce resilience during the 2026/27 campaign.

5.3.7 Equality, Diversity and Inclusion

Disability Confident Leader

Following a successful independent assessment and third-party validation process, the Trust has been awarded Disability Confident Leader status, the highest level of the Government's Disability Confident scheme.

This recognition demonstrates our commitment to creating an inclusive workplace where disabled colleagues can thrive and confirms that our employment practices meet rigorous standards for attracting, recruiting, retaining and developing disabled talent. As a Disability Confident Leader, the Trust is expected not only to champion disability inclusion within our own organisation but also to share good practice, support other employers and act as an advocate for greater accessibility and equality across the wider health and care sector.

This achievement reflects the sustained efforts of colleagues across the Trust to foster a culture where diversity is valued, and everyone is empowered to contribute their best.

New Staff Network Chairs

Following a period of recruitment challenge in identifying suitable candidates to lead the Disability and LGBTQ+ Staff Networks, we are pleased to report that new Chairs have now been successfully appointed to both networks.

The appointments provide renewed leadership and momentum for these important colleague forums, which play a key role in promoting inclusion, supporting staff wellbeing, and ensuring that the voices and experiences of underrepresented groups help inform organisational priorities.

Both Chairs have now convened their inaugural network meetings, providing an opportunity to engage with members, establish priorities for the coming year, and begin developing action plans aligned to the Trust's equality, diversity and inclusion objectives. This represents a positive step forward in strengthening colleague engagement and maintaining effective staff network representation across the Trust.

Strategic Board CQC Bitesize Session: EDI and Sexual Safety

In July, a dedicated Strategic Board CQC Bitesize Session focusing on Equality, Diversity and Inclusion (EDI) and Sexual Safety was delivered to Trust Board members as part of ongoing preparations for the anticipated Care Quality Commission (CQC) Well-Led Inspection.

The session provided Board members with an overview of the national and regulatory expectations relating to EDI, workforce culture, sexual safety, and organisational leadership. It also provided an opportunity for discussion and reflection on the Trust's progress, areas of strength, and opportunities for further development. It supports the organisation's commitment to maintaining a positive, inclusive culture and ensuring continued readiness for external scrutiny, while reinforcing the Board's role in providing effective oversight of EDI and sexual safety across the Trust.

This work demonstrates the Trust's proactive approach to strengthening leadership awareness and accountability in key areas that contribute to a safe, inclusive and well-led organisation.

Respect in Care Pilot Demonstrates Measurable Impact in Tackling Racism

The Trust is leading innovative work through its Respect in Care pilot, a quality improvement initiative designed to address racism experienced by staff on inpatient wards. Using a Quality Improvement (QI) methodology, the project has developed and tested an evidence-based intervention aimed at creating safer, more respectful environments for both staff and patients.

The pilot has demonstrated significant and measurable success, delivering rapid improvements within a short timeframe. Within three months, incidents of abuse reduced by 65%, falling from 102 to 36 incidents, while overall incidents decreased by 52%. These outcomes highlight the effectiveness of a structured, proactive approach to addressing racism and promoting respectful behaviours within clinical settings.

The benefits of the initiative have extended beyond incident reduction to positively impact workforce wellbeing and organisational resilience. Staff sickness rates reduced from 6% to 4%, alongside lower turnover levels and a 31% reduction in vacancy rates. These improvements demonstrate the strong link between creating inclusive, supportive working environments and achieving better workforce outcomes.

The success of the pilot provides a strong foundation for wider implementation across the Trust and offers valuable learning for other organisations seeking to address workplace racism. It reflects the Trust's commitment to embedding anti-racism within quality improvement practice and delivering meaningful, sustainable change that improves both staff experience and the quality of care provided.

Trust Celebration of South Asian Heritage Month

The Trust marked South Asian Heritage Month by celebrating the rich cultures, histories and contributions of colleagues with South Asian heritage. Throughout the month, a series of communications highlighted the experiences and achievements of staff from across the organisation, creating opportunities for learning, reflection and meaningful conversation.

A key feature of the celebration was the sharing of personal stories from staff members, who spoke about their cultural backgrounds, career journeys, and the

importance of identity and belonging in the workplace. These inspiring accounts provided valuable insight into the diversity of experiences within the Trust and helped to promote greater understanding, appreciation and inclusion among colleagues.

Hear the Story Podcast Launch

The Trust has developed Hear the Story, a new podcast series that brings together the voices of colleagues and people with lived experience to explore how understanding individual stories can improve care and support better outcomes.

Created as part of the wider See the Story campaign, the podcast supports the work of the Trust's Care Culture and Equity Group by promoting trauma-informed care, reducing health inequalities, advancing the Patient and Carer Race Equality Framework (PCREF), and strengthening a culture of compassionate care. Through shared experiences and personal reflections, the series highlights how listening, understanding and responding to people's stories can make a meaningful difference to care experiences. Alongside the podcast, the campaign provides practical resources to help teams embed these principles into everyday practice and support more equitable, person-centred care.

Responding to the EHRC Code of Practice and Supreme Court Judgment

Following the publication of the Equality and Human Rights Commission (EHRC) Code of Practice in July, issued in response to the Supreme Court judgment, the Trust established a dedicated Task and Finish Group to review the guidance and consider its implications for the organisation.

The group has met to assess the potential impact on Trust policies, practices and staff support arrangements, ensuring that the organisation remains compliant with legal requirements while continuing to promote an inclusive and respectful environment for all colleagues and service users. A briefing paper has been drafted for the Executive Management Team, outlining the key considerations arising from the guidance, the expected implications for the Trust, and recommended actions to support implementation.

This work demonstrates the Trust's commitment to responding proactively to changes in the legal and regulatory landscape, providing clear leadership and guidance, and ensuring that Equality, Diversity and Inclusion principles remain embedded across the organisation. The ongoing review will help to support consistent practice, informed decision-making, and effective communication with staff as national guidance continues to develop.

5.3.8 People Experience

Developing a Multi-Generational Employee Value Proposition

Through research and a series of generation-based focus groups, colleagues shared their experiences, needs and desires and what helps them thrive at work at there particular stage of life and career. This led to 262 statements (each a story told by staff) in our own words across all 4 cohorts – Gen Z, Gen Y (millennials), Gen X and Gen Baby Boomers. There were clear reoccurring themes across all the cohorts – but the needs behind them were unique to each cohort. Interestingly the reoccurring

themes were very similar, if not at times mirroring, the national research. Each statement was coded (counted) under the reoccurring themes

- Flexibility 38 (statements of needs and desires)
- Supportive Compassionate Managers 38
- Clear Communication and Involvement 38
- Development and progression opportunities 22
- Fairness and equity in treatment 12
- Well-being 29
- Connection with colleagues and sense of belonging to team at work 22

We have now moved into the second phase, with follow up cohort sessions focused on validating findings, exploring differences in needs across generations, and identifying each cohorts priority theme/top 3 statements and confirm a single practical action colleagues would like to see taken forward in 2026. A wider electronic survey has also been shared with all volunteers to ensure as many voices as possible contribute to shaping future priorities.
Early findings continue to reinforce the importance of compassionate leadership, meaningful career development, flexibility, psychological safety, and strong team connections.

e.g. **Generation X** colleagues highlighted the importance of psychological safety, compassionate leadership (at all levels) and being actively involved in decisions that affect their work. A strong theme was the need for managers who listen, involve staff from the outset of change, and create environments where experience and expertise are valued – especially at times of crisis / urgency. Career development also featured prominently, particularly opportunities to gain experience outside existing roles, access development later in careers that can accommodate health/complex/changing personal situations, and receive practical support with retirement/return and pension planning. The group's emerging suggestions included compassionate leadership and coaching training for managers at all levels, proactive career development opportunities protected development time (in other roles / current role), opportunities to experience different roles across the Trust, and better local support to help staff plan for retirement. **Generation Z** colleagues reinforced the importance of meaningful career development, autonomy and positive relationships with managers. The group spoke about the importance of flexibility and trust, recognising that whilst they are passionate about their work, work-life balance remains a key priority. Social connection and the overall health of teams (i.e. relationships with one another) emerged as strong themes, alongside a desire for managers who coach and build confidence rather than simply direct. Practical ideas included strengthening coaching skills for managers, making career conversations and PDR reviews more meaningful and frequent throughout the year, and placing greater focus on supporting healthy, connected teams.
The remaining cohort sessions will take place over the coming weeks, with the final insights informing future workforce initiatives, and a refresh of the Trust's Employee Value Proposition informed by these insights.

Understanding and Improving Workforce Health Inequalities

We have commenced a workforce health inequalities body of work to better understand whether some groups of colleagues at risk of / experience health inequalities in their communities, barriers to support, or unequal access to services.

The work will bring together national health inequality data with workforce demographic data (and also sickness absence trends, occupational health information, wellbeing service uptake, NHS Staff Survey results) and colleague engagement activities to build a clearer picture of where inequalities may exist across our workforce.

The findings will help identify priority groups requiring additional focus, improve how we target and promote support, and inform the future development of our Health and Wellbeing Plus+ offer. Colleague engagement activity will form a key part of the project, ensuring any actions are shaped by lived experience as well as workforce data, with the aim of improving equitable access to support for all colleagues.

Preventing Third Party Harassment

In preparation for the strengthened legal duty on employers to prevent third-party harassment from October 2026, work is progressing on a readiness plan. These are sensible steps that are realistically required to conform to the strengthen duty, they do not take away or prevent any of the other work elsewhere in the Trust (e.g. No Excuse for Abuse, Culture Care, Staff Network). This includes the development of a dedicated policy (early draft created), reporting routes and support arrangements (No Excuse for Abuse Framework is being updated by our EDI lead), awareness training for staff and managers (online training being created by Head of Learning and Development), strengthened learning processes through Datix reviews (All reports to be reviewed in safety huddles MDT's), and new comms campaign around No Excuse for Abuse framework.

With support of EMT and ODG, divisions will be asked to designate one lead to ensure monitor workplace risk assessments being completed to identify and mitigate potential harassment risks locally. The programme has been developed collaboratively with staff networks, Staff Side, Culture of Care Clinical Lead, EDI Lead, Strategic HRBPs, and external legal advisers, with a continued focus on providing all our colleagues with an environment they feel safe in.

New Sickness Absence Management Policy

The new Sickness Absence Management Policy has now been launched, promoting a consistent, proactive and compassionate approach to supporting colleague attendance and wellbeing. The policy places a strong emphasis on early intervention, meaningful wellbeing conversations, and ensuring colleagues can access the right support at the right time.

To support implementation, a raft of resources have been developed, including manager guidance, e-learning modules, easy read process guides and a new suite of practical "How To" guides for a number of topics available through the People Resources Hub for Managers. These resources are designed to help managers apply the policy confidently and consistently.

2026 National Staff Survey

Preparations are underway for the 2026 National Staff Survey, which launches on 5 October and runs until 30 November. Following Humber's highest-ever response rate in 2025 (64%), the focus this year is to maintain or improve participation levels and

with the ambition that every division achieves a response rate above 50%. A comprehensive and living and breathing communications campaign is underway. As in previous years, managers will play a key role in promoting the survey, supported by communications packs, promotional resources and real-time response rate reporting. The survey remains one of the Trust's most important mechanisms for understanding colleague experience, with results an important tool local teams/departments to take ownership of their colleagues experiences and Trust wide initiatives.

2025 Natonal Staff Survey – turning results into meaningful actions
Following the 2025 National Staff Survey, over 120 teams participated in local listening conversations focused on what would help colleagues feel more valued at work. The feedback identified a number of recurring Trust-wide themes;

- Communication, Engagement and Staff Voice
- Feedback, Recognition and Team Culture
- Managers Development and Support
- Leadership Visibility and Trust
- Leadership Culture and Behaviours
- Creating the Conditions for Teams to Thrive

Each theme has an executive-sponsored task and finish group established to develop and implement improvements based directly on colleague feedback. The groups in July and August have met to identify a combination of quick wins, medium-term improvements and longer-term actions, ensuring that staff voices continue to shape organisational priorities and tangible change across the Trust. An update paper is prepared and scheduled for EMT in October, with the next steps the EMT sponsors check-in with their group in October.

5.4 Executive Medical Director Updates

5.4.1 Leadership Viability

The Executive Medical Director continues to undertake regular visits to clinical teams across the Trust to strengthen engagement with frontline staff and gain direct insight into service delivery. Recent visits to the Avondale Unit included discussions with clinical teams regarding the management of significant incidents, staff wellbeing, psychological support, reflective practice and post-incident debriefing arrangements.

Time was also spent with teams in the Hull Community Mental Health Team based at the Waterloo Centre, alongside discussions with clinical and operational leaders regarding community mental health services. These visits provide valuable opportunities to review clinical pathways and operational processes, support continuous improvement in medicines management and patient safety, and ensure that service delivery remains focused on providing timely, safe and high-quality care for patients.

5.4.2 Medical Education

The Trust continues to demonstrate strong performance in medical education. The 2026 GMC National Training Survey reported positive outcomes across several

indicators, including no reported patient safety or undermining concerns from doctors in training, performance within the top 10% of comparable UK training organisations, and a national first-place ranking from trainers for trainer experience. No areas requiring regulatory intervention were identified.

Progress continues against the NHS England 10-Point Plan for Improving Resident Doctor Working Lives, with the Trust approaching full compliance. The Trust has also been recognised externally for good practice and invited to share learning with other NHS providers.

The Trust remains committed to supporting the development of all medical staff. Recent development programmes for Specialty and Specialist (SAS) doctors have been well attended and positively evaluated, supporting career development, leadership capability and professional practice.

5.4.3 Medical Staffing

Work continues to enhance the experience of resident doctors through the development of policies covering annual leave, exception reporting and non-resident on-call arrangements. These policies have been developed in partnership with resident doctor representatives and are progressing through the Trust's governance processes.

5.4.4 Resident Doctor Workforce Expansion and Locally Employed Doctors

The Trust has received national guidance regarding the expansion of resident doctor training posts and the review of locally employed doctors. At present, the Trust is unable to support requests for additional training posts. Work is underway to review the medical workforce and financial models to ensure the organisation is well placed to consider future opportunities for training post expansion. The Trust does not currently employ any locally employed doctors (LED) and therefore the national guidance has no direct implications currently.

5.4.5 Medical Business

The Trust successfully completed its 2026 Revalidation and Appraisal Annual Organisation Audit, with no issues or concerns identified.
Preparations are underway for the 2027/28 medical job planning cycle to commence in October, aligned to the NHS England 90-Day Service-Level Planning Challenge. This work aims to strengthen service-level activity planning and ensure medical workforce deployment is informed by demand, capacity and service need, supporting effective workforce planning, improved productivity and the delivery of high-quality patient care

5.4.6 Mental Health Legislation

The Associate Hospital Manager (AHM) service continues to support the Trust's statutory obligations. Recruitment activity has strengthened the cohort, with additional appointments progressing through the relevant processes.

The Mental Health Legislation Team continues to experience workforce capacity pressures. These are being reviewed for longer-term resourcing requirements, with priority currently given to the delivery of core statutory functions.

5.4.7 Patient and Carer Experience

A review of the Trust's Patient and Carer Experience forums identified opportunities to strengthen engagement, improve flexibility and enhance the link between feedback and service improvement.

Work is underway to develop a future engagement model that supports greater involvement of patients, carers and communities in shaping services and aligns with wider NHS priorities.

In addition, governance arrangements supporting delivery of actions arising from the Community Mental Health Service User Survey have been strengthened. Improvement work continues to be co-produced with people with lived experience, including pilot work within Hull Integrated Care Team for Older People (HICTOP) to inform future service improvements.

5.5 Executive Director of Finance, Resources, Estates and Digital Updates

5.5.1 Leadership Visibility

A series of site visit continue to be arranged with the senior Finance Directorate team to learn more about services and for services to learn more about the work of the directorate and for any questions on our portfolio to be raised.

Since the last Board meeting have visited Barts House Goole with Iain Omand and the Humber Centre with Rob Atkinson, I have also accompanied the Non-Executive Directors on unannounced visits at Maister Court (With Steph Poole) and Townend Court (With Phillip Earnshaw).

5.5.2 Cyber Security Updates

NHS Cyber Security Operations Centre (CSOC) release several alerts each month, these were referred to as CareCERT advisories but are now known as Cyber Alerts, the Trust must ensure that action is taken to deploy the remediation for each.

Alerts fall into two types of notification:

Cyber Alerts - The trust must ensure that action is taken to deploy the remediation for each Cyber Alert as soon as possible but within 10 working days.

High priority Cyber Alerts - any remediation patches must be deployed as soon as possible, and we must provide a response to CSOC within 48 hours to confirm that any remediation has been deployed.

The Trust are using software to track that status of its digital estate which provides the data included in this section of the report.

Activity updated since the last board report

- Cyber Alerts issued during 2026: 102 (Including 15 in August)
- High Priority Cyber Alerts Issued during 2026: 22 (Including 2 in August)
- August Cyber Alerts with patch(s) NOT approved for deployment: 0
- August Cyber Alerts with patch(s) fully deployed to all devices (or not applicable): 1
- August Cyber Alerts not 100% deployed (due to devices still to check in): 0

There were no Distributed Denial of Service (DDoS) attacks against the Trusts internet connections during September or October 2025

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There were no Distributed Denial of Service (DDoS) attacks against the Trusts internet connections during September or October 2025

Servers:

There are 53 servers, 45 on-premises and 8 in Azure cloud running Windows Server 2022.

All servers are fully patched to August 2026.

The Trust's contractor Waterston provide a service to manage elements of the trust infrastructure, including management and quarterly restore testing of backups. Reports are provided and reviewed quarterly, and the latest report (July 2026) shows there are no issues to report.

5.5.3 Digital Data and Technology

Digital & BI – CEO Highlights

Dorset Care Record successfully went live on the Interweave platform, extending the NHS-owned shared care record solution into a further Integrated Care System. The deployment represents a significant milestone for Interweave's national expansion and demonstrates the platform's ability to support large-scale interoperability across organisational boundaries.

The Trust secured approximately £1 million of national funding for the Wayfinder programme, enabling the next phase of digital transformation within mental health community services, including improved patient communication, appointment management and digital engagement.

Nottinghamshire successfully transitioned from its legacy Graphnet shared care record platform, with Interweave providing the replacement interoperability capability. This represents a major implementation achievement and further evidence of the maturity and scalability of the platform.

A Trust-wide Artificial Intelligence governance framework was formally implemented, establishing controls for the safe adoption of AI technologies and positioning the Trust as one of the relatively few NHS organisations with a comprehensive governance approach to AI deployment.

Interweave continued to influence national interoperability policy through engagement with NHS England's emerging Single Patient Record programme, with evidence from live deployments and operational performance being used to inform wider national discussions on information sharing and interoperability architecture.

To provide assurance on the realisation of benefits from digital programmes through a monthly BeDigital Benefits Report has been developed. The report will present a clear view of planned versus actual benefits achieved, enabling oversight of the impact and value delivered by digital tools across the organisation. The report has been presented to Digital and Data Group and Be Digital Group and is due to be presented at Executive Management Team ahead of presentation to the Finance, Productivity and Digital Group.

5.5.4 Facilities Management Updates

Adult Inpatient Redesign Update

The Adult Mental Health Inpatient Redesign Programme continues to progress through the key design, planning, service-change assurance and enabling infrastructure workstreams required to deliver Phase 1 - a new 18-bed Acute Inpatient Unit at Willerby Hill.

Following a competitive procurement exercise through the NHS England ProCure23 (P23) Framework, Integrated Health Projects (IHP) has been appointed as Principal Supply Chain Partner (PSCP) to deliver RIBA Stage 4 Detailed Design and develop the final Phase 1 cost, with the intention, subject to affordability and the required approvals, to continue through to construction.

RIBA Stage 3 is complete, and the formal Stage 4 design commencement workshop took place on 11 September 2026. Staff and public planning engagement in August was well attended and generally positive.

The hybrid planning application remains targeted for November 2026, although additional bat survey requirements create a potential risk to determination.
The refreshed PCBC is scheduled for Executive Project Board consideration on 14 September 2026, after which the programme will progress through Clinical Senate and wider NHS England service-change assurance.
The next major milestones are planning submission in November 2026 and completion of RIBA Stage 4 design and final cost in December 2026.

Hard FM - Operational Estates

York LLP are progressing at Malton to improve the fire exit routes and the water quality. The Humber NHS Estates and Facilities team continue to monitor, liaise and assist York LLP.

Further works to replace the roof covering to Fitzwilliam Ward are being developed by York LLP.

Hard FM - Development and Sustainability

Solar PV now live at Humber Centre; with works nearing completion at ERCH. Battery installations in progress at both Humber Centre and ERCH.

Sustainable Travel and Transport Survey - engagement has been positive, with survey closing on 11 Sept; this will then inform the Trust's Sustainable Travel and Transport Plan (Due for end of Dec 26).

NHSE Utility Review complete - this has provided the Trust with assurance that we are managing our utilities spend and utilisation efficiently, with no scope for rebate.

Property

Whitby Hospital Property Transfer: a five-case business case is being developed for consideration by EMT, Finance Committee, and Trust Board. Once approved, this will be submitted for review and validation by DHSC. The business case will include areas that require clarification, before NHS PS release any further information, such as; TUPE, contract liabilities and clarification on the red line boundary for the site.

Draft Head of Terms received for Freedom Centre (Neighbourhood MH Centre). These have been reviewed, with and amendments drafted and returned to the landlord.

Property transfers for both Providence Place and Bridlington MC - Documentation has been signed off by the Trust.

Planned transfer of Market Weighton for 30 September, subject to agreement for an AGA to be removed.

Safety

Inaugural Fire Safety Group meeting held in September to align with the updated HTM 05-01; reporting to the Trust's H&S Group.

Responsible Person SOP for Fire, H&S and the new Martyn's Law (Terrorism Act) has been drafted for review at the September H&S Group.

Soft FM - Hotel Services
PLACE assessments have commenced for 2026.

Annual sharps audit being brought in house and led by waste manager.

New domestic monitoring system due to go live, this will be harmonised with other soft FM software platforms.

There is now a green waste skip at Willerby increasing the Trust's ability to recycle *(one of the first items to be put in it will be the burnt turf from the fire walk*).

5.5.5 PARTNERSHIPS AND STRATEGY

The Trust has been notified and received a letter of intention to award for the NOEPC Public Health Services Framework Procurement. The Trust submitted a response for 78 lines across 5 Lots, and we were successful on 77 of those lines.

The LD Cancer Screening Project has been nominated for an award for the Humber and North Yorkshire Cancer Alliance Excellence in Cancer Award for their accessible Lung Cancer video that was coproduced. The nomination is in the Championing the Patient Voice category.

Hull has approved the Trust's response to the SEND White Paper and the associated Experts at Hand expert health offer. Mobilisation is now progressing at pace, with the outcome from East Riding still awaited.

The Trust has submitted a bid to the Department for Environment, Food and Rural Affairs (DEFRA) to support Farmers Welfare across parts of N Yorkshire and East Riding. This is for £164k pa (3 years duration). The outcome is expected October 2026.

The Trust has been invited to apply for funding from the NHSE Health Inequalities Provider Accelerator Programme, which aims to increase healthy live expectancy in target areas. The Trust's project will commence in Autumn 2026 and will focus on community based, coproduced mental health prevention activity in East Hull.

5.5.6 Finance Updates

The Team is currently gathering evidence to support it application for Future Focussed Finance Level 2 accreditation (now banded at One NHS Finance Towards Excellence Accreditation). Level 2 accreditation means we don't just have a good finance team, we have an organisation with good financial management, financial understanding, partnership working and finance skills that embedded more widely.

The Finance Team (Financial Services and Management Accounts) are planning a series of visits across Trust Sites with a particular focus on our inpatient units. Visits will have a focus on finance and support to understand our policies and procedures but will be an excellent opportunity for the team to meet frontline staff and support them in patient care.

6. Communications Update

See Appendix 1 & 2

7. Health Stars Update

See Appendix 3

Communications Board Report – July– August 2026

Strategy theme: Promoting people, communities, and social values

Project title	Strategic intent	Key activity during the reporting period	Progress and impact	Target outcomes by 2027
Shared Content Strategy	To improve the consistency, accessibility, and impact of content by coordinating how stories and messages are planned, created, and shared across channels.	Content planning meetings embedded as standard practice. Increased coordination around events and public health initiatives. Engagement rate is climbing towards target	415,000 content views during reporting period Average social media engagement rate of 6.28% percent, with a peak of 48 percent. Reduction in single use content, limited to one off announcements. 20 people focused stories suitable for press or social media published since April 2025. 251 social media posts published across the period, averaging 3,5 posts per day. This brings the yearly total to 1,373.	Sustained average social media engagement rate of 8%. No single use content outside exceptional announcements. Fully embedded content planning and logging process. A minimum of ten people focused press or social media stories published each year. Consistent weekday posting of three to twelve posts, excluding event days.
Health Inequalities	To reduce barriers to accessing information by improving the availability, accessibility, and inclusivity of patient communications.	Patient information library is live on the Trust website. Leaflet Library | Humber Teaching NHS Foundation Trust	All managers have been contacted to submit leaflets under the new process. Stakeholders contacted to invite them to share resources. Patient Information Procedure has been reviewed to support and give guidance – approval via ODG.	Measurable increase in access to patient information, with usage KPIs set six months after launch. Accessibility checklist applied to all documents submitted through the Brand inbox.

Project title	Strategic intent	Key activity during the reporting period	Progress and impact	Target outcomes by 2027
		The Trust website is undergoing second phase of auditing for WCAG 2.	Additional development work commissioned to improve visibility of Choice & Medication library. All accessibility issues within the Humber website on previously existing pages have been rectified. Preparing to undergo final phase of WCAG audit testing. New Recite Me accessibility tool for trust website has been selected. YoY saving and improved features. Accessibility checklist is continuing to be well used by members of staff. Approvals process for brand has been streamlined significantly, encouraging engagement.	Month on month increase in the number of documents available in multiple accessible formats.

Strategy Theme: Developing an Effective and Empowered Workforce

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
Cultural communications	To support a positive and inclusive culture through clear, compassionate internal communication, strengthen leadership visibility, improve message cascades, and	Activity continues to progress positively in support of the strategic aim of strengthening internal communication, staff engagement and access to	Improved access to information, support and opportunities to have their voice heard, with clearer and more engaging communications helping to maximise staff participation	New staff newsletter design, name, and editorial focus agreed by Executive Management Team. Sustained improvement in staff engagement with internal communications.

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
	increase two way communication.	clear, timely and consistent information. Recent activity has focused on supporting key Trust-wide priorities. Refreshed communications and design assets have been developed for the NHS Staff Survey and staff flu vaccination programme to support awareness and participation. Work is also underway with Workforce colleagues to develop a new Staff Wellbeing Hub, bringing together access to staff support and resources in one place. Communications are also being developed to reinforce the Trust's No Excuse for Abuse framework, supporting a culture in which staff feel safe, respected and protected from bullying, harassment and unacceptable behaviour.	in key Trust initiatives. In particular, effective communications around the NHS Staff Survey will support the Trust in hearing from as many colleagues as possible, ensuring staff experiences and views can inform future improvements. Promoting the flu vaccination programme will help maximise uptake and support staff, patients and colleagues by reducing the risk of flu across our services. The new wellbeing and No Excuse for Abuse communications will also make it easier for staff to find appropriate support and understand the behaviours and protections expected across the organisation.	Continued year on year improvement in Staff Survey participation and feedback on communication and leadership visibility.

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
Communications training hub	To build confidence and capability across the organisation by sharing communications skills and expertise through accessible online and in person training.	Communications training booklet created. Media training has now been accessed by 73 staff across the Trust Working with EPRR Team to create bespoke Director on Call media training Media Training is now accessible on ESR and shows against staff's training records, legitimising the sessions and adding greater impact. Working with Medical Education Team to deliver media training to doctors	Increased access to consistent communications and media training materials. Improved visibility and sustainability of training through ESR, reducing reliance on ad hoc sessions. Strengthened protection for potential times of crisis.	Fully launched communications training hub combining digital and in person offer. Measurable increase in uptake of communications and media training. Improved staff confidence in local communication activity, reflected in feedback and reduced reactive demand on the communications team.
Humbelievable recruitment campaign	To support recruitment and retention through a strong, consistent employer brand and an award winning, data led recruitment marketing campaign.	New creative developed including staff voices about what they like most about working at the Trust, embracing team ethos and Being Humber values. This is front and centre of September back-to-school/work life balance	Recruitment campaign performance maintained in line with same period in 2025/26. Ads simplified with stronger message toward how Humber 'does it differently', supportive environment, and	Sustained or improved recruitment campaign performance year on year. Nursing vacancy rate reduced to around 6% or below. Continued growth in jobs bulletin subscribers and engagement,

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
		focused campaign, which has been set up and is now live.  	region-leading performance. We are different to others. Join Humber jobs bulletin subscriber base consistently sits at 2700, with an open rate consistently above 40%	supporting a strong recruitment pipeline.

Strategy Theme: Enhancing prevention, wellbeing and recovery.

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
Trauma-informed communications	To support the Trust's aspiration to embed a trauma-informed culture by recognising the impact of trauma, fostering safe and trusting communication, and adapting practices to support recovery and prevent re-traumatisation.	Ongoing promotion of podcast 1/2 Podcast episode 3 and 4 launched in September. Co-produced Trauma Informed Language Guide will be published in September. Combined with Style guide to create a 'How we Communicate Guide' incorporating Being Humber and our Trauma Informed approach.	Over 500 podcast listens on youtube. 9400+ views of clips on facebook 177 visits to intranet hub.	80% of materials submitted to the Brand inbox meet agreed trauma-informed communication standards by Q3 2027. Improved staff self-assessment of trauma-informed practice and community awareness by Q3 2027. Increased use of accessibility tools including ReachDeck and AccessAble to more than 60% by 2027.
Digital accessibility	To maintain a fully inclusive and accessible digital environment by implementing website accessibility audits and acting on recommendations, removing barriers to accessing digital communications.	Final phase of accreditation process underway. Initial actions from first accreditation process phase complete. Increased usage of Microsoft Sway newsletter templates and reduction in inaccessible formats.	Improved consistency and quality of accessible digital content. Tightening of guidelines and processes surrounding creating patient information.	AbilityNet accreditation achieved and maintained. Trust website named in the Top 30 NHS websites for accessibility. All Recommendations from accessibility audits implemented to meet web accessibility standards. Measurable increase in the percentage of digital content and platforms meeting accessibility requirements. Expanded accessibility resources available through the Brand Centre.

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
		More text templates and accessibility guidance added to Brand Centre. Patient information library launched.	Significant portion of pages within the trust website is of WCAG 2.2 standard.	

Communications Partner Projects

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
Community and primary care – Virtual Ward referrals	Closed - project complete			
Mental health - Recovery and Wellbeing College bookings	Closed – project complete			
Forensic – recruitment	Closed – project complete			
Children's and learning disabilities	To strengthen communications across children's and learning disabilities services through a Communications Champions Forum, supporting consistent messaging and shared responses to local health priorities.	Continuation of potty training and immunisation campaigns with PR and NHSE materials.	100,000 views of campaign content. Three external facing stories have been produced and growing reactive and proactive communications channels continue.	Identify external facing stories and share through channels – aim for 3 external facing per year

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
			2,800 clicks to Connect website for advice on potty training	

Strategy Theme: Fostering Integration Partnerships and Alliances

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
Cultivating collaboration and managing internal efficiencies	To strengthen collaboration, improve internal culture, and embed more sustainable ways of working within the communications function, supporting a resilient and future-ready service aligned to organisational priorities.	Action taken to address internal culture themes identified through team survey feedback – focused relationship strengthening in Q2 and now structured use of efficiency tools in Q3, which is spearheaded by Loren as our digital representative. Supporting Estates with their annual communications plan. Supporting QI with improved engagement through internal communications channels.	Increased focus on priority areas through clearer planning. Strategic approach to service-level communications and relation building. Positive feedback on communications involvement in Trust-wide projects. Higher levels of efficiency and collaboration due to introduction of shared digital tools across the team.	At least 80% overall team satisfaction. More than 60% of senior managers report feeling well supported by the communications team. At least 80% of team members report confidence in new processes and tools by year end.

Strategy theme: Optimising an efficient and sustainable organisation

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
Strategic BeDigital Communications	To empower staff and communities to understand and confidently use digital tools, promote innovation and quality, and support the shift from analogue to digital in line with the national 10 Year Plan.	Communications support provided to Trust-wide BeDigital programmes, including Wayfinder and the NHS App appointments go live. Positive case studies from digital investment captured and shared. Supporting the Digital Team with their HSJ Digital Award submissions. Interweave communications support ongoing – recently shortlisted for the HTN Award for 'Partnership of the Year'.	Improved visibility and understanding of Trust-wide digital programmes and their benefits. Stronger narrative around the value of digital investment and innovation. Increased confidence among senior leaders through clearer reporting of digital communications impact aligned to organisational goals and the 10 Year Plan. External recognition of project progress and success. Strengthening of digital media relationships to support future innovation coverage.	See BeDigital Strategic Communications Plan 2026-28, which is in line with the Trust's Enabling Digital Strategy. See Interweave Communications Strategy 2025-27.

Strategy Theme: innovating for Quality & Patient Safety

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
CQC communications support	To support quality improvement and regulatory readiness by providing clear, timely communications aligned to CQC requirements and internal quality priorities.	Member of CQC well-led task & finish group. Well-led briefing pack designed with Clinical Governance. Full audit of website service pages completed	Board and governors supported for inspection readiness. Shared response plan to all inspections including Support teams to ‘ shine a light’ on the things we are proud of, so inspectors can see the full picture of our services.	Sustained improvement across CQC self-assessment domains. Clear and consistent communications support embedded within quality governance structures. Improved organisational readiness and assurance ahead of inspection activity.
Freedom to Speak Up	To increase awareness, confidence, and appropriate use of the Freedom to Speak Up process, supporting a culture of openness, learning, and patient safety.	Plan for 2026/2027 by using staff survey results to help with planning for the next year. New intranet development to make ambassadors more visible. Book in to attending 2026 FTSU Meetings	Data from the staff survey will help inform relevant plans and decisions. Ensure consistent support and relationship building with the communications team. More visibility of FTSU and reporting procedure in staff facing areas.	Increase in the percentage of staff who report awareness of Freedom to Speak Up and understanding of the process through Staff Survey results. Increase in low-level Freedom to Speak Up reporting, indicating greater confidence to raise concerns early.

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
		New posters on staff sites		

Media & Communications Dashboard – July/August

NHS Humber Teaching NHS Foundation Trust

Media Coverage

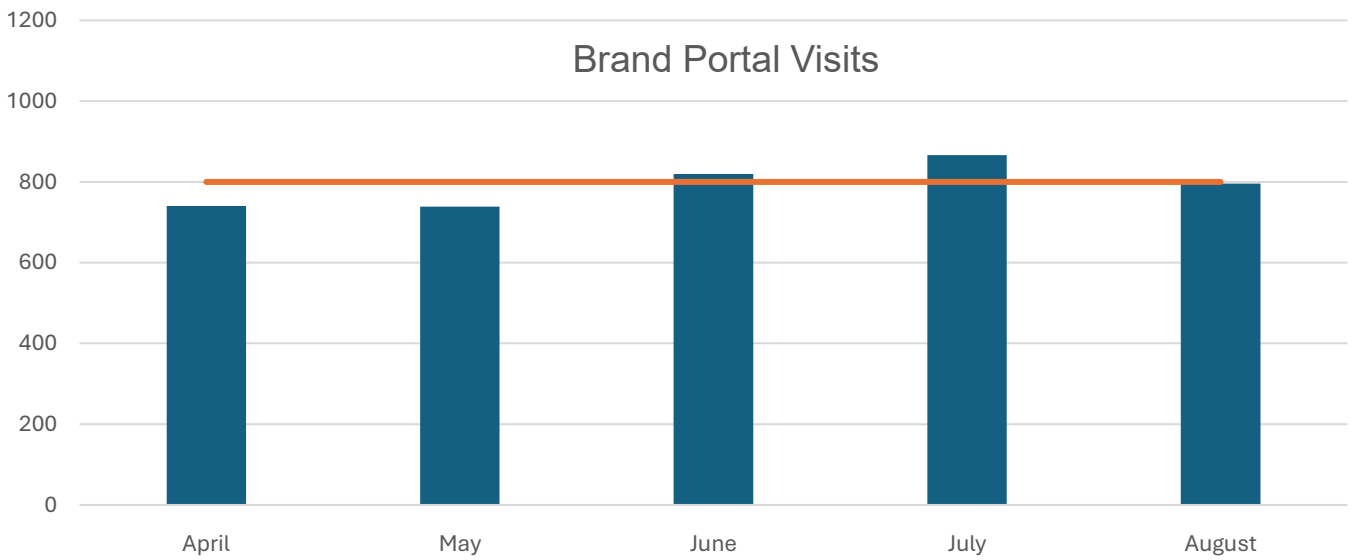
37 positive stories published in local/national media

0 Negative stories published

Media Pick Up Rate	Number of Items
Press releases issued	19
Published in national media	25
Published in local media	39
Total media mentions	47

Monthly target of 5 positive stories:
1 negative story

Brand Management



Measuring the enquiries to the Brand inbox and visits to the brand website helps us understand if staff are engaging with the information and support, we offer.

August is a significant month for staff annual leave so slight dip below target is not concerning. We continue to hold regular 'Ask Emma' sessions with our in-house Graphic Designer to build confidence and awareness of our Brand Portal and its resources.

Number of amend required on submission for approval of branded materials

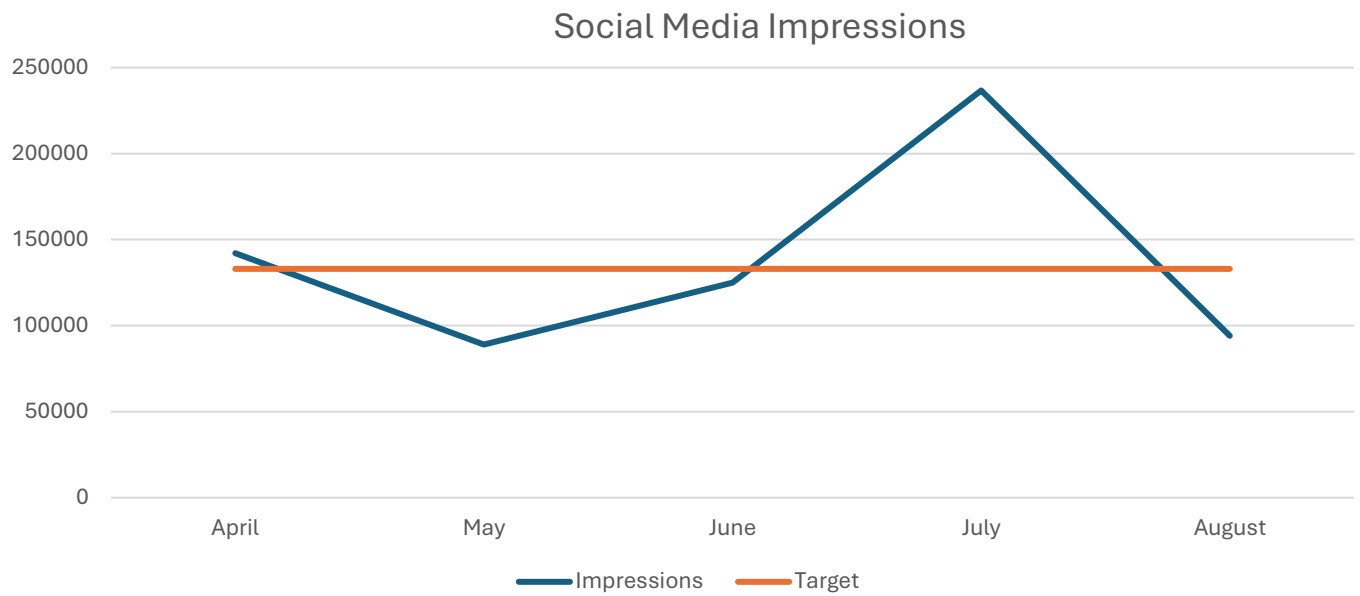
Month	Approved	Target
July	75%	50% ✓
August	100%	50% ✓

Brand compliance is now measured by the number of amendment rounds required before approval. Fewer amendments indicate stronger adherence to Trust branding and more effective use of brand guidance.

Media & Communications Dashboard – July/August

NHS Humber Teaching NHS Foundation Trust

Social Media



Social media performance is measured through engagement rate and impressions, giving a fuller picture of both audience interaction and reach. Social media impressions fell in August due to a seasonal dip in new website content surrounding holiday season, compared to the sharp increase in July produced by the announcement of the Adult Mental Health Redevelopment project.

Social Media Trends

Month	Engagement Rate (target 4%)	Audience Growth (Target 1.6%)	Followers gained YTD
April	6%	0.6%	121
May	3.90%	0.30%	219
June	5%	0.8%	365
July	7%	0.9%	519
August	4%	0.6%	640

Social media performance remained strong overall, with engagement exceeding or meeting target. Strong engagement in July was noted due to the Adult Mental Health Redevelopment project.

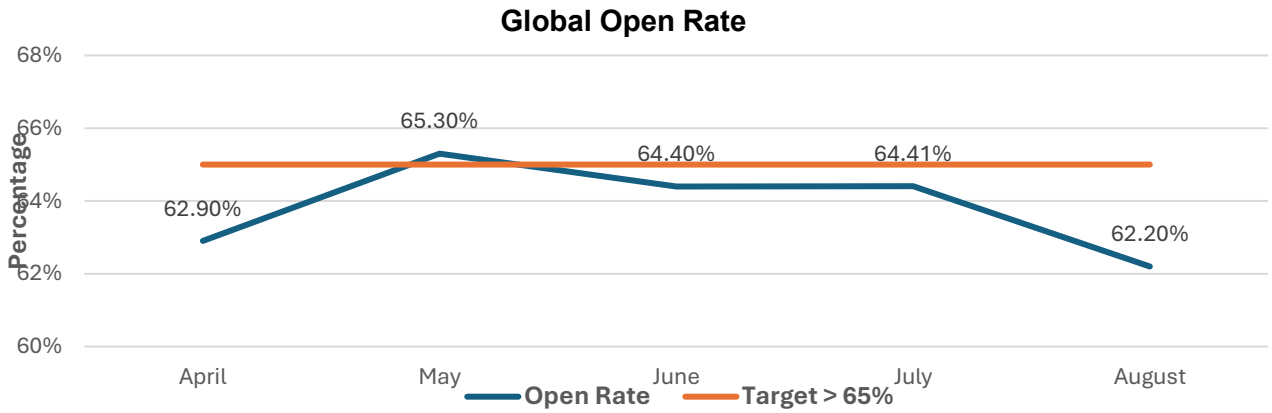
Historically, audience growth is strongest during periods of increased campaign activity, including major recruitment campaigns, awards season and Trust events, with peaks typically seen in September, January and March.

Media & Communications Dashboard – July/August

NHS Humber Teaching NHS Foundation Trust

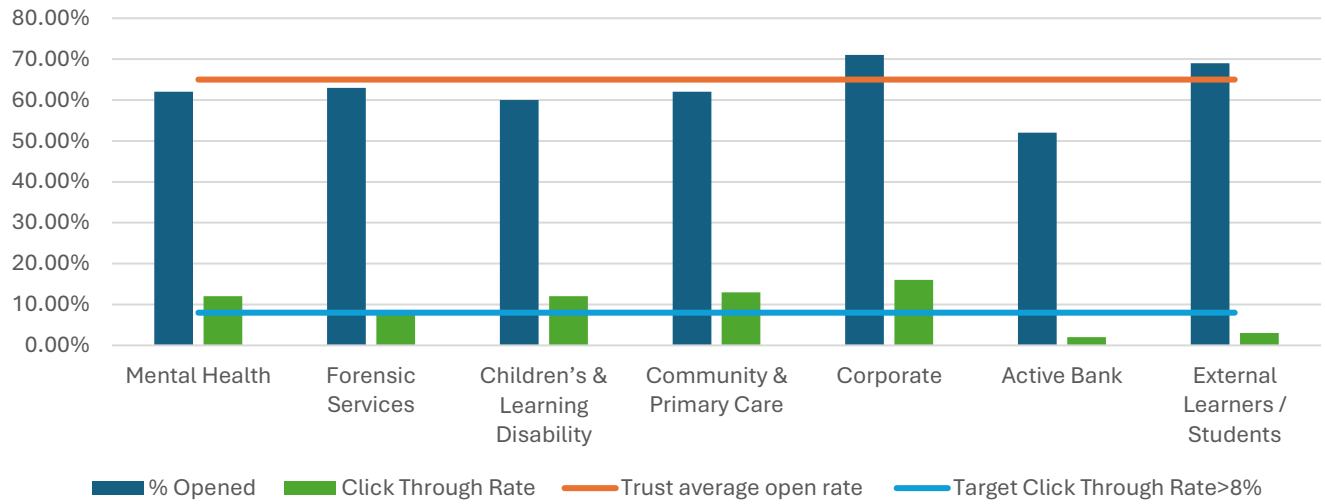
Internal Communications

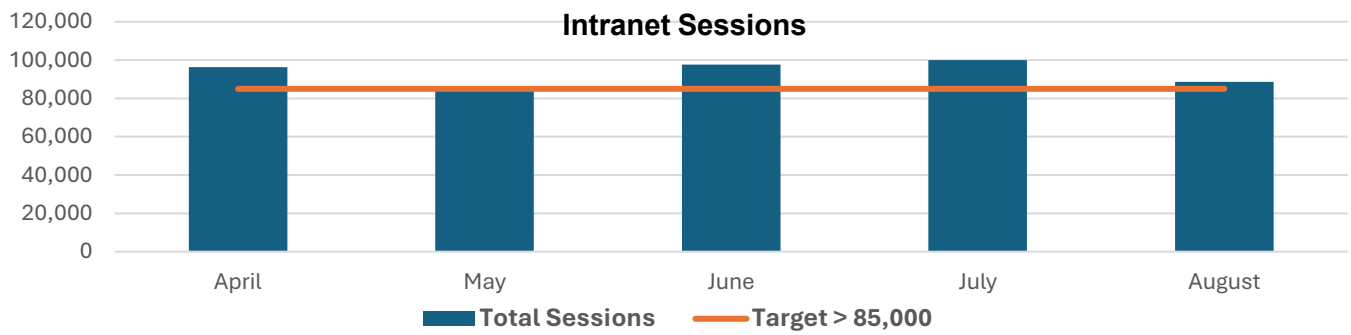
Internal communications KPIs remain unchanged to support year-on-year comparison. Performance continues to be strong overall, although email engagement dipped below target in July and August, likely reflecting lower staff availability during the summer leave period.



Global Open Rate & Click Through by Division

Open rates for clinical divisions were below target during the quarter; however, click-through rates remained strong at 13% and 11.95%, both well above the 8% target. This suggests that while overall reach was lower, the content continued to generate good engagement among staff who opened the emails.



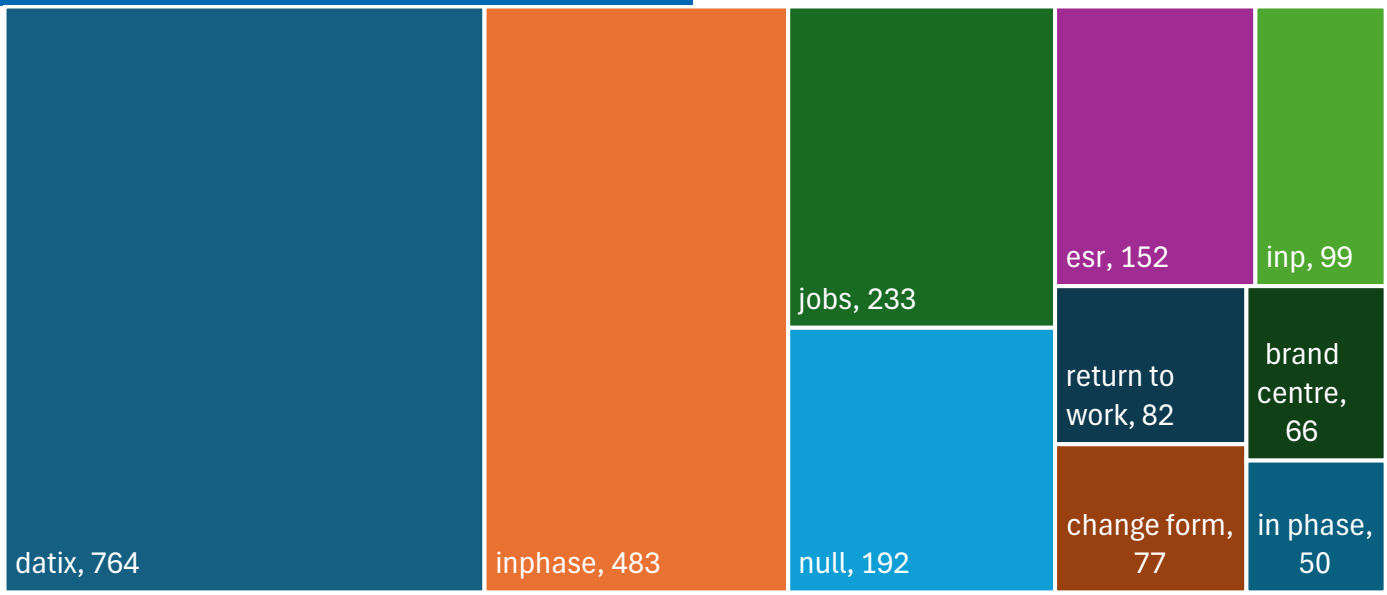


Intranet sessions remained above the 85,000 monthly target. Unlike other internal communications measures, which dipped in August, intranet activity remained relatively strong, likely supported by increased interest in the mental health inpatient redevelopment announcement.

Media & Communications Dashboard - July/August

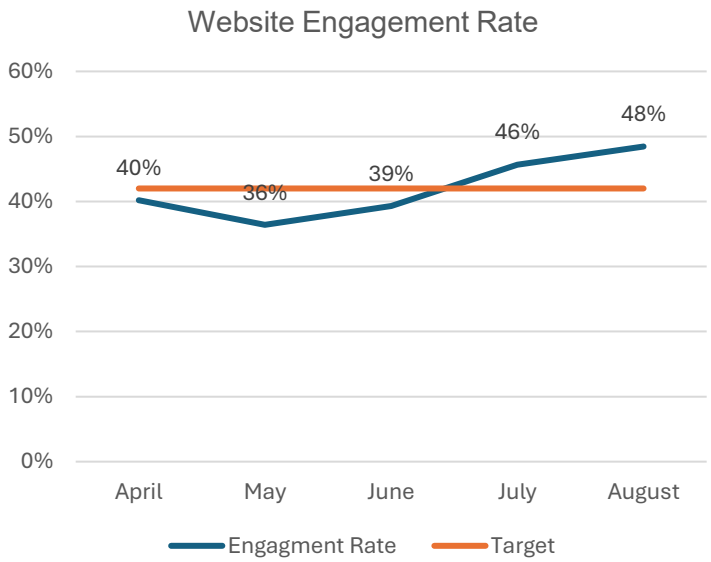
NHS Humber Teaching NHS Foundation Trust

Intranet Search

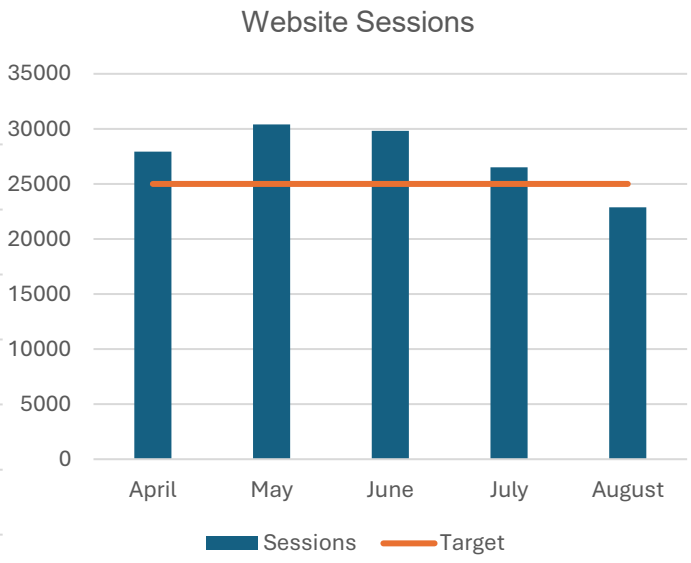


Following the introduction of AI-powered intranet search, this visual provides insight into the information staff search for most frequently. The size of each block reflects search volume, enabling high-demand content to be identified at a glance and helping to inform ongoing improvements to navigation, content visibility and the overall search experience. InPhase-related searches featured prominently during the period, with 646 searches across common variations including “InPhase”, “in phase”, “inp” and “inph”. This reflects strong staff demand for access to the newly introduced system and reinforces the need to ensure it is easy to find through search and navigation.

Website



Website engagement improved during July and August, rising to 46% and 48% respectively and exceeding the 42% target for two consecutive months.

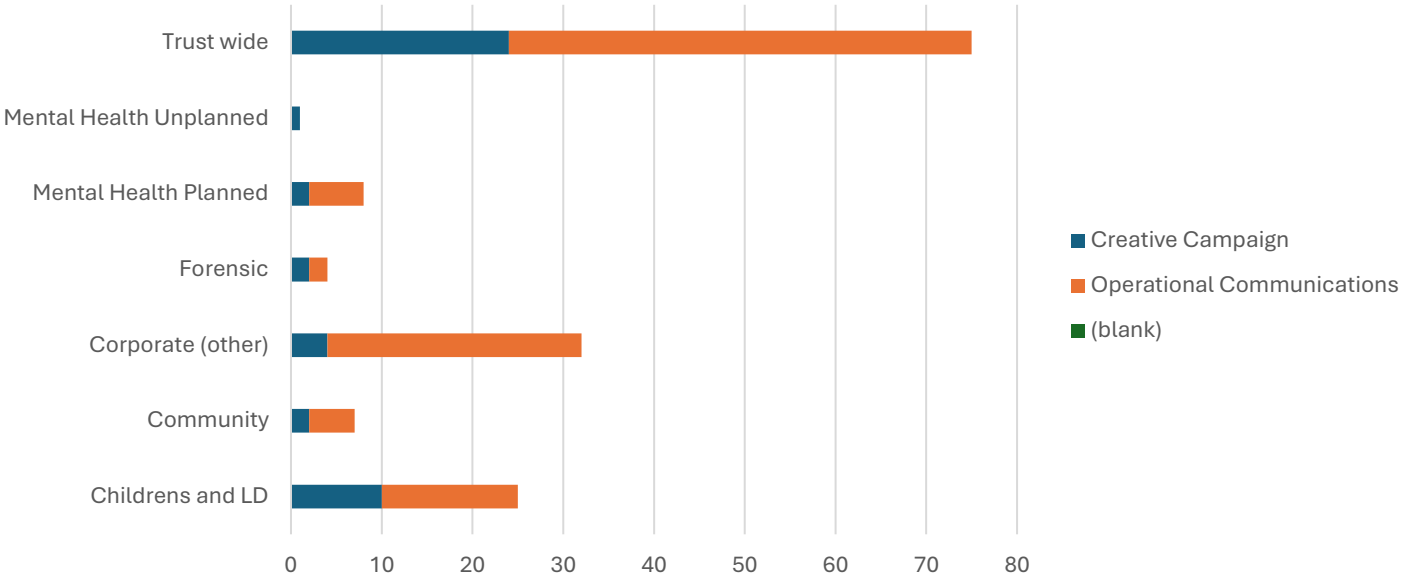


Website sessions remained above the 25,000 monthly target from April to July, peaking at over 30,000 in May. Activity reduced over the summer, with August falling below target at around 23,000 sessions. Performance will continue to be monitored alongside ongoing website improvements.

Media & Communications Dashboard – July/August

NHS Humber Teaching NHS Foundation Trust

Activity by Division



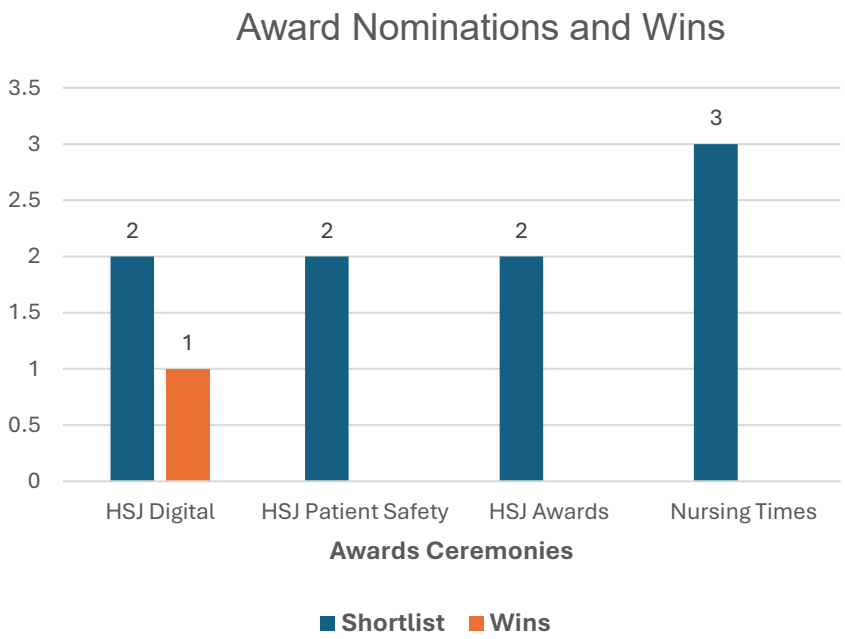
During the quarter, the Communications team managed 152 requests, a significant increase from 94 in the previous quarter (+62%). Operational communications continued to account for the majority of activity, with 107 requests (70%), up from 62, while creative campaigns increased from 32 to 45 requests. Trust-wide activity remained the largest area of demand, accounting for 75 requests – almost half of all activity. Corporate activity was also significant at 32 requests, while Children's and Learning Disability generated the highest level of divisional demand (25 requests). Demand across other divisions remained comparatively low and will continue to be monitored to identify opportunities for proactive communications support.

Awards

Since the last report, the HSJ Awards shortlist has been announced. We are proud to be shortlisted for Trust of the Year as well as to have Core Needs Project nominated for it's fifth award this year!

HSJ Patient Safety Awards is held on 28th September. We are nominated for;

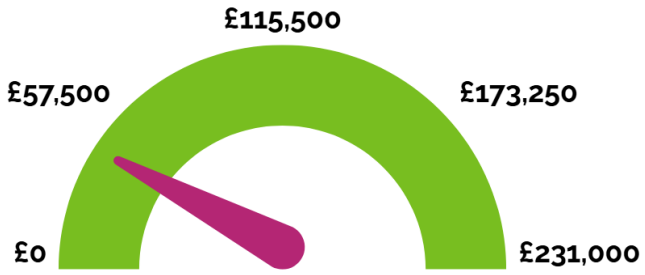
- Palliative & End of Life Safety Initiative of the Year, Bleed Support and Care Box.
- Patient Safety Pilot Project of the Year ,Core Needs Project.



Health Stars: Performance Dashboard

July/August 2026

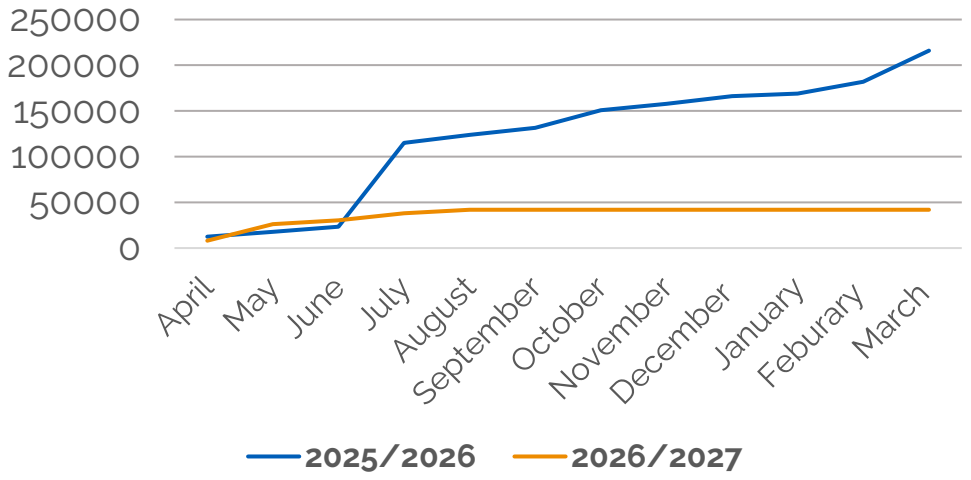
Funds raised to date



£41,914

Target: £231,000

Income by month



Fundraiser of the month

CEO Challenge

Michele Moran raised £2970 through her 'Challenge the CEO'



HIGHLIGHTS

- ★ 12 people took on the Yorkshire 3 Peaks and people did the Yorkshire 1 Peak and raised a total of £4173.
- ★ Attended the Skybet Ebor Community Sweepstake and won a donation of £1000.
- ★ Fiona Scott, Ward Clerk on Fitzwilliam Ward, organised a Bingo Night and raised £1136.

CHALLENGES

- ★ Corporate fundraising is difficult in the current economic climate.
- ★ Event sign-ups are slower than hoped.

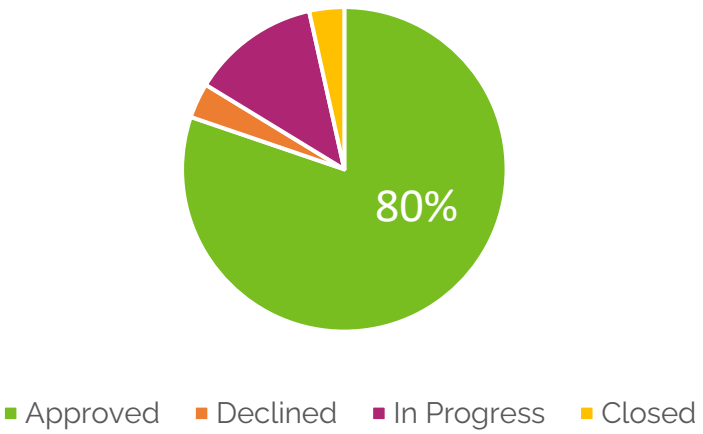
Wishes

Total wishes received to date:

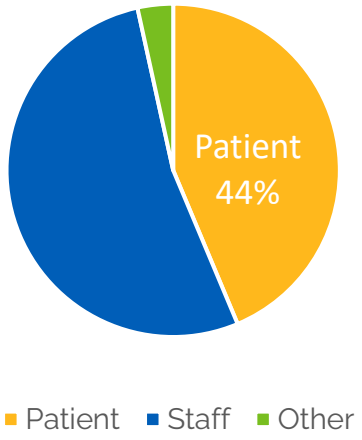
86

(2025/26 = 50)

Wishes approvals



Wish Benefit



Humber Teaching NHS Foundation Trust

Agenda Item 07

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Publications and Policy Highlights
Author/s:	Michele Moran Chief Executive
Recommendation:	

To approve		To discuss	
To note	√	To ratify	
For assurance			

Purpose of Paper:
Please make any decisions required of Board clear in this section:

To inform and update the Trust Board on recent publications and policy since the July 2026 Board meeting (as detailed below):

- Preventing Unlawful Access to Patient Records
- Ten Year Capital Plan for Health and Social Care
- NHS Hospital Programme
- NHS Staff Standards
- NHS Leadership and Management Framework
- House of Commons Health and Social Care Committee - Independent Commission on Adult Social Care
- NHS Employers - Post-incident support framework
- Beyond productivity: AI and NHS workforce implications
- Acute provider collaboratives: delivering system impact in a changing NHS landscape
- Mental health personalised care framework: the modern care programme approach
- Supporting autistic people and people with a learning disability to live well in their communities
- Expansion of Community Mental Health Support across England
- Framework for NHS Boards: Monitoring Research Activity

Key issues:

Positive Assurances to Provide:	**Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):**
• Lead Executive Directors have reviewed the publications relevant to their portfolios. • Existing programmes of work provide a strong platform to respond to the	• N/A.

emerging national priorities outlined within the publications.	
Key Risks/Areas of Focus: • N/A.	**Decisions Made:** • N/A.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	Each publication is reviewed to determine its relevance to the three shifts within the Long-Term Plan.
Analogue to Digital	Each publication is reviewed to determine its relevance to the three shifts within the Long-Term Plan.
Sickness to Prevention	Each publication is reviewed to determine its relevance to the three shifts within the Long-Term Plan.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		**Date**
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	
Enhancing prevention, wellbeing and recovery	
Fostering integration, partnership and alliances	
Developing an effective and empowered workforce	
Maximising an efficient and sustainable organisation	
Promoting people, communities and social values	

Areas to include within the report:	
Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	
Public Exemption:	
Is the report exempt from public disclosure	Yes/No

Publications and Policy Highlights

The report provides a summary of key publications and policy since the previous Board meeting.

1. Preventing Unlawful Access to Patient Records

Patients using NHS services rightly expect their information to be kept secure by the people who treat them. This is why recent reports in the media of staff accessing patient information in unauthorised circumstances are concerning.

NHS England has written a letter to NHS trusts requesting that trust boards place a renewed focus on educating staff about this matter while also implementing a tough approach in response to those who breach patient trust in this way. It is supported by a campaign to remind staff of the law and the potential impact on patients.

Link: NHS England » Preventing unlawful access to patient records

Lead: Executive Director of Finance, Resources, Estates and Digital:

NHS England issued this guidance to address concerns about NHS staff accessing patient records without a legitimate work-related reason. The Guidance has been reviewed by the Trusts IG Group and Executive Management Team; an action plan is in place with appropriate monitoring and escalation via the established Trust Governance routes.

2. Ten Year Capital Plan for Health and Social Care

The Department of Health and Social Care has published a report which sets out how capital investment over the next decade will improve and modernise health care infrastructure, in line with the ambitions set out in the 10 Year Health Plan for England: fit for the future. It outlines how capital investment will enable the three shifts of hospital to community, analogue to digital and sickness to prevention, as well as support wider government missions.

Link to the report: 10 Year Capital Plan for Health and Social Care

Lead: Executive Director of Finance, Resources, Estates and Digital:

The Trust welcomes a longer-term approach to capital in the NHS which should provide certainty to enable capital plans to support service transformation. A full review of the 10-year plan will be presented to the Finance, Performance and Digital Committee.

3. New Hospital Programme

The Department for Health and Social Care have published a report which sets out progress made during 2025/26, following the New Hospital Programme reset and publication of the “New Hospital Programme: plan for implementation” in January 2025. It includes information on scheme progress, programme achievements, future delivery priorities, funding, the methodology used for reporting scheme status and financial data.
Link: https://www.gov.uk/government/publications/new-hospital-programme-annual-report-financial-year-2025-to-2026

Lead: Executive Director of Finance, Resources, Estates and Digital:

This report summarises progress with the 46 hospital schemes (seven of which are open) from the £9.6bn committed as part of the current spending review as well as a further commitment of up to £15bn across future 5-year waves. A full review of the report will be presented to the Finance, Performance and Digital Committee

4. NHS Staff Standards

The 10 Year Health Plan committed to developing a new set of staff standards which will outline minimum standards for employment across a range of areas, aimed at improving staff experience. The standards set out the actions employers must take to deliver them and what staff can expect at work as a result. The documents published here bring together:

The standards have been developed by the Department of Health and Social Care and NHS England, working closely with employers and trade unions through the Social Partnership Forum, and are intended to be implemented locally through partnership working. The standards are for NHS staff, employers and leaders, and should be used alongside existing workforce policies and initiatives to support implementation. The standards will apply to secondary care, which includes acute, mental health, ambulance services and community healthcare.

Link: NHS staff standards - GOV.UK

Lead: Executive Director of People and OD:

Since the publication of the NHS Staff Standards, significant progress has been made in establishing the foundations for implementation across the Trust. EMT has received and discussed detailed papers setting out the Trust's readiness, governance arrangements and implementation approach. A Trust-wide gap analysis against the six NHS Staff Standards is underway, with development of a formal implementation plan, executive and board-level accountability arrangements, and a quarterly assurance dashboard to support ongoing oversight and reporting. The review of the Being Humber behavioural framework has also commenced to ensure alignment with the new national standards and to provide a single cultural framework for implementation.

5. NHS Leadership and Management Framework

The NHS College of Leadership and Management has published a Leadership and Management framework which aims to set clear expectations for all NHS leaders and managers, including line managers. It includes a code of practice and leadership and management standards for all NHS leaders and managers. It also contains a self-assessment tool to enable evaluation against the expected standards of managers.

Link: Leadership and Management Framework

Lead: Executive Director of People and OD:

The Trust has completed initial mapping against existing leadership and management development activity, which demonstrates strong alignment with current approaches including Being Humber, PROUD, coaching, mentoring and appraisal processes.

A phased implementation plan has been agreed, focusing on awareness and alignment during autumn 2026, engagement and leadership development during winter 2026/27, and integration into appraisal, talent management and development processes during 2027. The Trust's approach is intentionally focused on leadership development and culture rather than compliance, ensuring the framework builds on existing strengths while meeting national expectations.

6. House of Commons Health and Social Care Committee - Independent Commission on Adult Social Care

This report is based on evidence from Baroness Casey, who was appointed in April 2025 to lead an independent commission on social care reform. It urges the next prime minister to confirm that full proposals to fix adult social care should be published before 2028 and that work to implement reforms must not be delayed to the next general election.

Link: Independent Commission on Adult Social Care

Lead: Interim Chief Operating Officer:

The recent Independent Commission on Adult Social Care report from the Health and Social Care Committee highlights the growing urgency for national adult social care reform and raises concerns that current timelines for delivering recommendations may be too slow given the scale of pressures across the sector. The report notes increasing and unmet demand for care, workforce challenges, significant pressures on unpaid carers, and rising financial pressures on local authorities, all of which are contributing to a system widely regarded as unsustainable in its current form.

The Committee has called for the work of the Casey Commission to be accelerated, arguing that delaying reform risks missing opportunities to influence future spending decisions and secure the political consensus required for meaningful change. The Committee recommends that the next Prime Minister enable the Commission to publish its findings as soon as they are available and bring forward proposals for reform earlier in the current Parliament. For NHS organisations, the report reinforces the importance of adult social care capacity and reform as critical enablers of patient flow, timely discharge, and the long-term sustainability of health and care services. We will continue to work with our system colleagues to:

- Strengthen health and social care partnerships to support integrated care and discharge.
- Continue improving patient flow and reducing delayed discharges.
- Expand community and preventative models of care.
- Demonstrate improvements in outcomes, productivity and patient experience.
- Align Trust plans with future social care reform and integration opportunities.
- Ensure mental health and community services are represented in reform discussions.

7. NHS Employers - Post-incident support framework

Violence and abuse can occur in all healthcare settings, including community services and patients' homes, and can affect any member of staff.

This guidance offers a support framework with actionable steps for staff affected by physical violence and psychological trauma within NHS settings.

Link: Post-incident-support-framework-July2026_0.pdf

Lead: Executive Director of People and OD:

The Trust already has strong oversight and governance arrangements in place in relation to staff safety, wellbeing and workplace harassment. The NHS Employers Post-Incident Support Framework aligns with work currently underway to implement the NHS Staff Standards, particularly the Violence Prevention and Reduction Standard, alongside the Trust's EDI agenda and No Excuse for Abuse programme.

The framework also supports the Trust's preparations for the strengthened duty under the Employment Rights Act 2025 to take all reasonable steps to prevent third-party harassment. Existing and planned work relating to violence prevention, risk assessment, reporting, staff support, training and organisational learning will help demonstrate compliance with these requirements while ensuring colleagues who experience violence, abuse or psychological trauma receive appropriate support.

8. Beyond productivity: AI and NHS workforce implications

This report explores what non-clinical AI means for the workforce, from changing roles and skills to the governance, training and support staff need to use AI safely and effectively. Commissioned by NHS England, the report was developed by the three London Health Innovation Networks, UCL Partners, Health Innovation Network South London and Imperial College Health Partners, drawing on published evidence and insight from NHS leaders, clinicians, operational teams and workforce representatives.

Link: UCLP-Implication-of-AI-on-the-NHS-Workforce-06.26.pdf

Lead: Executive Director of Finance, Resources, Estates and Digital:

This report identifies that AI is likely to transform the NHS workforce but no just reducing staff numbers or generating productivity gains but by adopting a workforce centred transformation approach.

This report will be taken through the Trusts digital governance structure.

9. Acute provider collaboratives: delivering system impact in a changing NHS landscape

Provider collaboratives are a proven delivery mechanism for the NHS’s priorities, and they continue to play a key role in dealing with complex challenges that transcend individual organisations, including pathway redesign, workforce and productivity. In a briefing by NHS Alliance, examples are given of where provider collaboration is delivering real benefits for patients against a changing NHS landscape.

Link: Acute provider collaboratives: delivering system impact in a changing NHS landscape

Lead: Executive Director of Finance, Resources, Estates and Digital

This report identifies where acute provider collaboratives are delivering tangible benefits through joint/collaborative working. The report identifies that flexibility is required locally for providers to determine where collaboration at scale will genuinely add value.

10. Mental health personalised care framework: the modern care programme approach

This framework sets out the approach and related principles and actions for delivering personalised care for adults and older people with severe mental health problems.

Personalised care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs.

Link: NHS England » Mental health personalised care framework: the modern care programme approach

Lead: Interim Chief Operating Officer:

The Trust is already progressing work aligned to the NHS England Mental Health Personalised Care Framework (Modern Care Programme Approach), which builds on existing Care Programme Approach and Community Mental Health Transformation principles.

A dedicated working group has been established to coordinate implementation and review current practice against the framework requirements, with oversight provided through the Trust's governance arrangements, including the Mental Health Legislation Committee. An insight report, led by the Clinical Director, is currently being prepared and will be presented through the Trust's governance and assurance processes**.**

11. Supporting autistic people and people with a learning disability to live well in their communities

This publication by NHS England sets out the essential components that help autistic people and people with a learning disability to live good, meaningful lives in their communities. It is designed to support local systems plan and deliver this support across all ages.

Link: NHS England » Supporting autistic people and people with a learning disability to live well in their communities

Lead: Interim Chief Operating Officer

The guidance signals the direction of future national policy by emphasising prevention, early intervention and a reduction in reliance on inpatient care. It also supports implementation of forthcoming Mental Health Act reforms, which will place a greater expectation on services to provide effective support within community settings and address the significant health inequalities experienced by autistic people and people with a learning disability.

For the Trust, the guidance reinforces the importance of continuing to develop community-based alternatives to admission, intensive support and crisis prevention services, alongside strong partnership working across health, social care, housing, education and the voluntary sector. These approaches will be critical to improving outcomes, reducing avoidable hospital admissions and ensuring people can receive care and support closer to home. All developments underway are considered in line with these objectives.

12. Expansion of Community Mental Health Support across England

People struggling with their mental health will get help earlier and closer to home, with 159 new NHS mental health facilities opening across England.

Backed by £343 million, the rollout includes:

- 100 new community mental health centres, offering walk-in support without a referral and without a months-long wait
- 59 dedicated mental health emergency departments giving people in crisis specialist care in a place designed for them

The new centres will make it far easier for people to get the right help the first time they ask for it, by bringing mental health and specialist teams together under one roof - working alongside GPs, councils, the voluntary sector and families, with direct links into housing and employment support.

Link: Major expansion of community mental health support across England - GOV.UK

Lead: Executive Director of Finance, Resources, Estates and Digital

The Trust has been successful in securing funding (in principle) for the development of neighbourhood health centres, details of which are being progressed and form part of the Trusts approved capital programme.

13. Framework for NHS Boards: Monitoring Research Activity

NHS England has published a framework which defines what NHS boards need to do to monitor research and describes what a high-performing, research-active organisation looks like. It helps NHS organisations work together to conduct research more quickly and efficiently, and to recruit more participants into interventional research. It does this by giving boards the tools to understand and assess their research activity, income and performance, and to support effective oversight and decision-making.

Link: NHS England » Framework for NHS boards: monitoring research activity

Lead: Executive Medical Director:

Humber Teaching NHS Foundation Trust is well aligned with the principles of the framework, with an established and growing research portfolio, strong research participation, increasing external research income, and continued investment in research capacity and capability.

During 2025-26, the Trust supported 54 NIHR portfolio studies and 13 non-portfolio studies, recruited 4,858 participants into research studies, and secured £1.275 million in external research funding. The framework provides a useful structure to support ongoing Board oversight and assurance of research activity, performance, impact and governance, ensuring research continues to contribute to improved patient outcomes, workforce development and service innovation.

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 08

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Board Assurance Framework Q1 2026/27
Author/s:	Oliver Sims Risk and Incident Lead Manager
Recommendation:	

To approve		To discuss	
To note	√	To ratify	
For assurance			

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	This report presents Quarter 1 2026/27 Board Assurance Framework (BAF) following review by the Executive Management Team. Board is asked to note the risks, controls, assurances and gaps in assurance relating to the strategic objectives, as well as the aligned scores and appetite ratings.

Key issues:

Positive Assurances to Provide:

- Progress against the identified risks to each of the Trust's strategic goals is reflected within the framework to allow for consideration to be given to assurances in place, which enables focused review and discussion of the challenges to the delivery of the organisational objectives.

- Each of the Board Assurance Framework sections continue to be reviewed by the assigned assuring committee, alongside the recorded risks, to provide further assurance around the management of risks to achievement of the Trust's strategic goals.

- Overall assurance rating for each of the strategic goals is applied based on the review of the positive assurance, negative assurance and gaps in assurance identified against the individual goal. The overall rating for each strategic goal is determined based on the assurance available to the Executive Lead at the time of review.

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Following recommendations arising from the annual Internal Audit review of the Board Assurance Framework and the annual review of the Risk Management Enabling Strategy, the BAF template has been revised to improve clarity, consistency and alignment with recognised good practice.

- The Quality Committee has completed an in-depth review of strategic goal 2 – this will be included in the next version of the BAF

- EMT has reviewed –
  - the current iterations of the aligned sections of Board Assurance Framework
  - confirmed the risk scores applied to the section of the Board Assurance Framework
  - confirm the risk appetite ratings applied to the section of the Board Assurance Framework presented for review.

- As part of the updated quarterly review process for the Board Assurance Framework, each aligned board committee is asked to review the BAF in conjunction with the following questions to further

	strengthen the development of the document each quarter and to provide further assurance around review and challenge arrangements in place: 1. Each committee is asked to review the Board Assurance Framework and to identify any further elements for consideration as part of the ongoing development of the document for the current reporting quarter. 2. Each Committee is asked to confirm the risk scores applied to the section of the Board Assurance Framework presented for review. 3. Each Committee is asked to confirm the risk appetite ratings applied to the section of the Board Assurance Framework presented for review.
Key Risks/Areas of Focus: The Board is asked to review the current iteration of the Board Assurance Framework sections aligned to its remit and identify any additional controls, assurances, gaps or mitigating actions for inclusion.	**Decisions Made:** Current assurance ratings for each section of the Board Assurance Framework are detailed below following review by EMT: **Strategic Goal – Innovating for Quality and Patient Safety** - Current rating 8 – High. **Strategic Goal – Enhancing prevention, wellbeing, and recovery.** - Current rating 12 – High. **Strategic Goal – Fostering integration, partnerships, and alliances.** - Current rating 8 – High. **Strategic Goal – Promoting people, communities, and social values.** - Current rating 6 – Moderate. **Strategic Goal – Developing an effective and empowered workforce.** - Current rating 8 – High. **Strategic Goal – Optimising an efficient and sustainable organisation.** - Current rating 8 – High.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	Supports discussion relating to prevention, recovery, place-based partnerships, neighbourhood working and integrated models of care.
Analogue to Digital	Not applicable to Quality Committee aligned Board Assurance Framework sections.
Sickness to Prevention	Directly supports the strategic objective of enhancing prevention, wellbeing and recovery, including reducing health inequalities and improving population health outcomes.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee	Aug 2026	People & Organisational Development Committee	Aug 2026
Finance Committee	July 2026	Executive Management Team	08.09.26
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	√
Enhancing prevention, wellbeing and recovery	√
Fostering integration, partnership and alliances	√
Developing an effective and empowered workforce	√
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	√

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	√

Public Exemption:

Is the report exempt from public disclosure	No

Humber Teaching
NHS Foundation Trust

Board Assurance Framework

Quarter 1 2026/27

Humber Teaching NHS Foundation Trust Strategic Goals / Objectives

Innovating for quality and patient safety	Enhancing prevention, wellbeing, and recovery	Fostering integration, partnerships, and alliances	Promoting people, communities, and social values	Developing an effective and empowered workforce	Optimising an efficient and sustainable organisation
Attain a CQC rating of outstanding for safety to inform our ultimate aim of achieving a rating of outstanding in recognition of our success in delivering high-quality, safe, responsive and accessible care. Work in partnership with our staff, patients, service users, carers and families to co-produce integrated services which take a collaborative, holistic and person-centred approach to care. Use patient experience and other forms of best available evidence to inform practice developments and service delivery models for the services we provide and commission. Shape the future of our health services and treatments by building on our existing research capacity, taking part in high-quality local and national research, embedding research as a core component of our frontline clinical services and translating research into action.	Focus on putting recovery at the heart of our care. This means supporting people using our services to build meaningful and satisfying lives, based on their own strengths and personal aims. We will offer holistic services to optimise health and wellbeing including our Recovery College, Health Trainers, Social Prescribing and Peer Support Workers. Empower adults, young people, children and their families to take control by becoming experts in their own self-care, making decisions and advocating for their needs. Embed a trauma informed approach to supporting the people who use our services. In doing this, we will acknowledge people's experiences of physical and emotional harm and deliver our services in a way that enables them to feel safe and addresses their physical, psychological and emotional needs. Work collaboratively with our stakeholders to co-produce models of service delivery and deliver transformation programmes that meet the needs of the communities we serve and address health inequalities, both in our provider role and in our role as lead commissioner. Continually strive to improve access to our services and minimise the impact of waiting times for our patients, their carers and families.	Use our system-wide understanding of our local population's health needs and our knowledge of the impact and effectiveness of interventions to plan services. Work closely with all six Place-based partnerships across Humber and North Yorkshire to facilitate collaboration and empower local systems. Place-based partnerships have responsibility for improving the health and wellbeing outcomes for the population, preventing ill health and addressing health inequalities at a local level. Collaborate with system partners to maximise the efficient and effective use of resources across health and care services. Work alongside our partners in health, social care, the voluntary, community and social enterprise sector, Healthwatch, local government and other fields to develop integrated services as part of the Humber and North Yorkshire Health and Care Partnership. Take a collaborative approach to facilitating the provision of modern innovative services, building on our role as Lead Provider for perinatal mental health and aspects of specialised mental health commissioning. Empower Humber staff to work with partners across organisational boundaries, embracing a 'one workforce' approach to enable patients to access the right support, in the right place, at the right time.	Take action to address health inequalities and the underlying causes of inequalities, both in our role as a provider of integrated health services and our role as a developing anchor institution, supporting the long-term aim of increasing life expectancy for our most deprived areas and for population groups experiencing poorer than average health access, experience, and outcomes. Celebrate the increasing cultural diversity of Humber, offering opportunities for our staff, patients, families and the communities we support to safely express their views and shape and influence our services. Work collaboratively with our partners in the voluntary sector to build on our shared strengths - our deep knowledge of service users' needs and our ability to respond to changing circumstances. Strengthen Humber's relationships with statutory partners including housing, education and Jobcentre Plus to deepen our understanding of our communities. Work alongside economic development and health and care system partners to ensure that our investments in facilities and services benefit local communities. Offer simplified routes into good employment for local people. Provide opportunities to people with lived experience of mental and physical ill health, autism and learning disabilities and people from communities experiencing deprivation.	Grow a community of leaders and managers across Humber with the capability, confidence, and values to create a highly engaged, high performing and continually improving culture. Ensure all colleagues are highly motivated to achieve outstanding results by creating a great employer experience, so that they feel valued and rewarded for doing an outstanding job; individually and collectively. Attract, recruit, and retain the best people by being an anchor employer within the locality; with roles filled by staff that feel happy and proud to work for Humber. Prioritise the health and wellbeing of our staff by understanding that staff bring their whole self to work, so we place mental and physical wellbeing at the heart of the individual's experience of working at Humber. Enable new ways of working and delivering health care, anticipating future demands and planning accordingly. Engage with schools, colleges, and universities to create a highly skilled and engaged workforce who want to grow and develop to deliver high-quality care. Develop a culture of learning, high engagement, continuous improvement, and high performance that builds on our values and enables us to realise the potential of our people. Maximise a diverse and inclusive workforce representative of the communities we serve.	Embrace new, safe and secure technologies to enhance patient care, improve productivity and support our workforce across the health and social care system. We will design technologies around the person's needs and will make sure that people are not excluded from accessing services due to digital poverty or poor rural connectivity. Work with our partners to optimise the efficiency and sustainability of the Humber and North Yorkshire Health and Care Partnership in our role as lead provider. Continue to develop our estate to provide safe, environmentally sustainable, and clinically effective environments that support operational delivery. Work with our partners and communities to minimise our effect on the environment to meet the NHS climate change target. Empower all staff to contribute to the efficiency and sustainability of the organisation by making informed decisions about the efficient use of resources.

RISK APPETITE

Strategic Goal	Executive Lead	Risk Appetite (Agreed by Trust Board August 2026)	Threshold Risk Score
Innovating for quality and patient safety	Executive Director of Nursing	**SEEK**	15
Enhancing prevention, wellbeing, and recovery	Chief Operating Officer	**MATURE**	15+
Fostering integration, partnerships, and alliances	Chief Executive	**MATURE**	15+
Promoting people, communities, and social values	Executive Medical Director	**MATURE**	15+
Developing an effective and empowered workforce	Executive Director of People and OD	**MATURE**	15+
Optimising an efficient and sustainable organisation	Executive Director of Finance	**SEEK**	15

RISK APPETITE DEFINITIONS	
Minimal (Low risk)	Preference for ultra-safe business delivery options that have a low degree of inherent risk and only have a potential for limited reward.
Cautious (Moderate risk)	Preference for safe delivery options that have a low degree of residual risk and may only have limited potential for reward.
Open (High risk)	Willing to consider all potential delivery options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward (and value for money etc.).
Seek (Significant risk)	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk.
Mature (Significant risk)	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

BOARD ASSURANCE FRAMEWORK SUMMARY

Strategic Goal	Risk	Executive Lead	Assuring Committee	Initial Risk Rating (Before Mitigation)			Current Risk Rating (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Quarterly Update Summary to Trust Board from Executive Lead
				I	L	Rating I X L	I	L	Rating I X L			
Innovating for quality and patient safety	Quality and patient safety underpins all that we do. Failure to innovate for quality improvement and patient safety could result in service delivery not meeting required quality standards resulting in substandard care which could impact on patient safety and outcomes, trust reputation and CQC rating.	Executive Director of Nursing	Quality Committee	4	3	12 HIGH	4	2	8 HIGH	SEEK	IN	The Trust continues to strengthen quality improvement and patient safety through ongoing CQC preparedness activities, a programme of mock inspections, implementation of PSIRF, and an expanding culture of learning and improvement. Assurance remains positive, with quality standards oversight and recent service inspections demonstrating continued progress towards the Trust's ambition of achieving outstanding care.
Enhancing prevention, wellbeing, and recovery	Failing to enhance prevention, wellbeing and recovery could result in patients not accessing support and services that will address their health and care needs leading to poorer health outcomes and adversely widening health inequalities for our populations.	Chief Operating Officer	Quality Committee	4	4	16 SIGNIFICANT	4	3	12 HIGH	MATURE	IN	The Trust has maintained focus on recovery-oriented, person-centred care, working closely with system partners to improve patient flow, reduce out-of-area placements, address waiting times, and tackle health inequalities. Progress continues across recovery services, trauma-informed care, service transformation programmes, and improving access to support for patients, carers, and families.
Fostering integration, partnerships, and alliances	Failure to foster integration, partnerships and alliance could result in the Trust not being able to influence the delivery of health and social care regionally, which could impact on the development of system-wide solutions that enhance ability to deliver excellent services.	Chief Executive	Audit Committee	4	3	12 HIGH	4	2	8 HIGH	MATURE	IN	Controls include active collaboration with ICB and Place partners on community service models, population health training, and pathway redesign. Data-sharing agreements and use of the Yorkshire & Humber Care Record strengthen integrated working, while joint planning supports neighbourhood hubs and specialist service developments.
Promoting people, communities, and social values	Failure to promote people, communities and social values may result in Trust services not having a measurable social impact which could affect the health of our population and cause increased demand for services.	Executive Medical Director	Quality Committee	3	3	9 HIGH	3	2	6 MODERATE	MATURE	IN	The Trust continues to advance its commitment to reducing health inequalities, strengthening community partnerships, promoting inclusion and diversity, and creating opportunities for local people and those with lived experience. Positive progress has been demonstrated through community engagement initiatives, social value programmes, workforce development opportunities, and collaborative working with voluntary and statutory sector partners.
Developing an effective and empowered workforce	Failure to recruit and retain high-quality workforce could result in service delivery not meeting national and local quality standards resulting I substandard care being delivered which could impact on patient safety and outcomes	Executive Director of People and OD	People and OD Committee	4	3	12 HIGH	4	2	8 HIGH	MATURE	IN	A Trust-wide workforce plan, leadership development programmes, strengthened induction, and targeted recruitment and retention initiatives are in place. Sickness management, wellbeing support, flexible working, and ESR optimisation underpin workforce stability, while WRES/WDES/GPG actions and the Respect framework are driving inclusion.
Optimising an efficient and sustainable organisation	Failure to optimise efficiencies in finances, technology and estates will inhibit the longer-term efficiency and sustainability of the Trust which will reduce any opportunities to invest in services where appropriate and put at risk the ability to meet financial targets set by our regulators.	Executive Director of Finance	Finance Committee	4	3	12 HIGH	4	2	8 HIGH	SEEK	IN	Digital transformation, improved data quality, and financial controls continue to support operational efficiency. Estate modernisation, capital delivery, and sustainability initiatives are in place to ensure safe, modern environments. Collaborative financial planning with system partners be completed to strengthen long-term organisational sustainability.

Innovating for quality and patient safety

Lead Director: Ex Dir. Nursing

Lead Committee: Quality Committee

Quality and patient safety underpins all that we do. Failure to innovate for quality improvement and patient safety could result in service delivery not meeting national and local quality standards resulting in substandard care being delivered which could impact on patient safety and outcomes.

Risk Score: 8 HIGH

Initial Risk Rating (Before Mitigation)			Current Risk Rating (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)
I	L	Rating I X L	I	L	Rating I X L		
4	3	12 - HIGH			8 - HIGH	15	IN APPETITE

Risk Analysis	Quarter 2 (2025/26)	Quarter 3 (2025/26)	Quarter 4 (2025/26)	Quarter 1 (2026/27)
Current Risk Rating	8 HIGH	8 HIGH	8 HIGH	8 HIGH
Risk Appetite Threshold	15	15	15	15

Controls – (Current Inputs)

Strategic Objective 1 - Attain a CQC rating of outstanding for safety to inform our ultimate aim of achieving a rating of outstanding in recognition of our success in delivering high-quality, safe, responsive and accessible care. (Dates if applicable)

(A) Peer review process in place aligned to CQC fundamental standards.
(B) Quality Standards Group oversees CQC inspection preparation including oversight of the divisional and directorate self-assessments.
(C) Programme of mock inspections in place – reviews undertaken to date (Hull CMHT), Whitby Ward and Older Peoples inpatients wards
(D) Well led compliance overseen by EMT and Trust Board
(E) In line with Trust suicide prevention plan there is a reduction in completed suicides within Trust services.
(F) Implementation and monitoring of PSIRF with thematic learning reviewed through Quality Committee.
(G) Board oversight of safety culture measures including Freedom to Speak Up, staff survey results and safety incident trends.

Strategic Objective 2 - Work in partnership with our staff, patients, service users, carers and families to co-produce integrated services which take a collaborative, holistic and person-centred approach to care. Use patient experience and other forms of best available evidence to inform practice developments and service delivery models for the services we provide and commission.

(A) The Trust currently has 1 Patient Safety Partner -
(B) The Trust currently has 17 panel volunteers. Data on panel volunteer representation at interviews is not currently collected, but this is being reviewed by HR.
(C) Review of the Contact Point CAMHS referral process due to increased demand.
(D) QI training increased with 1241 total places delivered.
(E) QI initiative linked to CQC domains and patient safety incidents identified.
(F) Trust FFT process
(G) NHS National Staff Survey
(H) Trust complaints management process

Strategic Objective 3 - Shape the future of our health services and treatments by building on our existing research capacity, taking part in high-quality local and national research, embedding research as a core component of our frontline clinical services and translating research into action.

(A) Introduction to research included as part of staff training, e.g. Preceptorship programme, Medics teaching, student placements.
(B) Research Champions in clinical services.
(C) New research collaborations with external sponsors across the country where Trust staff are named and funded as co-applicants/collaborators.
(D) External research grant funding secured with our Trust as the lead NHS organisation.
(E) New treatments/novel interventions evaluated as part of national trials for which our Trust is a site.
(F) Professional Strategy development and implementation

Positive Assurance – (Current Outputs)

Strategic Objective 1 - Attain a CQC rating of outstanding for safety to inform our ultimate aim of achieving a rating of outstanding in recognition of our success in delivering high-quality, safe, responsive and accessible care (dates if applicable)

(A.B.C) The Trust's current CQC rating is 'Good' (2019 assessment)
(A.B.C.) Inspection of Orion (Inspire) services rated as 'Good' 2025.
(A.B.C.) Townend Court inspection – rated as Good 2026
(A.B.C.) Crisis inspection – rated as Good 2026
(B) Self-assessments completed by divisions on CQC domains and quality standards
(B) Quality and Safety performance report to QPAS / Quality Committee / Trust Board
(C) Updated schedule of mock CQC inspections – reports and progress through QPaS and EMT
(E) Annual Learning from deaths review
(E) Incident reporting on suspected suicide via Quality Dashboard
(F, G) PSIRF implementation continues to support a systems-based approach to learning from patient safety incidents. Improvement programmes have demonstrated reductions in avoidable harm. Staff survey and Freedom to Speak Up indicators demonstrate continued staff engagement in patient safety initiatives.

Strategic Objective 2 - Work in partnership with our staff, patients, service users, carers and families to co-produce integrated services which take a collaborative, holistic and person-centred approach to care. Use patient experience and other forms of best available evidence to inform practice developments and service delivery models for the services we provide and commission (Dates if applicable)

(A) The Involving Patients and Families Subgroup of the PSIRF has recently been set up; this is a new project which will help the Trust to look at ways it can recruit more Patient Safety Partners.
(A.B) 186 (43%) Divisional QI activities underway or complete have indicated that they have included Patients and Carers in the planning and delivery of the work.
(C) Updated referral model for Contact Point CAMHS.
(D) 695 recorded Quality Improvement (QI) activities of which 420 were complete, 187 live and 88 not viable / closed.
(F) FFT response rate and feedback mechanisms in place. Community mental health survey improved results – reduction in formal complaints as informal complaints are successfully managed and resolved
(F) Friends and Family Test 'Safe' question output
(G) Staff Survey results around 'Safe' questions – Trust staff feel supported to report incidents
(H) Review of complaints process looking at areas of further development and how can included experts by experience and be more trauma informed

Strategic Objective 3 - Shape the future of our health services and treatments by building on our existing research capacity taking part in high-quality local and national research, embedding research as a core component of our frontline clinical services and translating research into action.

(A.B) Annual Research Report indicates high level of research activity in the Trust.
(A) Research module contained wit preceptorship programmes
(C) Performance in Initiating and Delivering (PID) research is published on Trust website
(C.D) Performance management system (EDGE) used to monitor recruitment to studies and Assistant Director R&D and Research Support Manager maintain monitoring dashboard to review progress.
(D) Increased numbers of participants recruited into NIHR Portfolio studies.
(D.E) National Institute for Health and Social Care Research (NIHR) fellowship awards for clinical staff.
(F) Trust multi-professional strategy embedded and progress of enabling plans of Nursing strategy.

Negative Assurance / Gaps in Assurance – Required Outputs	Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on Actions
Strategic Objective - Attain a CQC rating of outstanding for safety to inform our ultimate aim of achieving a rating of outstanding in recognition of our success in delivering high-quality, safe, responsive and accessible care (1) Trust CQC rating for 'Safe' domain remains requires improvement (2019 assessment). (2) Internal assessment against key inspection domains and evidence against quality standards. <u>Linked Risk(s):</u> NQ66 - Failure to fully prepare for CQC inspection resulting in a poor inspection rating, which may lead to reputational impact for the Trust.	SO1. 1 - Patient Safety Priorities monitoring.	Next Check point: Sept 2026	Kate Baxendale	Leads identified for each priority. Working group established and all have a project group underpinned by charter. Agreed for two-year period and work underway around reporting.
	SO1. 2 – Continued delivery of programme of mock inspections.	Next Check point: Sept 2026	Kate Baxendale	Ongoing programme underway across Trust services.
Strategic Objective 3 - Work in partnership with our staff, patients, service users, carers and families to co-produce integrated services which take a collaborative, holistic and person-centred approach to care. Use patient experience and other forms of best available evidence to inform practice developments and service delivery models for the services we provide and commission. (1) CYP and Adult ADHD and CYP Autism waiting lists are currently outstripping demand due to significant rise in referrals. Due to the size of the current ADHD medication waiting lists for CYP the current children's and adult services are not able to start anyone on medication as the services are at capacity. <u>Linked Risk(s):</u> OPS31 – Failure to effectively address waiting times within the Trust's Children's Neurodiversity services which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain	SO3. 1 Neuro diversity services work at ICB level to determine how processes can be standardised / streamline to reduce system pressures	Next Check point: Sept 2026	Lynn Parkinson	ICB aware of top priorities around waiting time and considering system pathways to remedy pressures.
	SO3. 1 - Waiting list Capacity and Demand work ongoing to identify areas for further support. (Neuro diversity and Adult ADHD)	Next Check point: Sept 2026	Lynn Parkinson	Adult ASD/ADHD Assessment waiting times are improving

Enhancing prevention, wellbeing, and recovery



Lead Director: Chief Operating Officer

Lead Committee: Quality Committee

Failing to enhance prevention, wellbeing and recovery could result in patients not accessing support and services that will address their health and care needs leading to poorer health outcomes and adversely widening health inequalities for our populations.

Risk Score: 12 HIGH

Initial Risk Rating (Before Mitigation)			Current Risk Rating (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)
I	L	Rating I X L	I	L	Rating I X L		
4	4	16 - SIGNIFICANT	4	3	12 - HIGH	15+	IN APPETITE

Risk Analysis	Quarter 2 (2025/26)	Quarter 3 (2025/26)	Quarter 4 (2025/26)	Quarter 1 (2026/27)
Current Risk Rating	12 HIGH	12 HIGH	12 HIGH	12 HIGH
Risk Appetite Threshold	15+	15+	15+	15+

Controls – (Current Inputs)

Strategic Objective - Focus on putting recovery at the heart of our care. This means supporting people using our services to build meaningful and satisfying lives, based on their own strengths and personal aims. We will offer holistic services to optimise health and wellbeing including our Recovery College, Health Trainers, Social Prescribing and Peer Support Workers.

(A) Work with Integrated Care Board colleagues and provider collaboratives to improve local capacity to reduce the need for out of area placements. Targeted escalation meetings with place partners and provider collaboratives are in place to resolve the complex care packages of patients that are required. Embedded social worker in older people's inpatient units and the increase in older adult step-up bed occupancy.
(B) Work with social care providers to improve timely discharge of care which in turn should reduce Out of Area placements. - ADD
(C) We continue to review access and recovery data by ethnicity and deprivation decile.

Strategic Objective - Empower adults, young people, children and their families to take control by becoming experts in their own self-care, making decisions and advocating for their needs.

(A) Improved telephony infrastructure across all three Trust GP practices.
(B) Promotion of the NHS App supported by digital volunteers in practices increasing App utilisation, improved digital access to appointments, care navigation and Total Triage.
(C) Working with PCN colleagues to ensure that ARRS roles deliver additional capacity within practices via the PCN.
(D) Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7%.
(E) Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% of patients receiving one.
(F) Respond effectively to the NHS 111 option 2 calls.
(G) Build on the community mental health model of “no wrong door”.
(H) Continue to develop and expand the resources provided by the recovery college and deliver the objectives in the recovery strategic framework.
(J) Good attendance at all system meetings internally and externally to anticipate and monitor patient flow between partners.
(I) Independent placement support team and initiatives supporting adolescent eating disorders and recovery
(K) 'Waiting Well' procedure for both adults and children

Strategic Objective - Embed a trauma informed approach to supporting the people who use our services. In doing this, we will acknowledge people’s experiences of physical and emotional harm and deliver our services in a way that enables them to feel safe and addresses their physical, psychological and emotional needs.

(A) Trauma in Care Strategy Task and Finish group established.
(B) Trauma-informed Plan

Positive Assurance – (Current Outputs)

Strategic Objective - Focus on putting recovery at the heart of our care. This means supporting people using our services to build meaningful and satisfying lives, based on their own strengths and personal aims. We will offer holistic services to optimise health and wellbeing including our Recovery College, Health Trainers, Social Prescribing and Peer Support Workers.

(A, B, C) Supporting improvements in the quality and safety of all-age inpatient care, by finalising and publishing system 3-year plans to localise and realign inpatient care in line with the mental health inpatient commissioning framework.
(A, B, C) The Trust has consistently delivered over 700 patients a month who complete 2+ contacts at discharge.
(A, B, C) The Trust have consistently delivered above the 48% reliable recovery objective over the last year
(A, B, C) The Trust also demonstrates a 67% reliable improvement rate over the last year
(A, B, C) The Trust continues to work with the Integrated Care Board & Public Health to achieve 6 week and 18-week access targets.
(A, B, C) Waiting lists in Dietetics are reducing due to recent investment.
(A, B, C) Core CAMHS are almost <18 week compliant.
(A) At the end of Q1 2026/27, delayed transfers of care averaged 18.2% within Adult and Older People services (17.5% including PICU). Average out-of-area placements were 14 within Adult/Older People services (17 including PICU), indicating continuing system flow challenges.

Strategic Objective - Empower adults, young people, children and their families to take control by becoming experts in their own self-care, making decisions and advocating for their needs.

(A, B, C, D, E, F, G, H) Improved Friends and Family Test and patient satisfaction results.
(A, B, C, D, E, F, G, H) Ongoing provision of extended access appointments over and above PCN target.
(J) Escalation processes in place using the SCC where necessary.

Strategic Objective - Embed a trauma informed approach to supporting the people who use our services. In doing this, we will acknowledge people’s experiences of physical and emotional harm and deliver our services in a way that enables them to feel safe and addresses their physical, psychological and emotional needs.

(A) Trauma in Care Strategy Task and Finish group action plan for key pieces of work.
(B) Trauma-informed self-assessment by divisions

Strategic Objective - Work collaboratively with our stakeholders to co-produce models of service delivery and deliver transformation programmes that meet the needs of the communities we serve and address health inequalities, both in our provider role and in our role as lead commissioner.	Strategic Objective - Work collaboratively with our stakeholders to co-produce models of service delivery and deliver transformation programmes that meet the needs of the communities we serve and address health inequalities, both in our provider role and in our role as lead commissioner.
(A) For 2026/27 there were 867 QI charters at Q1 (B) The Trust continues to host our six-monthly Humber Co-production Network meetings chaired by the Chief Executive. Community Vision informed the group on the work they are leading to support voluntary sector organisations. (C) Trust Patient Care and Performance Accountability Review Process aligns information on clinical and non-clinical operational performance, activity, finance, and quality and Patient Safety, to give an accurate organisational overview and have been applied to the Divisions in the Operations Directorate. (D) Trust working with Neighbourhoods, local authority and voluntary section aligned to the NHS 10-year plan	(A), QI charters - 753 live/completed activities, 264 undertaken in partnership, and 438 demonstrating benefit (B) The Patient and Carer Experience team and divisional engagement leads are meeting with Community Vision to identify future opportunities for partnership working. (C) Children and Learning Disabilities – Segment 1. The Division had maintained and sustained improvement and were commended on their leadership. Community and Primary Care - Segment 2, with a moderate concern for Whitby Ward and a minor concern for finance. Forensics – Segment, with a moderate concern for sickness.
Strategic Objective - Continually strive to improve access to our services and minimise the impact of waiting times for our patients, their carers and families.	Strategic Objective - Continually strive to improve access to our services and minimise the impact of waiting times for our patients, their carers and families.
(A) Waiting Times Procedure in place (B) Waiting times review is key element of Divisional performance and accountability reviews and 'Waiting Well' procedure for both adults and children	(A.B) Review completed of all services with high levels of waiting times and service-level recovery plans developed. (B) Waiting times performance assurance report against national oversight framework. Trust ongoing work to minimise impact of waiting time and monitor waits via audits and incident management.

Negative Assurance / Gaps in Assurance – Required Outputs	Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on Actions
Strategic Objective 1 - Focus on putting recovery at the heart of our care. This means supporting people using our services to build meaningful and satisfying lives, based on their own strengths and personal aims. We will offer holistic services to optimise health and wellbeing including our Recovery College, Health Trainers, Social Prescribing and Peer Support Workers. (1) The Recovery College full review of courses and prospectus (2) There are system challenges around patient flow and a lack of places to discharge patients is leading to a bottleneck which is increasing out of are placements due to reduced flow (3) CQC Improvement notice (Hull CMHT). Patient's do not feel care plans engage with them and their families and fully implements recovery elements needed. <u>Linked Risk(s):</u> OPS33 - As a result of system pressures / increased demand and complexity / acuity of care, there has been impacted patient flow within Trust community inpatient services which may lead to reduced patient experience and quality of service provision	SO1.1 The Recovery College is currently going through a full review of courses and prospectus, with a transition back to more face-to-face sessions.	Next Check point: Sept 2026	Lynn Parkinson	Future reporting will capture both face-to-face and online attendance, and feedback will be captured more accurately. A new focus group is also being set up to help develop and co-produce future courses/sessions.
	SO1. 2 Weekly Multi-Agency Discharge Event meetings	Next Check point: Sept 2026	Lynn Parkinson	Ongoing meetings continue to support discharge planning and flow across partner organisations.
	SO1. 3 Audit around how the Trust involves patients and families	Next Check point: Sept 2026	Lynn Parkinson	.
Strategic Objective 4 - Embed a trauma informed approach to supporting the people who use our services. In doing this, we will acknowledge people's experiences of physical and emotional harm and deliver our services in a way that enables them to feel safe and addresses their physical, psychological and emotional needs. (1) Mental Health Division to apply the principles to the Trauma Service.	SO4. 1 - Development of Trauma in Care Strategy and implementation in Mental Health	Next Check point: Sept 2026	Lynn Parkinson	

Fostering integration, partnerships, and alliances

Lead Director: Chief Executive

Lead Committee: Audit Committee

Failure to foster integration, partnerships and alliance could result in the Trust not being able to influence the delivery of health and social care regionally, which could impact on the development of system-wide solutions that enhance ability to deliver excellent services.

Risk Score: 8 HIGH

Initial Risk Rating (Before Mitigation)			Current Risk Rating (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)
I	L	Rating I X L	I	L	Rating I X L		
4	3	12 - HIGH	4	2	8 - HIGH	15+	IN APPETITE

Risk Analysis	Quarter 1 (2025/26)	Quarter 2 (2025/26)	Quarter 3 (2025/26)	Quarter 4 (2025/26)
Current Risk Rating	8 HIGH	8 HIGH	8 HIGH	8 HIGH
Risk Appetite Threshold	15+	15+	15+	15+

Controls – (Current Inputs)	Positive Assurance – (Current Outputs)
Strategic Objective - Use our system-wide understanding of our local population's health needs and our knowledge of the impact and effectiveness of interventions to plan services.	Strategic Objective - Use our system-wide understanding of our local population's health needs and our knowledge of the impact and effectiveness of interventions to plan services.
(A) Working with the ICB and North Yorkshire Place to support the definition of an effective core offer for community services.	(A) The ICB held a regional workshop during 2026 to identify key themes for community nursing. Four priority improvement areas were identified: standardising and promoting self-management, reducing deferred appointments, improving triage and allocation processes, and expanding clinic-based activity. Four supporting workstreams have been established and are being monitored through Place arrangements in York and North Yorkshire. The current community specification value is £68.93m and will increase to £69.713m following approved uplifts.
Strategic Objective - Work closely with all six Place-based partnerships across Humber and North Yorkshire to facilitate collaboration and empower local systems. Place-based partnerships have responsibility for improving the health and wellbeing outcomes for the population, preventing ill health and addressing health inequalities at a local level.	Strategic Objective - Work closely with all six Place-based partnerships across Humber and North Yorkshire to facilitate collaboration and empower local systems. Place-based partnerships have responsibility for improving the health and wellbeing outcomes for the population, preventing ill health and addressing health inequalities at a local level.
(A) North Yorkshire Council and NHS partners, including Humber Teaching NHS Foundation Trust, have commenced delivery of the 'Ambitious for Health' programme to develop a shared ambition for improving health outcomes across North Yorkshire. (B) The Trust continues to support neighbourhood health developments across Humber and North Yorkshire through dedicated resource from the Partnerships & Strategy and PMO teams. (C) Mental Health services continue to contribute to East Riding neighbourhood developments and associated neighbourhood health plans alongside system partners.	(A) The Trust is supporting delivery of the North Yorkshire 'Ambitious for Health' programme, helping to shape neighbourhood health services, integrated care models and service redesign across primary, community and social care. (B, C) Mental Health and Community Services continue to work with neighbourhood partners, Public Health teams and VCSE organisations to develop population-based solutions and improve service delivery at Place level
Strategic Objective - Collaborate with system partners to maximise the efficient and effective use of resources across health and care services.	Strategic Objective - Collaborate with system partners to maximise the efficient and effective use of resources across healt and care services.
(A) Humber continues to work with system partners to develop collaborative workforce solutions, workforce digital optimisation, professional mentoring networks and opportunities for workforce scaling across organisational boundaries.	(A) Humber continues to contribute to system-wide workforce planning, regional digital workforce programmes and one-workforce developments. Discussions continue regarding joint delivery arrangements and workforce scaling models to support service resilience and sustainability across Humber and North Yorkshire.
Strategic Objective - Work alongside our partners in health, social care, the voluntary, community and social enterprise sector, Healthwatch, local government and other fields to develop integrated services as part of the Humber and North Yorkshire Health and Care Partnership.	Strategic Objective - Work alongside our partners in health, social care, the voluntary, community and social enterprise sector, Healthwatch, local government and other fields to develop integrated services as part of the Humber and North Yorkshire Health and Care Partnership.
(A) Community Services continue to work with the ICB and Place partners on neighbourhood health developments and service redesign initiatives. (B) Children and Learning Disability Services are working with both Hull and East Riding Local Authorities to support the Experts at Hand offer and SEND reforms. (C) Children and Learning Disability Services are supporting system-wide Enteral Feeding procurement across the ICB. (D) Mental Health Services continue to work alongside Public Health, neighbourhood teams and VCSE partners to identify need, develop neighbourhood models and support targeted funding opportunities.	(A) The Trust is providing dedicated support to the 'Ambitious for Health' programme and wider neighbourhood health developments across Humber and North Yorkshire. (B) Collaborative working is supporting delivery of SEND reforms and system-wide procurement programmes. (C) Mental Health services continue to work alongside Public Health analytics teams, neighbourhood programmes and VCSE organisations to develop population-focused service solutions and capital investment proposals. (D) Partnership working across health, care and voluntary sector organisations continues to strengthen integrated service delivery arrangements across the system.
Strategic Objective - Empower Humber staff to work with partners across organisational boundaries, embracing a 'one workforce' approach to enable patients to access the right support, in the right place, at the right time.	Strategic Objective - Empower Humber staff to work with partners across organisational boundaries, embracing a 'one workforce' approach to enable patients to access the right support, in the right place, at the right time.

(A) Reporting data has been improved for partners and it now provides users and information accessed information. (B) Data sharing agreements have been updated to provide patient information using the national record locator.	(A, B) National Record Locator implementation has been completed, enabling Humber patient information to be shared across regions of England and further strengthening integrated care delivery. (A, B) Regional workforce transformation initiatives, mentoring programmes and digital workforce developments continue to progress, supporting Humber's contribution to a one-workforce approach across organisational boundaries. (A, B) Humber continues to support population health management through wider system data sharing arrangements and collaborative planning processes.

Negative Assurance / Gaps in Assurance – Required Outputs
Strategic Objective - Collaborate with system partners to maximise the efficient and effective use of resources across health and care services. (1) At the end of Quarter 1 2026/27, delayed transfers of care averaged 18.2% within Adult and Older People services (17.5% including PICU). Average out-of-area placements were 14 within Adult and Older People services (17 including PICU), indicating continuing system flow challenges and reliance on effective partnership working across health and social care services. Linked Risk(s): OPS29 - As a result of system pressures, increase acuity / complexity of care, issues with access to suitable accommodation via social care and a lack of a 'no right to reside' discharge pathway linked MoJ decision making, there has been impacted patient flow within Trust mental health inpatient services which may lead to reduced patient experience and quality of service provision

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on Actions
SO3. 1 Work is ongoing to restructure services and review bed capacity	Next Check point: Sept 2026	Lynn Parkinson	Weekly Multi Agency Discharge Event meetings take place.
SO3. 2 Awaiting new structures which will determine future joint working approaches	Next Check point: Sept 2026	Michele Moran	

Promoting people, communities, and social values

Lead Director: Executive Medical Director

Lead Committee: Quality Committee

Failure to promote people, communities and social values may result in Trust services not having a measurable social impact which could affect the health of our population and cause increased demand for services.

Risk Score: 6 MODERATE

Initial Risk Rating (Before Mitigation)			Current Risk Rating (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)
I	L	Rating I X L	I	L	Rating I X L		
3	3	9 - HIGH	3	2	6 - MODERATE	15+	IN APPETITE

Risk Analysis	Quarter 2 (2025/26)	Quarter 3 (2025/26)	Quarter 4 (2025/26)	Quarter 1 (2026/27)
Current Risk Rating	6 MODERATE	6 MODERATE	6 MODERATE	6 MODERATE
Risk Appetite Threshold	15+	15+	15+	15+

Controls – (Current Inputs)

Strategic Objective - Take action to address health inequalities and the underlying causes of inequalities, both in our role as a provider of integrated health services and our role as a developing anchor institution, supporting the long-term aim of increasing life expectancy for our most deprived areas and for population groups experiencing poorer than average health access, experience, and outcomes.

(A) Finalised annual report content on health inequalities in access and waiting times across a range of services. Embedded HI in one of the four "key promises" in the draft multi-professional plan
(B) Completed two accessibility audits on the Trust website.
(C) Two podcasts exploring Care, Culture and Equity themes have been recorded.

Strategic Objective - Celebrate the increasing cultural diversity of Humber, offering opportunities for our staff, patients, families and the communities we support to safely express their views and shape and influence our services.

(A) The demographic profile of SCOPEs has remained relatively unchanged since the last report with a marginal increase in ethnicity results. However, there is an increase of over 3% in the number of part-time staff.
(B) Staff Network Leadership: A comprehensive induction programme has been completed for our new Anti-racism network chair, with meetings with senior leaders, executive sponsors, and through new guidance to support them in their new roles.
(C) Respect in Care: Pilot project to develop scalable intervention model to address anti-racism.

Strategic Objective - Offer simplified routes into good employment for local people.

(A) Engagement with regional education providers remained a key focus, supporting the Trust's future workforce pipeline and promoting NHS careers across schools, colleges, universities and alternative provision settings. T Level placements with local colleges currently total 87, with over 100 expected by 2026. Careers events and work experience continue to provide early exposure to NHS careers, particularly for students from deprived communities. Work has expanded to Year 9 students who may lack clear career pathways or family support. Targeted initiatives are encouraging more young men into traditionally female-dominated roles, with males comprising 21% of placements. A Child Development Careers Morning further showcased diverse careers within children's services.

Strategic Objective - Work collaboratively with our partners in the voluntary sector to build on our shared strengths - our deep knowledge of service users' needs and our ability to respond to changing circumstances. Strengthen Humber's relationships with statutory partners including housing, education and Jobcentre Plus to deepen our understanding of our communities.

Positive Assurance – (Current Outputs)

Strategic Objective - Take action to address health inequalities and the underlying causes of inequalities, both in our role as a provider of integrated health services and our role as a developing anchor institution, supporting the long-term aim of increasing life expectancy for our most deprived areas and for population groups experiencing poorer than average health access, experience, and outcomes.

(A) Commenced a QI pilot project on Avondale with Citizens Advice Hull and East Riding, offering bespoke advice for ward patients who are identified in MDT meetings.
(A) Successful in bid for £30k Grant funding from North Yorkshire Combined Authority to support a Farmers Mental Health project.
(A) Ongoing work to supporting the Community MH Grants Scheme. Around halfway through the project, have given away £94,000 to 21 projects addressing HI.
(B, C) "People & Community Promise – We will use our professional expertise to deliver on prevention, address health inequalities and work in partnership with our communities".

Strategic Objective - Celebrate the increasing cultural diversity of Humber, offering opportunities for our staff, patients, families and the communities we support to safely express their views and shape and influence our services.

(A) Positive EDI Outcomes in Staff Survey - Our 2025 staff survey clearly demonstrates a strong and deeply embedded culture of inclusion across the Trust. Our scores for People Promise 1: We Are Compassionate and Inclusive, sitting only 0.17 below the best score, show that colleagues feel respected and valued for who they are.
(B) International Holocaust Remembrance Alliance (IHRA) - The Trust has formally adopted the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism, in line with NHS England and Department of Health and Social Care expectations.
(B) Staff Safety & Support: A comprehensive communications campaign has been developed that provides a proactive, ongoing discussion with staff regarding civil unrest and global conflicts.
(C) Respect in Care project reduced racially abusive incidents and improved staff safety through a targeted, ward-based anti-racism intervention. It developed, tested, and evaluated a practical model to reduce incidents of racial abuse, strengthen staff confidence and improve wellbeing.

Strategic Objective - Offer simplified routes into good employment for local people.

(A) Since 2017, 299 staff have successfully completed an apprenticeship, reflecting the Trust's ongoing commitment to workforce development and career progression. There are currently 145 apprentices on programme, a 20.8% increase from 120 last year, working across 145 of the Trust's 282 teams, demonstrating growing organisational reach and impact.

Strategic Objective - Work collaboratively with our partners in the voluntary sector to build on our shared strengths - our deep knowledge of service users' needs and our ability to respond to changing circumstances. Strengthen Humber's relationships with statutory partners including housing, education and Jobcentre Plus to deepen our understanding of our communities.

(A) During Quarter 1, the Trust worked in collaboration with 13 voluntary organisations which is a reduction of just one compared to Quarter 4. The Trust continues to work on building strong connections with Voluntary Services and the VCSE.	(A) As a snapshot at the end of Q1 26/27 there were 93 volunteers which shows no movement as at the end of Q4. No volunteers moved into a career with 27 new volunteers currently going through the recruitment process. (A) Network membership exceeds 80 people consisting of staff, partner organisations and patients/carers (A) VCSE spend increased to £10,038,792 from £9,395,097
Strategic Objective - Work alongside economic development and health and care system partners to ensure that our investments in facilities and services benefit local communities.	Strategic Objective 5 - Work alongside economic development and health and care system partners to ensure that our investments in facilities and services benefit local communities.
(A) P&S and PACE will work collaboratively to strengthen engagement with staff, gathering insights into their experiences as members of the communities they serve. (B) The Trust's Five-Year Estate Strategy (to 2027) provides the framework for estate development and supports Trust and ICB priorities, including the Redesigning Mental Health Inpatient Services capital programme, expected to begin in 2027 following business case development and public consultation. The strategy also drives improvements across the adult mental health inpatient estate, including a new Female HDU and redesigned learning disability provision. Estate plans are continually refined at locality and divisional level to support flexible working, maximise space utilisation, and improve service delivery. Progress is overseen through the Estate Strategy and Capital Delivery Group, while the Trust's Green Plan 2025–2028 promotes carbon reduction and the use of local suppliers and materials where appropriate. (C) There is a continuation of the 2024 regulations (Provider Selection Regime) which require commissioning bodies (including NHS England, Integrated Care Boards and NHS Foundation Trusts) to apply key criteria when assessing suppliers for their suitability to deliver health care services. These criteria include an assessment as to whether what is proposed might improve economic, social and environmental well-being in the geographical area relevant to a proposed contracting arrangement. (D) The Trust continues to host our six-monthly Humber Co-production Network meetings chaired by the Chief Executive, with the next meeting planned for Thursday 10th September 2026. The Network has a current membership of over 80 people made up of staff, partner organisations and patients/carers. The Network showcases co-production work taking place nationally, regionally and within our Trust and offers a place to share best practice and learning.	(A) Ongoing work will support the PCREF agenda by ensuring staff voices inform organisational understanding of community inclusion, equity and belonging, helping to shape future priorities and actions. (B) The Trust continues to contribute to the ICB strategic capital plan. This facilitates a collaborative approach to plan for capital priorities, which recognising the financial pressures on the system. (B, C, D) As an anchor institution and key ICS partner, the Trust helps ensure its estate remains compliant, well maintained and effectively utilised to support healthcare delivery. It also acts as a landlord for NHS and third-sector partners, enabling services to be delivered from appropriate locations, as demonstrated through the Hull Place Pilot and One Public Estate initiatives. (B, C, D) Our Trust considers the extent to which suppliers have acted to increase social value within their own activities, and how social value improvements can lead to other improvements in health outcomes. (B, C, D) Total local spend (DN, HG, HU and YO postcodes) = £32,581,570, down from £34,709,726.
Strategic Objective - Provide opportunities to people with lived experience of mental and physical ill health, autism and learning disabilities and people from communities experiencing deprivation.	Strategic Objective 6 - Provide opportunities to people with lived experience of mental and physical ill health, autism and learning disabilities and people from communities experiencing deprivation.
(A) At the end of Quarter 1 2026/27, 70 individuals were registered on the Trust's Expert by Experience (EbE) database. During the quarter, 23 individuals were paid for involvement work, contributing a combined 156 hours across 11 projects and initiatives. No individuals chose to leave the database.	(A) Currently there are 5 x Band 2 Peer Support Workers (4.6 wte) and 2 Band 3 Peer Support Workers (1.2wte). There were 8 Band 7 Experts by Experience Programme Facilitator on the Trust bank. This is a slight reduction on Q4 2025/26.

Negative Assurance / Gaps in Assurance – Required Outputs
Strategic Objective - Offer simplified routes into good employment for local people. (1) Changes to the apprenticeship landscape may affect apprenticeship numbers and levy utilisation in 2026/27. With Level 3, Level 5 and Level 7 leadership apprenticeships ending, the final cohorts will start in September 2026.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on Actions
SO4. 1- The Apprenticeship Team is identifying replacement programmes and development pathways to sustain leadership opportunities and maximise levy investment.	Next Check point: Sept 2026	Kwame Fofie	Level 3, 5 and 7 leadership apprenticeships ending with final cohorts beginning September 2026 and replacement programmes being identified.

Developing an effective and empowered workforce

Lead Director: Executive Dir. of People and OD

Lead Committee: P&OD Committee

Failure to recruit and retain high-quality workforce could result in service delivery not meeting national and local quality standards resulting in substandard care being delivered which could impact on patient safety and outcomes

Risk Score: 8 HIGH

Initial Risk Rating (Before Mitigation)			Current Risk Rating (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)
I	L	Rating I X L	I	L	Rating I X L		
4	3	12 - HIGH	4	2	8 - HIGH	15+	IN APPETITE

Risk Analysis	Quarter 2 (2025/26)	Quarter 3 (2025/26)	Quarter 4 (2025/26)	Quarter 1 (2025/26)
Current Risk Rating	8 HIGH	8 HIGH	8 HIGH	8 HIGH
Risk Appetite Threshold	15+	15+	15+	15+

Controls – (Current Inputs)	Positive Assurance – (Current Outputs)
Strategic Objective - Grow a community of leaders and managers across Humber with the capability, confidence, and values to create a highly engaged, high performing and continually improving culture.	Strategic Objective - Grow a community of leaders and managers across Humber with the capability, confidence, and values to create a highly engaged, high performing and continually improving culture.
A) Implementation and oversight of an organisation-wide workforce plan that aligns leadership capacity, capability and succession planning with strategic priorities and agreed values and behaviours. (B) Internally delivered PROUD Leadership Programme; Alumni programme, Being Humber culture and values programme, Humber Talent Programme and revised induction processes. Management Fundamentals identified as a core organisational requirement	(A) Medium term WFP submitted and is compliant. Internal Pan due for completion in May, POD Committee August 2026 (B) The Trust delivers a consistent, values-led leadership and culture approach through the PROUD Leadership. New cohort of the Humber Talent Programme underway. National Staff Standards being mapped across Being Humber and similarly with NHS Leadership and Management Framework principles. Trust Leadership and Management Hub launched, POD Committee August 2026
Strategic Objective - Ensure all colleagues are highly motivated to achieve outstanding results by creating a great employer experience, so that they feel valued and rewarded for doing an outstanding job; individually and collectively.	Strategic Objective - Ensure all colleagues are highly motivated to achieve outstanding results by creating a great employer experience, so that they feel valued and rewarded for doing an outstanding job; individually and collectively.
(A) Trust delivered Listening Exercises to understand more explicitly workforce perception or reward, recognition and the employee value propositions	(A) Exec Sponsors and ODG leads identified to deliver on key programmes of work directly related to workplace value. Underway with specific outputs to be reports in late 2026.
Strategic Objective - Attract, recruit, and retain the best people by being an anchor employer within the locality; with roles filled by staff that feel happy and proud to work for Humber.	Strategic Objective - Attract, recruit, and retain the best people by being an anchor employer within the locality; with roles filled by staff that feel happy and proud to work for Humber.
(A) Ongoing monitoring of hard to recruit roles in the recruitment and retention steering group. (B) Strengthen local and system pipelines through targeted recruitment campaigns, apprenticeships, university partnerships and system collaborations. (C) Actively review and invest in retention through leadership development, career pathways, wellbeing interventions, flexible working and proactive Stay Conversations.	(A, B, C) 6.52% Trust vacancy rate, Registered Nurse vacancy rate 7.07%, consultant vacancy rate 20.69% (June 2026) (open risk WF38), POD Committee August 2026 (A, B, C) Staff recommending the Trust as a place to work has improved year on year since 2019 reported at 70% in 2025 – above the benchmark and national averages. The Trust continues to demonstrate strong advocacy, ranking 7th out of 49 Mental Health, Learning Disability and Community providers, with sustained year-on-year improvement at a time when several higher-ranked organisations have declined, POD Committee August 2026 (B) 145 apprenticeships, 87 T-levels, 25 Work experience placements since April 2025, POD Committee August 2026
Strategic Objective - Prioritise the health and wellbeing of our staff by understanding that staff bring their whole self to work, so we place mental and physical wellbeing at the heart of the individual's experience of working at Humber.	Strategic Objective - Prioritise the health and wellbeing of our staff by understanding that staff bring their whole self to work, so we place mental and physical wellbeing at the heart of the individual's experience of working at Humber.
(A) Health & Wellbeing Offer: A comprehensive programme of wellbeing support is in place. Delivery and impact are overseen by the Health & Wellbeing Steering Group, with regular assurance reporting to EMT and the People & OD Committee. (B) Sickness Absence: A structured, data-led approach is embedded through Towards a Healthier Workforce Model, targeting services with sickness absence of ≥8% to support early intervention and workforce resilience. (C) MSK issues showing decline in the NSS 2025.	(A) Proactive Health & Wellbeing Support: 147 Physical MOTs delivered since January 2026, POD Committee August 2026 (B) 27 teams in scope of Rapid response Sickness Intervention Model. New sickness policy due for launch in August 2026. Psychologist successfully appointed into Occ Health team. [C] Physio support offer promoted, MSK deep dive to EMT outlining assurances, Trust exploring being part of a pilot programme with the University of Hull Physio department. MSK Nurse being recruited.
Strategic Objective - Enable new ways of working and delivering health care, anticipating future demands and planning accordingly.	Strategic Objective - Enable new ways of working and delivering health care, anticipating future demands and planning accordingly.
(A) Workforce and Medical Workforce Plans embedded within medium-term service and financial planning, focused on sustainable supply, vacancy trajectories and *grow-your-own* pipelines. (B) Plans under development to optimise use of ESR in readiness for the new workforce solution (C) Job Evaluation and Job Matching Preparedness - In preparation for national job matching activity underway to meet national requirements	(A) Local workforce plans embedded in the Medium-Term Plan. Improving consultant vacancy trajectory (reduced from ~30% to ~21%). Starters exceed leavers, with planned intake peaks aligned to NQN pipelines. Grow-your-own supply routes established (B) Commencement of Manager Self Service implementation in July 2026. (C) The Trust has successfully completed the national Job Evaluation Readiness Assessment and submitted recent audit. (D) Chat bot being trialled and Digital ID proposed to be launched in spring 2026.

Strategic Objective - Maximise a diverse and inclusive workforce representative of the communities we serve.	Strategic Objective - Maximise a diverse and inclusive workforce representative of the communities we serve.
(A) No Excuse for Abuse and Respect Framework relaunched, with targeted approach to identify challenged areas (B) WRES, WDES, Gender Pay Gap delivered annually with work plans to support improvement initiatives.	(A, B) Workforce representation - ethnic diversity has increased to 11% (March 2026) exceeding regional demographic of 5.1%, LGBTQ+ has increased to 4.77% (March 2026) exceeding the local demographic of 3.8%. Disability representation has increased to 10.68% (March 2026) this remains below the regional demographic of 16–20% regionally but the organisation continues to make significant improvements, POD Committee August 2026 (A, B) Disability representation at senior levels (8A and above) remains slightly below workforce representation, but it has improved from 8.4% to 9.6% is encouraging (+1.2%). Ethnically diverse representation in senior roles remains strong despite a slight decline from 17.9% to 16.8%. LGBTQ+ representation in senior roles provides the strongest improvement year-on-year, increasing from 11.2% to 15.2% in March 2026, POD Committee August 2026
Strategic Objective - Develop a culture of learning, high engagement, continuous improvement, and high performance that builds on our values and enables us to realise the potential of our people.	Strategic Objective - Develop a culture of learning, high engagement, continuous improvement, and high performance that builds on our values and enables us to realise the potential of our people.
(A) OD programme and leadership - expansion of Trust mentoring and coaching offer, delivering a minimum of 3 themed PROUD Alumni sessions per year to support ongoing leadership development (B) Career development conversations are being embedded across the organisation through the Trust's appraisal process	(A) There are currently 101 colleagues engaged in current and upcoming cohorts of the PROUD Leadership Programme. The redesigned programme will deliver up to 80 development places annually while increasing organisational capacity through the release of 20 training days to support wider leadership and management development. (B) Trust appraisal compliance was 95.1% at the close of the 2026 appraisal window, which were inclusive of career development conversations. Appraisal quality audits will commence in July 2026 to assess the effectiveness and consistency of appraisal discussions across the Trust

Negative Assurance / Gaps in Assurance – Required Outputs	**Mitigating Actions to Address Gaps**	Target Date	Action Lead	Update on Actions
Strategic Objective - Maximise a diverse and inclusive workforce representative of the communities we serve. • Racial abuse from patients towards ethnically diverse staff increased to 40% in the 2025 Staff Survey, prompting targeted improvement work to reduce this. • Reports of harassment, bullying or abuse from colleagues among ethnically diverse staff increased slightly, but the overall trend remains improved compared with 2021.	SO7. 1 - EDI	Next Check point September 2026	Karen Phillips	Actions refreshed as part of the NSS, WRES, WDES and Gender pay gap action planning process and ratified at Board. EDI assurance/insight report presented to EMT providing assurance against actions. EDI insight report presented to each P&OD Committee.
Strategic Objective - Attract, recruit, and retain the best people by being an anchor employer within the locality; with roles filled by staff that feel happy and proud to work for Humber. 1. Consultant vacancy rate for June 2026 – 20.69% 2. Hull CMHT challenges regarding recruitment and retention Linked Risk(s): WF38 – As a result of the current level of consultant vacancies, agency solutions are being used to ensure that services are kept safe which has financial impact for the Trust, and may also affect our ability to maintain an effective and engaged workforce	SO3. 1 - Medical Vacancies 2 - Hull CMHT	Next Check point: Sept 2026 Next Check point: Sept 2026	Kwame Fofie Claire Jenkinson	Based on information for March 2026 - 8 vacancies, 1 vacancy has been appointed to and will commence in post in April 2026. 7 covered by agency, reduced to 6 agency doctors by April 2026. Recruitment and retention Steering Group oversight. Incentives proposed for all teams with challenged 10% + vacancy rates.
Strategic Objective - Prioritise the health and wellbeing of our staff by understanding that staff bring their whole self to work, so we place mental and physical wellbeing at the heart of the individual's experience of working at Humber. The Workforce Scorecard (March 2026) reported a rolling sickness rate figure of 5.55% (Trust target 5%), and above national and regional benchmarks. With long term sickness increasing to 90 live cases. The highest reason for sickness absence within the organisation remains stress, anxiety and mental ill health The National Staff Survey identifies this as an area of focus. The NSS 'We are Safe and Healthy' theme score declined in 2025 compared to 2024 results, however, remains better than national and benchmark averages. With the biggest decline for the question relating to MSK issues Linked Risk(s): WF57 - Persistent and elevated sickness absence rates across Trust staff groups -currently averaging 5.6% (Dec 25) pose a significant risk to workforce capacity, operational delivery, and the ability of the organisations to meet performance expectations under the 2025/26 NHS Oversight Framework as well as reduced staffing levels compromising patient safety, increase waiting times, and hinder service recovery.	SO4. 1 - Sickness absence	Next Check point September 2026	Karen Phillips	Deep dives into sickness reported into EMT and P&OD Committee twice yearly, which identified trends and actions. Divisional accountability reviews monitoring and exploring absence routinely. Reports continue to feed into EMT and People & OD Committee. The Trust reports improved position sustained over three consecutive months and reduced LTS cases. Significant divisional improvement noted across Mental health, Children's & LD and Forensic services. Focus on burnout, psychological and MSK support as part of the Trust NSS plan.
Strategic Objective - Enable new ways of working and delivering health care, anticipating future demands and planning accordingly. There is a requirement to ensure ESR Manager Self-Service and readiness for the new workforce solution will be delivered to plan and within required timescales Work to continue regarding the internal Band 5 job evaluation review.	SO5 – 1 - ESR Optimisation SO5 – 2 - National Role Profiling – Band 5-6	Next Check point September 2026	Karen Phillps	Plans developed to fully optimise ESR in readiness for the new workforce solution. 2026 will see the roll out of the three final functionality elements implemented – appraisals in ESR, Manager Self Service and full establishment control. Plan in place to review and consolidate all band 5 job descriptions with activity managed through an internal working group.

Optimising an efficient and sustainable organisation

Lead Director: Executive Dir. Finance

Lead Committee: Finance Committee

Failure to optimise efficiencies in finances, technology and estates will inhibit the longer-term efficiency and sustainability of the Trust which will reduce any opportunities to invest in services where appropriate and put at risk the ability to meet financial targets set by our regulators.

Risk Score: 8 HIGH

Initial Risk Rating (Before Mitigation)			Current Risk Rating (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)
I	L	Rating I X L	I	L	Rating I X L		
4	3	12 - High	4	2	8 - High	15	IN APPETITE

Risk Analysis	Quarter 2 (2025/26)	Quarter 3 (2025/26)	Quarter 4 (2025/26)	Quarter 1 (2026/27)
Current Risk Rating	8 HIGH	8 HIGH	8 HIGH	8 HIGH
Risk Appetite Threshold	15	15	15	15

Controls – (Current Inputs)	**Positive Assurance – (Current Outputs)**
Strategic Objective - Embrace new, safe and secure technologies to enhance patient care, improve productivity and support our workforce across the health and social care system.	Strategic Objective - Embrace new, safe and secure technologies to enhance patient care, improve productivity and support our workforce across the health and social care system.
(A) Trust has moved the tenant for Power BI and now has 20 users up and running. (B) The mobile phone contract has been awarded in 2024.	(A) Trust Data Quality Maturity Index (DQMI) score at 99% above national average (95%). (A) Patient communication, electronic referral service, electronic prescription service, voice requisition and hand-held device app to be fully implemented in 25/26. (A) Implementation of the new data lake/lake house business intelligence system which include artificial intelligence capabilities. Digital benchmarking / BeDigital, Finance Committee July 2026 (A) Create a centre of excellences within the Interweave team to lead on user centred design the Yorkshire & Humber Care Record (B) Mobile phone contract provides 50% reduction in spend and access to different mobile phone networks providing the best connectivity for our mobile workforce.
Strategic Objective - We will design technologies around the person's needs and will make sure that people are not excluded from accessing services due to digital poverty or poor rural connectivity.	Strategic Objective - We will design technologies around the person's needs and will make sure that people are not exclud from accessing services due to digital poverty or poor rural connectivity.
(A) Trust has reviewed its Digital Governance Structures in 2025 to ensure appropriate oversight and assurance at Executive and Board Level	(A) The Trust has successfully implemented a new Electronic Patient Record. Finance Committee July 2026
Strategic Objective - Work with our partners to optimise the efficiency and sustainability of the Humber and North Yorkshire Health and Care Partnership in our role as lead provider.	Strategic Objective - Work with our partners to optimise the efficiency and sustainability of the Humber and North Yorkshi Health and Care Partnership in our role as lead provider.
(A) The Trust is building on its role as Specialist Lead Provider and is currently exploring opportunities for core mental health services to follow a similar collaborative approach with the Trust identified as the preferred Host.	(A) Overall, the Trust has a high level of sustainability with a good cash position. Cash balance £18.951m at Month 3. Finance Report Month 3, July 2026 (A) Trust has delivered a balanced position as part of the ICS Plan and has a breakeven 2025/26 plan. Trust breakeven position and balanced year-end forecast. Finance Report July 2026
Strategic Objective - Continue to develop our estate to provide safe, environmentally sustainable, and clinically effective environments that support operational delivery.	Strategic Objective - Continue to develop our estate to provide safe, environmentally sustainable, and clinically effective environments that support operational delivery.
(A) The Trust continues to prioritise its capital investment priorities based on available information to maximise impact across the Trust's Estate	(A) Approved £61.817m four-year capital plan. Capital Programme; Estates Update, Finance Report July 2026.
Strategic Objective - Work with our partners and communities to minimise our effect on the environment to meet the NHS climate change target.	Strategic Objective - Work with our partners and communities to minimise our effect on the environment to meet the NHS climate change target.
(A) Trust Green Plan developed.	(A) Provision of virtual private network technology allow staff to work from any location (including home) enabling a reduction of the estate required for corporate staff and reducing our CO2 emissions from staff travel. (A) The Trust is currently exceeding the carbon reduction targets outlined in the Green Plan, achieving an approximate 33% reduction in T/CO_2e from the baseline year
Strategic Objective - Empower all staff to contribute to the efficiency and sustainability of the organisation by making informed decisions about the efficient use of resources.	Strategic Objective - Empower all staff to contribute to the efficiency and sustainability of the organisation by making informed decisions about the efficient use of resources.
(A) Planning Guidance requires the system to deliver a balanced net financial position for 2025/26. (B) Humber Financial Times is issued to all staff (C) The Trust has a breakeven financial plan that meets the ICS planning target set for it.	(A, B, C) Forecast delivery of 2026/27 target and 44% reduction achieved in 2025/26. Agency & Bank Update – Finance Committee July 2026

Negative Assurance / Gaps in Assurance – Required Outputs	Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on Actions
Strategic Objective - Work with our partners to optimise the efficiency and sustainability of the Humber and North Yorkshire Health and Care Partnership in our role as lead provider. (1) Wider ICS Financial Position is showing a deficit plan of £101m at Month 3 2026/27. The Trust has a Breakeven Plan. Linked Risk(s): FII247 – As a result of difficulties within the ICS to meet challenging financial targets for 2026/27, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery.	SO3. 1 Medium Term Financial Planning has been initiated across the ICB	Next Check point: September 2026	Pete Beckwith	National Guidance has been circulated, and initial plans have been shared with the ICB
	SO3. 1 Deliver a balanced net system financial position for 2026/27.	Next Check point: September 2026	Pete Beckwith	Trust has submitted an approved balanced plan to NHSE. At Month 4 the Trust is on target to deliver a Balanced Position at Year end Year End.
Strategic Objective 6 - Empower all staff to contribute to the efficiency and sustainability of the organisation by making informed decisions about the efficient use of resources. (1) Details of staff understanding of Trust finance measures and controls Linked Risk(s): FII223 – Risk to longer-term financial sustainability if block contract values are insufficient to cover the Trust Cost base.	SO6. 1 Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2026/27.	Next Check point September 2026	Pete Beckwith	Current plan delivers the expected reduction, Agency is monitored at Finance Committee, EMT, ODG and forms part of the Accountability Review process Agency reduction of £2.390m or 44% in 2025/26. A further 30% reduction is required for 2026/27

RISK SCORING MATRIX

			IMPACT				
			Negligible	Minor	Moderate	Severe	Catastrophic
			1	2	3	4	5
LIKELIHOOD	Almost Certain	5	5 x 1 = 5 Moderate	5 x 2 = 10 High	5 x 3 = 15 Significant	5 x 4 = 20 Significant	5 x 5 = 25 Significant
	Likely	4	4 x 1 = 4 Moderate	4 x 2 = 8 High	4 x 3 = 12 High	4 x 4 = 16 Significant	4 x 5 = 20 Significant
	Possible	3	3 x 1 = 3 Low	3 x 2 = 6 Moderate	3 x 3 = 9 High	3 x 4 = 12 High	3 x 5 = 15 Significant
	Unlikely	2	2 x 1 = 2 Low	2 x 2 = 4 Moderate	2 x 3 = 6 Moderate	2 x 4 = 8 High	2 x 5 = 10 High
	Rare	1	1 x 1 = 1 Low	1 x 2 = 2 Low	1 x 3 = 3 Low	1 x 4 = 4 Moderate	1 x 5 = 5 Moderate

RISK TERMINOLOGY DEFINITIONS

Initial Risk Rating	The initial risk rating represents the inherent or gross risk. It is the assessment of the risk prior to the consideration of any controls or mitigations in place.
Current Risk Rating	The current risk rating presents the residual risk level. It is the assessment of the risk after identification of controls, assurances and inherent gaps, reflecting how the risk is reduced in either likelihood of occurrence or impact should it occur.
Target Risk Rating	The assessment of the anticipated score following successful implementation of identified actions to create further controls. Target risk ratings must also be considered with regards to risk appetite and the level of risk the organisation is willing to accept.
Assurance	Sources of evidence used to demonstrate the effectiveness of identified controls. Assurances sources also allow for monitoring of risk controls to ensure that they are appropriate.

Humber Teaching NHS Foundation Trust

Agenda item 09

Title & Date of Meeting:	Trust Board – 30 September 2026
Title of Report:	6-month Safer Staffing Report – Interim reviews May 2026
Author/s:	Sadie Milner, Head of Nursing and Patient Safety Specialist Kate Baxendale, Deputy Director of Nursing, Quality and Professions Sarah Smyth, Executive Director of Nursing, Quality & Professions
Recommendation:	

To approve		To discuss	
To note		To ratify	√
For assurance			

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	To present the six-month Safer Staffing Interim Review for the period 1st October 2025 to 31 March 2026 across the Trust's inpatient services. To provide assurance regarding the effectiveness, safety and sustainability of current staffing establishments through triangulation of acuity and dependency data, workforce metrics, quality indicators, financial information and professional judgement. To highlight areas of good practice, emerging risks, workforce pressures and proposed actions arising from the reviews. To seek approval of the report and support for the actions and recommendations identified. The report has been shared at Quality and Patient Safety Group, Organisational Delivery Group, the Executive Management Team and the People and Organisational Development Committee. Final approval has been provided the Quality Committee. All groups and Committees were assured with the findings and recommendations.

Key issues:

Positive Assurances to Provide:

- Good overall assurance that staffing arrangements remain safe and effective across all inpatient services reviewed.
- Staffing establishments continue to support delivery of safe care, with Care Hours per Patient Day (CHPPD) generally meeting or exceeding recommended levels.
- Strong performance across statutory and mandatory training, clinical supervision and workforce governance arrangements.
- Successful recruitment activity has reduced vacancy levels and improved workforce stability across a number of wards.
- Most patient safety incidents were categorised as no or low harm, with robust investigation, oversight and

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Development of business cases for staffing model reviews within older people's services, including Maister Lodge/Court and Mill View Lodge.
- Review of night staffing arrangements at Mill View Lodge, including proposals to move to two registered nurses overnight.
- Continued recovery plans for clinical supervision compliance where below target, including use of Professional Nurse Advocates.
- Review and reduction of bank and agency utilisation through recruitment, workforce planning
- Further work to improve e-rostering accuracy, workforce reporting and staffing triangulation.
- Deep dives into specific quality indicators including AWOL/absconsion incidents, violence

learning processes in place for moderate harm incidents. • Improvements seen in several quality indicators, including reductions in self-harm, violence and aggression incidents in a number of services, reduced sickness in some areas and reduced reliance on temporary staffing. • Positive feedback from NHS England regarding safer staffing oversight and governance arrangements.	and aggression, enhanced observations and delayed transfers of care. • Development of divisional safer staffing dashboards and enhanced reporting mechanisms, including Red Flag Shift reporting.
Key Risks/Areas of Focus: • Ongoing workforce pressures associated with sickness absence, maternity leave and temporary staffing dependency in some services. • Financial pressures and staffing overspends in a number of wards where additional staffing is required to safely manage high-acuity patient groups. • Delayed discharges and external system pressures impacting patient flow and ward capacity. • Environmental constraints within some service areas requiring additional staffing mitigations. • High-acuity patient cohorts, including areas experiencing increased violence and aggression, enhanced observation requirements and complex physical health needs. • Continued focus required on clinical supervision recovery, ILS/BLS compliance and ensuring workforce establishments remain aligned to patient acuity and dependency • headroom does not include maternity/paternity	**Decisions Made:** • To approve the six-month Safer Staffing Interim Review and note the overall assurance regarding safe staffing across inpatient services. • To support progression of identified business cases and staffing model reviews where required. • To endorse the permanent implementation of the Westlands twilight shift model, subject to completion and approval of the Quality Impact Assessment. • To support continued monitoring of high-risk areas through existing governance arrangements and safer staffing review processes. • To note that no changes to current staffing establishments were required for the majority of wards reviewed, with targeted actions identified for a small number of services.
Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	The report highlights ongoing work to improve patient flow, reduce delayed discharges, support admissions avoidance, and strengthen discharge planning across inpatient and community services. Safer staffing reviews ensure services have the workforce capacity to support timely transition of patients to the most appropriate care setting and maintain effective partnership working across health and social care systems.
Analogue to Digital	The report demonstrates continued development of digital workforce systems through enhanced e-rostering, safer staffing dashboards, workforce reporting, Red Flag Shift reporting, and improved data triangulation. These initiatives support more accurate staffing oversight, informed decision-making, and data-driven workforce planning.
Sickness to Prevention	The report supports prevention through maintaining safe staffing levels, reducing workforce sickness absence, improving clinical supervision and

	training compliance, strengthening staff wellbeing initiatives, and ensuring sufficient staffing to deliver proactive, therapeutic, and recovery-focused care. The review also monitors quality and safety indicators to identify and mitigate risks before harm occurs.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee	20 August	People & Organisational Development Committee	12 August
Finance Committee		Executive Management Team	11th August
Mental Health Legislation Committee		Operational Delivery Group	27th July
Collaborative Committee		Other (please detail)	Safer staffing meeting July 8th QPaS 16 July

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	√
Enhancing prevention, wellbeing and recovery	√
Fostering integration, partnership and alliances	√
Developing an effective and empowered workforce	√
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	√

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	√

Public Exemption:

Is the report exempt from public disclosure	No

Executive Summary

This report presents the six-month Safer Staffing Interim Review for the period 1 October 2025 to 31 March 2026, providing assurance on the safety, effectiveness and sustainability of staffing establishments across the Trust's 18 inpatient wards. The review draws on acuity and dependency data, workforce metrics, quality and safety indicators, financial information, and professional judgement.

Overall, the review provides good assurance across all inpatient services, with staffing establishments continuing to support safe and effective care delivery. Care Hours Per Patient Day (CHPPD) generally met or exceeded required levels, workforce governance arrangements remained robust, recruitment activity improved workforce stability, and the majority of reported incidents resulted in no or low harm.

Whilst some services continue to experience pressures relating to sickness absence, maternity leave, temporary staffing requirements, delayed discharges and increasing patient complexity, appropriate mitigations are in place. Targeted actions have been identified in a small number of areas, including staffing model reviews, improvements to clinical supervision, enhanced workforce reporting, and strengthened safer staffing oversight arrangements.

The review concludes that there is sufficient assurance that inpatient services are safely staffed, with all wards achieving a rating of good assurance. Continued focus will be placed on workforce sustainability, reducing reliance on temporary staffing, improving patient flow, and further strengthening safer staffing governance across the Trust.

Six Month Review of Safer Staffing (Interim reviews)

Introduction
This report presents the Interim Safer Staffing Reviews, providing a mid-year position following the full Safer Staffing Establishment Review completed in November 2025. It is designed to offer proportionate assurance on whether staffing levels continue to support safe, effective, and high-quality care across our 18 inpatient wards.

This review covers reporting period **1st October 2025 to 31st March 2026.**

This approach aligns with emerging workforce safeguards, and reflects national expectations set out within NQB guidance, emphasising ongoing oversight, triangulation of data, and the importance of professional judgement in assessing safe staffing.

Purpose of the Interim Review
The purpose of this interim review is to provide assurance that staffing levels remain safe and appropriate by:

- Analysing acuity and dependency data, incorporating:
  - 28-day MHOST data collection for Mental Health, CAMHS and Forensic inpatient wards.
  - 30-day SNCT data collection for Community wards at Malton and Whitby
- Review of the quality and patient safety metrics
- Incorporating professional judgement, including clinical and operational insight, to contextualise quantitative data and identify any emerging risks.
- Financial position at the end of 2025/26
- Monitoring progress against actions agreed following the full establishment review in November 2025.

This review recognises ongoing limitations in the application of safer staffing tools, including:

- Inconsistent availability of validated tools across all clinical areas with no evidence based tool available for learning disabilities services.
- Constraints in smaller services where limited bed bases or patient numbers reduce the reliability of tool in determined or making recommendations on staffing establishment or Care Hours Per Patient Day (CHPPD) .

Given these limitations, greater emphasis is placed on triangulation of multiple data sources and expert professional judgement to support conclusions.

Summary of Safer Staffing Interim Review by Division and Ward

The following section outlines the safer staffing interim reviews by ward and is presented by division. The quality indicators are based on six-month averages between 1st October 2025 and 31st March 2026.

Data in this report has been collated from the Level 3 performance reports, Safer Staffing Productivity Report (Oct 25-Mar 26), the Trust's Incident Management Reporting System (Datix), budgeted establishments submitted by the finance team alongside the information gathered during the safer staffing reviews with the ward managers, clinical leads, matrons and service managers.

The safer staffing reviews were conducted by the Deputy Director of Nursing, Quality and Professions and Head of Nursing and Patient Safety Specialist and were attended by the ward managers, matrons, services managers, with representation from the finance and e-roster teams. Reviews took place on 7th and 8th May 2026.

Mental Health Division – Safer Staffing Interim Reviews 7th May 2026

Avondale	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	94%	99%	97%	100%	7.9	12.0	69%	25%	15%	5.4%
April 25 – Sept 25	95%	99%	99%	101%	7.4	11.6	74%	21%	5%	2.8%
Oct 24 – Mar 25	92%	94%	106%	105%	7.3	12.1	73%	20%	8%	5.5%
April 24 - Sept 24	90%	95%	99%	100%	9.2	11.1	75%	24%	27%	10.1%
Oct 23 - Mar 24	95%	95%	104%	98%	9.1	11.6	73%	27%	25%	6.5%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	85%	93%	38	87	161
April 25 – Sept 25	89%	91%	41	37	214
Oct 24 - Mar 25	88%	93%	39	44	96
Apr 24 - Sept 24	89%	92%	29	37	138
Oct 23 - Mar 24	89%	91%	35	29	136

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (admissions) tool. At the point of data collection there was an average of 7.9 patients on the ward (14 bedded unit). Recommended WTE = 14.5 and a Recommended CHPPD of 7.8. The validity of the tool is compromised due low bed occupancy during the data collection period. Where the tool is not recommending sufficient staff to safely staff the ward, professional judgement should be used.

The target CHPPD is currently set at 9.0. The ward averaged a CHPPD of 12.0 supported by an average OBD of 69%.

Nursing and HCA budgeted establishment is equal to 28.74 WTE (not including the Band 7). Within the wards budgeted establishment there are 2x Band 7s (clinical lead and ward manager), 6x Band 6 nurses, 6x Band 5 nurses, 16.74x Band 3 Health Care Assistants (HCAs). The wider multi-disciplinary team (MDT) includes 2x Activity Co-ordinators, a Band 6 Social Worker, and a Psychology Assistant. There were two Band 5 registered nurse vacancies however these posts have now been recruited in to. In addition, there were 3x HCA vacancies.

Bank and agency use has increased due to 2x RMNs on maternity leave, Band 6 secondments and vacancies during this period.

No changes to shift patterns or minimum safer staffing numbers since the last review with the nursing team predominantly working long shifts of 5 on long days (2 RMNs) and 5 on nights (2 RMNs).

Quality and Safety Indicators: Average sickness has increased from 2.8% in the previous reporting period to 5.4%% Oct- March with a rise in sickness absence to 9.0% by the end of this reporting period which has yet to recover.

Fill rates, Care Hours Per Patient Day (CHPPD), clinical supervision and statutory mandatory training all remain consistently strong for the six month averages. However, clinical supervision had fallen below the trust threshold towards the end of the period, the team are taking proactive steps to recover this position including seeking additional support from supervisors external to the team and the professional nurse advocates (PNAs).

Basic Life Support (BLS) training fell below the Trust 85% threshold in part due to long term sickness and two new starters but all are scheduled to attend training, which will recover this position. Immediate Life Support (ILS) was consistently over 90% Jan-March.

From a patient safety perspective, 38 medication-related incidents were reported during the period. 37 were classified as no or low harm, with one moderate harm incident appropriately reviewed through an Initial Incident Review (IIR) to identify learning and support quality improvement.

There were 87 reported incidents of violence and aggression, all classified as no or low harm, with the majority involving aggression directed towards staff. Twenty-eight incidents involving aggression between patients, or witnessed by other patients, were reviewed through safeguarding processes to ensure appropriate oversight and risk management.

A total of 161 self-harm incidents were reported during the six-month period, all resulting in no or low harm. This represents a significant reduction compared to the previous reporting period, when 214 self-harm incidents were recorded, providing assurance that measures to support patient safety, therapeutic engagement, and risk management are having a positive impact.

Professional Judgement: Avondale is a 14 bedded assessment unit; the ward has a high turnover of patients with average length of stay 4-5 days. Patient flow has remained consistent and bed occupancy averaged 69% over the 6 month period.

There are currently no significant staffing concerns, although a notable increase in sickness with continued engagement with staff to support those returning to work. Additional staffing challenges include secondments to other wards and maternity leave cover.

The team noted that assessment of patients out of hours can be challenging as this can lead to admissions, whereas assessing patients during working hours supports patients to be safely discharged with alternative care and support arrangements in place. Work is on-going in relation to admissions avoidance.

There have been no changes to the structural environment since the last review, however the unit has had a new alarm system installed.

Financial position: The ward demonstrated strong financial performance at the end of the financial year with a £31K underspend. At the end of the last quarter this equated to 0.55 WTE under spend on staffing.

Update on previous recommendations/actions: No actions or recommendations were made at the Safer Staffing Establishment Review in November 2025

Summary: Avondale continues to manage staffing safely, with strong fill rates and effective mitigation of any shortfalls. CHPPD is consistently above target. Successful recruited to recent vacancies will bring the team to full establishment in the coming months and should support a reduction in temporary staffing requirements. Overall, there is a good level of assurance that current staffing arrangements are safe and sustainable, with no changes required following this interim review. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified as a result of current ETOC demand.

Actions arising from Interim review
Review of out of hours and weekend admissions in the context of admissions avoidance
Focus on clinical supervision recovery including exploring the use of external supervisors and/or PNAs

Maister Court	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	92%	104%	81%	102%	6.2	15.2	94%	31%	-19%	10.8%
April 25 – Sept 25	104%	111%	83%	103%	6.0	17.0	90%	22%	-7%	7.1%
Oct 24 - Mar 25	88%	100%	83%	99%	5.8	15.3	95%	34%	23%	8.5%
April 24 - Sept 24	87%	98%	96%	107%	5.0	16.9	94%	32%	11%	9.1%
Oct 23 - Mar 24	88%	100%	94%	110%	5.5	16.6	96%	35%	11%	5.6%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Falls	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	91%	91%	5	7	20	2
April 25 – Sept 25	Nil returns	94%	16	6	47	1
Oct 24 - Mar 25	94%	83%	12	1	6	5
Apr 24 - Sept 24	93%	93%	18	12	9	0
Oct 23 - Mar 24	85%	95%	16	20	14	1

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (older people) tool. At the point of data collection there was an average of 5 patients on the ward (5 bedded unit). Recommended CHPPD of 6.2 which demonstrate consistency over time. However, the validity of the tool is compromised due to this being a 5 bedded unit therefore recommendations around WTE are not used based on this tool.

The target CHPPD is currently set at 10.3. The ward averaged a CHPPD of 15.2 over the six month period which is above target.

Nursing and HCA budgeted establishment is equal to 18.05 WTE (not including the Band 7)

Within the wards budgeted establishment there are 1x Band 7s, 1x Band 6 nurses, 5.4x Band 5 nurses, 11.65x Band 3 Health Care Assistants (HCAs). The wider multi-disciplinary team (MDT), and 1x Psychology Assistant, 1x OT Band . The recent addition of a full-time pharmacy technician has positively enhanced medicines management and safety on the ward.

There are currently no registered nurse vacancies, with 2 WTE HCA vacancies actively being recruited to. The team includes one newly qualified nurse in preceptorship, with further strengthening anticipated through the planned transition of a Band 7 Clinical Lead.

No changes to operational or staffing structure/shift patterns since the last review.

Quality and Safety Indicators: Sickness levels have increased from an average of 7.1% to 10.8% across October - March, peaking at 16.3% in March, driven in part by two WTE registered nurses on long-term sickness and additional maternity leave across both registered and HCA staff groups, which has a proportionately greater impact within a smaller team.

Staffing pressures related to sickness and maternity leave have led to increased reliance on bank and agency cover, although fill rates remain consistent and safer staffing levels are maintained. Band 6 planned return from maternity leave is being supported through a structured transition, including interim Band 6 secondment.

Clinical supervision and statutory and mandatory training compliance remain strong, providing assurance of workforce capability and oversight.

From a patient safety perspective, there were no cancellations of Section 17 leave during the reporting period, demonstrating the ward's ability to safely support planned patient leave and therapeutic activity. Medication safety remains positive, with only five medication-related incidents reported over the six-month period, all classified as no harm.

7 incidents were reported under the slips, trips and falls category however, three related to a patient intentionally placing themselves on the floor rather than accidental falls. All falls-related incidents resulted in no harm. There were 20 incidents of violence and aggression, all classified as no or low harm. 11 incidents involved physical aggression between patients and were appropriately reviewed through safeguarding processes. 2 self-harm incidents were reported during the period, both resulting in low harm.

Professional Judgement: Maister Court is a 5 bedded unit for older people with functional mental illness. Despite this being a small unit with a maximum of 5 patients, the level of care intervention is often high with patients with complex physical and mental health needs. Maister Court is not a standalone unit.

Whilst there are currently no significant staffing concerns within Maister Court sickness and maternity is having an impact on a small team.

The team is a mix of experienced and newer staff, though the single-RMN staffing model presents challenges in supporting students and preceptorship while maintaining safe cover. Bank use is effective in maintaining safe staffing level.

Missed staff breaks have been identified as a challenge, particularly where support is shared with Maister Lodge, where high acuity can limit capacity across both areas; this continues to be actively monitored as part of ongoing workforce and wellbeing oversight.

Patient flow is generally manageable, with some ongoing delays in transfer of care related to social care processes, though this has improved with the MADE framework. The patient cohort, predominantly older adults with functional mental illness and some frailty, requires frequent 1:1 support and escorted Section 17 leave, increasing workforce demand. Risk management is supported through appropriate use of Supportive Therapeutic Observations of Care (ETOC) and flexible approaches to care.

The ward environment is constrained by limited communal space, which can challenge the management of behaviours such as aggression, though staff respond creatively. There is no dedicated seclusion room, but alternative spaces can be utilised. Overall ward operations remain stable.

Financial position: The end of year position for 25/26 was a 110k overspend with an average of 4.3 WTE over budget in the last quarter of the financial year, impacted by maternity leave and long term sickness.

Summary: There is a good level of assurance that current staffing arrangements are safe, however some challenges have been noted with sickness, maternity leave, and staff being supported to take required breaks. The division are reviewing the staffing model across Maister Court and Lodge as part of a wider business case as

recommended in the annual Safer staffing establishment review in November 2025. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review and has informed the recommendations within this report to ensure sufficient capacity to safely meet patient need and observation requirements.

Update on previous recommendations/actions and actions arising from interim review: See under Maister Lodge.

Maister Lodge	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	106%	101%	90%	116%	8.0	15.8	72%	32%	9%	11.5%
April 25 – Sept 25	103%	102%	90%	116%	13.8	18.8	61%	23%	15%	7.3%
Oct 24 - Mar 25	109%	103%	98%	119%	12.2	17.5	66%	24%	8%	8.5%
April 24 - Sept 24	92%	100%	110%	121%	14.6	16.2	75%	21%	5%	5.4%
Oct 23 - Mar 24	104%	100%	100%	113%	7.5	21.3	56%	17%	-9%	7.1%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Falls	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	76%	90%	27	27	52	0
April 25 – Sept 25	97%	93%	17	30	52	0
Oct 24 - Mar 25	99%	91%	9	57	97	0
Apr 24 - Sept 24	97%	93%	10	46	79	2
Oct 23 - Mar 24	98%	92%	17	36	44	1

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (older people) tool. At the point of data collection there was an average of 12.3 patients on the ward (14 bedded unit). Recommended WTE = 22.7 and a Recommended CHPPD of 8.0.

This is lower than previous reporting periods as there were 5 patients in dependency level 5 at the last review. However, it should be noted that the MHOST tool has limitation as it assigns dependency levels based on individual care needs and does not take into account high levels of frequent but intermittent 1:1 care or 2:1 care or the need for zonal observations to reduce falls risk and/or manage safeguarding risks. Care Hours Per Patient Day are consistently above target but additional staff are consistently required to help achieve this and meet the needs of the patients.

The target CHPPD is currently set at 10.3. The ward averaged a CHPPD of 15.8 over the six month period.

Nursing and HCA budgeted establishment is equal to 33.7 WTE (not including the Band 7)

Within the wards budgeted establishment there are 1x Band 7s, 4x Band 6 nurses, 4.6x Band 5 nurses, 4x Band 4 Nurse Associates, 21.1x Band 3 Health Care Assistants (HCAs). The wider multi-disciplinary team (MDT) includes 1x Activity Co-ordinators, 0.6x APOT, 0.8 pharmacy technician, and 1x psychology assistant.

There are currently no registered nurse vacancies, with 2 WTE HCA vacancies actively being recruited to. The team includes 4 newly qualified nurse in preceptorship, with further strengthening anticipated through the planned transition of a Band 7 Clinical Lead.

No changes to operational or staffing structure/shift patterns since the last review, however, there has been a sustained need to exceed minimum staffing requirements to support the complex care needs of the patients result in ongoing reliance on temporary staffing.

Quality and Safety Indicators: Sickness levels have increased from an average of 7.3% to 11.5% across October–March, peaking at 12.1% in March, largely driven by three WTE registered nurses on long-term sickness throughout the period. Despite this, minimum safer staffing levels have been maintained; however, the ward continues to frequently require additional staffing above establishment to safely manage a highly complex patient group, and supportive therapeutic observations of care, leave, and transitions of care. This has resulted in sustained use of bank and peripatetic staff, with fill rates consistently above 100%, reflecting the additional resource required to maintain safety. There is regular senior leadership oversight, with ongoing monitoring of staffing, patient safety, and care quality supported by a recovery and action plan.

The workforce profile has shifted due to the loss of experienced Band 6 staff to the Care Home Liaison Team, with four newly qualified nurses recently recruited to strengthen the team. Workforce challenges have been compounded by long-term sickness, a HR process has concluded resulting in resignation, and ongoing review of night HCA working arrangements.

Clinical supervision compliance reduced during the period due to high acuity and ward activity, though a structured tiered approach remains in place and recovery is expected. Statutory and mandatory training compliance remains consistently above Trust targets.

From a patient safety perspective, there have been no cancelled Section 17 leave episodes during the reporting period. There has been an increase in medication related incidents with 27 incidents reported, however were all classified as no or low harm.

27 falls were reported during the period, reflecting the complexity and physical health needs of the patient cohort. Of these, 26 resulted in no or low harm, with one moderate harm incident currently subject to a Patient Safety Incident Analysis, providing assurance of robust governance, learning, and oversight. There were 52 incidents of violence and aggression, all categorised as no or low harm. Five incidents involved physical aggression between patients and were appropriately reviewed through safeguarding processes. No self-harm incidents were reported during the period, providing further assurance regarding patient safety.

Professional Judgement: Maister Lodge is a 14 bedded unit caring for older people with organic mental illness, although people of a working age are admitted where there is significant cognitive impairment. The team also provides end of life care.

The ward is managing a highly complex patient cohort within a large, zoned environment that requires continuous staff presence across multiple areas to maintain safety. The team are proactively reviewing incidents in the context of the environmental challenges. **Appendix 1** demonstrates some of the impact the environment has on safety and staffing and how the team are seeking to understand and manage this.

Demand for Supportive Therapeutic Observations of Care (ETOC) remains high, with several patients requiring frequent intermittent 1:1 or 2:1 support for personal care, mobility, and behavioural risks, often necessitating multiple staff per interaction and significantly increasing workload. The combination of cognitive impairment, violence and aggression, falls risk, and complex physical health needs creates sustained pressure on staffing, further compounded by time-intensive care interventions such as extended personal care and medication administration.

While staffing distribution is balanced and core operations are maintained, pressures arise from fluctuating staffing levels, reduced MDT presence at key times, and the need to sustain a safe skill mix alongside supporting preceptorship and workforce development. Environmental constraints, including ward layout, limited line of sight, and lack of dedicated seclusion facilities, increase reliance on staff to manage risk. These pressures have a direct impact on the need for bank and agency usage, with associated financial implications.

It was also noted that delayed transfers of care are contributing to issues with patient flow.

There are robust governance arrangements in place, including weekly assurance processes and proactive triangulation of key quality, operational, and safety metrics to monitor risk and inform decision-making. Despite the challenges, the team demonstrates strong cohesion, proactive workforce management, and effective use of escalation and support systems to maintain patient safety

Financial position: The ward continues to face notable financial pressures, with a £248k overspend last year and sustained requirement for temporary staffing required to maintain safety in response to acuity and patient complexity.

Summary: The ward is currently operating within a challenging financial and sustainability position, with cumulative pressures impacting the overall forecast. Despite this, there is a strong commitment to maintaining safe staffing and prioritising patient care, with good assurance that safety is being upheld, albeit through increased staffing levels and reliance on temporary workforce. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review and has informed the recommendations within this report to ensure sufficient capacity to safely meet patient need and observation requirements. Work is underway to strengthen the evidence base for the business case, including clearer capture of Supportive Therapeutic Observations of Care (EToC) and delayed transfer impacts and associated costs. In parallel, actions are in place to recover clinical supervision compliance, with additional support from Professional Nurse Advocates (PNAs).

Progress update on previous actions/recommendations from full Safer Staffing Establishment review in November 2025 :

Action for **Maister Lodge and Court**	Update
An evidence based business case should be considered by the senior managers to explore the staffing model at Maister Lodge and consideration should be given to having a staffing model that combines Maister Lodge and Court. This would support more flexible staffing across the units, provide opportunity to upskill our staff with the skills and expertise to support the care of functional and organic patient groups. here should be consideration for increasing the budgeted establishment in line with the recommendation of the MHOST tool and the professional judgment discussion which indicates that an increase in staffing levels may result in a safer, more sustainable staffing model	The ward manager confirmed that the business case has recently been submitted to increase the establishment to cover an additional 1 HCA on the early and late shifts and also an additional registered nurse on a night shift. The proposal reflects a joint roster of the two wards.

Action arising from Interim review
As part of the on-going monitoring of staffing requirements, quality and patient safety metrics, the team will also monitor and record additional staffing requirement due to Supportive Therapeutic Observations of Care (ETOC) as part of this triangulation and use data to support further development of the business case.

Mill View Court	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	101%	98%	97%	102%	7.5	7.7	92%	23%	14%	8.8%
April 25 – Sept 25	96%	99%	97%	100%	7.7	7.8	90%	16%	10%	7.4%
Oct 24 - Mar 25	96%	93%	106%	111%	6.7	8.4	91%	30%	12%	6.8%
April 24 - Sept 24	86%	86%	99%	109%	10.2	8.6	86%	28%	21%	14.6%
Oct 23 - Mar 24	102%	96%	104%	115%	8.3	9.2	83%	28%	11%	6.4%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	96%	88%	15	29	88
April 25 – Sept 25	94%	93%	26	12	30
Oct 24 - Mar 25	94%	91%	23	15	57
Apr 24 - Sept 24	94%	92%	16	29	73
Oct 23 - Mar 24	92%	94%	30	20	98

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (generic) tool. At the point of data collection there was an average of 13.6 patients on the ward (15 bedded mixed sex unit). Recommended WTE = 23.7 and a Recommended CHPPD of 7.5. This is consistent with previous data collection period when R-=CHPPD was 7.7.

The target CHPPD is currently set at 8.0. The ward averaged a CHPPD of 7.7 over the six month period. Whilst this is slightly under the target of 8.0, it is in line with the last two R-CHPPDs.

Nursing and HCA budgeted establishment is equal to 27.1 WTE (not including the Band 7).

Good skill mix on the ward. 2x Band 6s currently seconded to Band 7 team leader and clinical lead roles (Band 7 team leader on maternity leave). The ward has a budgeted establishment for 3x Band 6s, 7.8 x Band 5s, 1x funded Band 4 Nurse Associate however 2 currently in post to support Band 5 maternity leave cover, and 13.3x HCAS The wider MDT includes within the budget 1x Band 7 psychologists, 1x Band 6 Social Worker, 1x Occupational Therapist, 1x pharmacy technician and an activity worker.

Whilst bank and agency has increased since the last reporting period this is attributed to two HCAs leaving the team in October and January. Recently recruited into the HCA vacancies.

No changes to shift patterns or safer staffing numbers since the last review with the team working long shifts with 2 RMNs on each shift.

Quality and Safety Indicators: Average sickness has increased slightly from 7.4% in the previous reporting period to 8.8%% Oct- March. Sickness was noted to be 3.5% at the beginning of Q1 26/27 (April) which is a below the target threshold of 5%. At the time of the review there remained 1x HCA on long term sick.

Fill rates, clinical supervision and statutory mandatory training are above the trust target consistently. The team noted a drop in ILS/BLS training, but this position had recovered.

From a patient safety perspective, there were no cancelled Section 17 leave episodes during the reporting period, demonstrating effective prioritisation of patient care and leave arrangements. Medication safety has improved, with 15 medication-related incidents reported, all classified as no or low harm.

A number of falls were reported during the six-month period, all resulting in no or low harm and largely associated with patients requiring high levels of engagement due to complex physical health needs. There were 29 incidents of violence and aggression, all classified as no or low harm, including five incidents of patient-on-patient physical aggression; all were appropriately reviewed through safeguarding processes to ensure oversight.

A total of 88 self-harm incidents were reported, the majority resulting in no or low harm. Four incidents were classified as moderate harm due to the patient requiring escalation to acute hospital services for assessment or treatment. All moderate harm incidents were reviewed through the Corporate Safety Huddle process, with Initial Incident Reviews commissioned to support learning and improvement. One moderate harm incident related to a Category 4 pressure ulcer was reviewed by the Pressure Ulcer Review and Learning Group and was determined not to have been acquired in our care. There was also one patient death while on leave, for which a Patient Safety Incident Analysis is currently underway. Overall, the service demonstrates robust governance arrangements with appropriate investigation, oversight, and learning processes in place.

Professional Judgement: Mill View Court is a 15 bedded mixed sex treatment ward for adults with acute mental health difficulties. It is not a stand-alone unit.

Mill View Court is currently safely staffed, with staffing levels broadly aligned to patient need and sufficient to maintain safe care delivery. However, this is within the context of a highly dynamic and, at times, acutely unwell patient cohort, including periods of increased self-harm, falls, and violence and aggression, which have required responsive increases in staffing, particularly where multiple Supportive Therapeutic Observations of Care (ETOC) are in place.

Workforce pressures, including maternity leave, previous vacancies, and a small number of ongoing HR-related absences, have been effectively mitigated through recruitment, and use of bank staff, with minimal ongoing impact on day-to-day safety. The team demonstrates flexibility in deploying additional support, including AHP and activity worker input, to manage peaks in acuity. Overall, staffing is considered safe and sustainable, with appropriate escalation and mitigation processes in place to respond to fluctuating risk and patient complexity.

Financial position: The ward has demonstrated effective resource management, and efficient workforce planning. At the end of the financial year there was a £20K underspend equal to an average of 1 WTE in the last quarter of 25/26.

Summary: There is a good level of assurance that current staffing arrangements are safe. Minimal staffing challenges with improved sickness position and a low level of vacancies. There is sufficient resource within the budgeted establish to support the team delivering minimum safer staffing numbers. No recommendations or changes made as part of this interim review. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

Update on previous recommendations/actions: No actions or recommendations were made at the Safer Staffing Establishment Review in November 2025

Mill View Lodge	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	84%	106%	80%	100%	4.5	12.4	89%	31%	-9%	7.8%
April 25 – Sept 25	66%	103%	75%	100%	4.0	13.7	85%	22%	4%	8.8%
Oct 24 - Mar 25	74%	102%	76%	103%	6.4	14.0	88%	21%	27%	10.7%
April 24 - Sept 24	79%	100%	76%	103%	7.2	15.8	81%	19%	39%	4.6%
Oct 23 - Mar 24	82%	114%	81%	131%	4.7	17.1	79%	21%	36%	5.0%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Falls	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	78%	96%	18	9	23	2
April 25 – Sept 25	81%	91%	12	23	3	1
Oct 24 - Mar 25	82%	95%	15	26	19	1
Apr 24 - Sept 24	81%	97%	4	14	23	1
Oct 23 - Mar 24	87%	96%	14	22	31	16

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (older people) tool. At the point of data collection there was an average of 8.9 patients on the ward (10 bedded unit). Recommended CHPPD of 4.5 which is similar to the previous data collection period. Caution is applied in interpreting recommendations from the MHOST due to low patient numbers compromising the validity.

The target CHPPD is currently set at 8.8. The ward averaged a CHPPD of 12.4 over the six month period.

Nursing and HCA budgeted establishment is equal to 26.4 WTE (not including the Band 7).

Good skill mix on the ward with a budgeted establishment of 2x Band 7s (clinical lead and ward manager), 2x Band 6 nurses, 8.4 x Band 5, 1x Band 4 Nurse Associate (NA), and 15x HCAs (1x Band 2), and the team are also supported by OT, APOT, dietician, pharmacy technician and activity worker. There are two registered nurses in preceptorship.

At the time of the review there were minimal vacancies with 1.0x HCA and 0.4 x Band 5 vacant posts. 2x HCAs recently recruited and where due to commence in May. 2x HCAs who were on long term sickness have resumed work.

There have been no changes to minimum staffing levels since the last review with the staffing model currently a combination of early, lates or long days, plus twilight and 4 on nights (1x RMN)

Quality and Safety Indicators: Average sickness has decreased slightly from 8.8 % in the previous reporting period to 7.8%% Oct- March. Sickness was noted to be 4.1% at the beginning of Q4 (April) with no long term sickness.

At the previous review there where a number of staff unable to work due to on-going HR processes which have now completed. Recent budget analysis shows an improvement in staffing expenditure as bank and agency use has risen to support gaps in staffing which was also impacted by some long term sickness.

Initial concerns regarding fill rates were attributed to data inconsistencies, which have now been resolved, with March figures showing strong registered staff fill rates (97.9% on days in March)

Care hours per patient day remains consistently above target.

Clinical supervision had dipped during this reporting period but there are signs of a recovered position with supervision in April at 93%.

Overall statutory mandatory training remains consistently above target.

From a safety perspective, there has been a notable reduction in falls over the six-month period (9 in total), with one moderate harm incident appropriately investigated and reviewed through governance processes, providing assurance of learning and risk management. There was a slight increase in medication related incidents with 18 reported and all no harm/low harm. 23 violence and aggression incidents, all reported as no harm low harm. 7 incidents of physical aggression from patient to patient, appropriate safeguarding reviews completed. 2 self-harm incidents both reported as low harm.

As reported in the previous Safer Staffing report, there was a significant incident which resulted in a patient death. The Patient Safety Incident Investigation has now concluded and proposed changes to the staffing model are reflective of the learning from this investigation.

Professional Judgement: Mill View Lodge is a 10 bedded mixed sex ward caring for older adults with functional mental illness. Not a stand-alone unit.

The ward has experienced staffing pressures due to a number of staff suspensions over a prolonged period (7–8 months), impacting both HCA and registered staff groups and increasing reliance on bank and agency cover; this position has now significantly improved, with processes concluded and only one HCA vacancy remaining. Patient flow continues to be challenged by delays in transfers of care, primarily linked to social care pathways, alongside an increasing complexity in patients' physical health needs, requiring enhanced clinical oversight and multidisciplinary input. There have been no significant changes to the ward environment since the last review.

Proposed changes: It is proposed that night staffing is enhanced to include two qualified nurses, bringing the staffing model in line with that routinely adopted across other mental health inpatient wards. This change will increase workforce capacity, strengthen clinical decision-making, and provide greater resilience in responding to the complex mental and physical health needs of the older adult inpatient population. The additional qualified nurse will also support staff wellbeing by enabling appropriate break cover, reducing professional isolation, and providing greater opportunities for peer support and supervision, contributing to a more sustainable and consistent staffing model. While support can be accessed from Mill View Court, staff have expressed concerns about lone qualified nurse working at night.

Additionally, there is a proposal to review long-term night working arrangements, with HR support, and to reconfigure shift patterns to reduce mixed shift models. This aims to maximise workforce efficiency while maintaining flexibility and supporting staff wellbeing.

Financial position: At the last reviews the projected overspend for yearend was £172k due to backfilling maternity leave, long terms sickness and the 4 staff that were unavailable to work. The end of year position was £176K overspend, slightly over the projected. There is an exception that improvement will be seen in the first quarter of 26/27 reflecting the improved staffing position.

Summary: Overall, there is a good level of assurance that current staffing arrangements are being managed safely, demonstrated by consistent CHPPD and a more accurate reflection of fill rates is now evident. However, a number of proposed changes are recommended to strengthen workforce capability, efficiency and

patient safety, including moving to a staffing model of 2 registered nurses on nights, eliminating permanent night shift working, and moving to a model of long days rather than variable shift patterns. The outcome of this review fully supports these proposals. Bank and agency spend has been high due to staffing position in the last 6 months, but this projected to improve as the team move towards a full establishment and improved sickness absence rates. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

Progress update on previous actions/recommendations from full Safer Staffing Establishment review in November 2025 :

Action	Update
A review of demand template on E Roster is required to correct any anomalies associated with shift patterns and the Nurse Associate in order to more accurately reflect the fill rates.	Completed - The team have worked with the E-roster team to rectify issues with the demand template. Fill rates are now consistently above 90%

Action arising from the Interim review
Ward managers and service manager to work with the finance team to review staffing establishment and budget. Develop a business case to ensure sufficient registered nurse cover to support 2 registered nurses on a night shift
Work with HR, review permanent night shifts and short shift patterns taking into consideration flexible working
Review the remaining HCA Band 2 position and support with a competency based training or apprenticeship to uplift to Band 3

Newbridges	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	97%	96%	101%	105%	6.9	7.9	95%	19%	16%	7.5%
April 25 – Sept 25	97%	100%	99%	102%	7.7	7.7	95%	21%	26%	7.7%
Oct 24 - Mar 25	95%	92%	102%	109%	8.5	8.3	96%	28%	-3%	8.5%
April 24 - Sept 24	83%	82%	97%	104%	6.4	7.8	94%	20%	1%	7.5%
Oct 23 - Mar 24	82%	88%	85%	102%	5.4	8.0	91%	15%	-11%	11.1%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	86%	97%	43	59	11
April 25 – Sept 25	91%	95%	18	81	6
Oct 24 - Mar 25	90%	95%	9	44	36
Apr 24 - Sept 24	89%	95%	14	47	12
Oct 23 - Mar 24	87%	99%	8	26	15

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (generic) tool. At the point of data collection there was an average of 18 patients on the ward (18 bedded unit). Recommended WTE = 25.6 and a Recommended CHPPD of 6.9.

The target CHPPD is currently set at 8.0. The ward averaged a CHPPD of 7.9 over the six month period which is slightly below target but aligns with the current recommended care hours per patient days calculated during this reporting period.

Nursing and HCA budgeted establishment is equal to 33.2 WTE (not including the Band 7).

Within the wards budgeted establishment there are 2x Band 7s, 3x Band 6 nurses, 8.0x Band 5 nurses, 2x Band 4 Nurse Associates, 20.2x Band 3 Health Care Assistants (HCAs). The wider multi-disciplinary team (MDT) includes 1x Activity Co-ordinators, 1x APOT, 1x OT, 1x pharmacy technician, 1x social worker, and 1x clinical psychologist.

Staffing models remain unchanged with 6 staff on days (2 RNs) and 5 on a night shift (2 RNs).

Quality and Safety Indicators: Sickness levels have shown a slight reduction from 7.7% to 7.5% across October–March, with a significant improvement to 3.8% by the end of the reporting period.

Fill rates remain consistently strong. Bank and agency use has decreased further.

From a safety perspective, there were 77 Datix reports relating to seclusion, partly reflecting workforce skill mix limitations (e.g. Nurse Associate role restrictions). There were 59 violence and aggression incidents, 58 reported as no harm low harm. 1 moderate harm incident which was reviewed by safeguarding and an Initial Incident Review was also completed. All other incidents involving aggression by a patient to a patient have been reviewed by safeguarding. An increase in medication related incidents was noted with 43 reported and all no harm/low harm. 13 related to a patient refusing medication. 11 self-harm incidents all reported as no harm/low harm.

During this reporting period there was 1 patient death (unexpected/natural) for which a Patient Safety Incident Investigation is currently in progress.

Professional Judgement: Newbridges is an 18 bedded male mental health inpatient unit. It is a standalone unit over two floor with two stairwells, with environmental risks due to lines of sight and restrictions relating to no lone female working due to risk relating to client group. Consideration is given to environmental and security engagements.

There are currently no significant staffing concerns, with enhanced initiatives contributing to a sustained reduction in short-term sickness absence and a marked decrease in reliance on agency staff.

The ward benefits from a strong and stable skill mix, including established Band 7 leadership, a range of experienced nursing staff, and a fully embedded MDT, however ongoing staff development (including secondments and training pathways) presents some short-term staffing pressures due to limited backfill funding.

Patient flow remains impacted by delayed discharges, primarily due to limited housing availability and challenges in securing appropriate accommodation in a timely way. In addition, the ward is managing increased demand related to Section 17 leave, particularly for patients who smoke, which requires frequent risk assessments and dedicated staff to safely facilitate leave from the ward environment. This was identified during a recent CQC Mock inspection of the ward with action plan to address this in progress. Activity co-ordinators continue to support therapeutic engagement through off-ward activities such as boxing and swimming.

Since the last review, the ward environment has been significantly improved, including full redecoration, installation of a new alarm system, introduction of anti-ligature alarms on bedroom doors, and reconfiguration of communal spaces to enhance both safety and patient experience.

Financial position: The ward has demonstrated a strong improvement in financial performance, moving from a projected £11k overspend to a £38k underspend, reflecting robust financial oversight, effective resource management, and efficient workforce planning.

Summary: Newbridges continues to manage high acuity safely, with strong staffing fill rates and effective mitigation of any shortfalls. The ward benefits from high staff retention and a positive reputation, with vacancies filled promptly and strong internal interest during transfer windows, alongside a year-end underspend demonstrating effective financial stewardship. There is a well-established, collaborative culture across inpatient services, with ward managers working cohesively to share resources and good practice. Overall, there is a high level of assurance that current staffing arrangements are safe and sustainable, with no changes or following this interim review. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

Update on previous recommendations/actions: No actions or recommendations were made at the Safer Staffing Establishment Review in November 2025

PICU	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	103%	97%	97%	109%	13.3	25.2	69%	38%	9%	6.1%
April 25 – Sept 25	107%	98%	104%	117%	14.6	25.1	77%	45%	21%	4.4%
Oct 24 - Mar 25	84%	92%	99%	114%	17.0	23.9	74%	38%	15%	7.6%
April 24 - Sept 24	85%	93%	105%	114%	13.4	20.4	87%	45%	43%	5.0%
Oct 23 - Mar 24	98%	97%	98%	118%	12.0	20.8	76%	42%	29%	3.7%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	82%	90%	13	314	12
April 25 – Sept 25	90%	96%	13	344	105
Oct 24 - Mar 25	86%	93%	18	80	146
Apr 24 - Sept 24	90%	94%	23	98	112
Oct 23 - Mar 24	90%	95%	18	136	43

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (PICU) tool. The Recommended CHPPD as per the MHOST tool from this period is 13.3. Recommended WTE = 21.4. At the point of data collection there was an average of 6.9 patients on the ward (10 bedded unit). Caution should be applied as the reliability of the tool can be compromised when used on wards with smaller bed bases.

The target CHPPD is 16.6 and this was achieved consistently over the 6 months, averaging 25.2.

Nursing and HCA budgeted establishment is equal to 38.5 WTE (not including the Band 7).

Within the wards budgeted establishment there are 2x Band 7s, 4x Band 6 nurses, 7.6x Band 5 nurses, 1x Band 4 Nurse Associates, 25.9x Band 3 Health Care Assistants (HCAs). The wider multi-disciplinary team (MDT) includes 1x Activity Co-ordinators, 1x APOT, 1x OT, 1x social worker, 1x psychologist Band 7, and 1x pharmacy technician.

Minimal vacancies noted at the time of the review with 1x Band 5 and 1x Band 3 activity worker posts being actively recruited to.

There have been no changes to minimum staffing levels since the last review with 7 on long days (2 RNs) and 6 on nights (2 RNs).

Quality and Safety Indicators: Sickness levels have slightly increased from 4.4% to 6.1% across October–March, with a reduction to 4.9% by the end of the reporting period.

Safer staffing models remain unchanged, with consistently strong fill rates and a 7% improvement in reliance on bank and agency staffing, which is expected to further improve as recruitment stabilises.

From a safety perspective, incidents of violence and aggression have reduced compared to the previous reporting period but remain high, largely driven by a cohort of patients presenting with increased risk, including assaults on staff and incidents of racial abuse. 314 violence and aggression incidents were reported. 1 reported as moderate harm with an Initial Incident Review completed. All other incidents involving aggression by a patient to a patient have been reviewed by safeguarding. Robust measures are in place to support staff wellbeing and safety, including strong encouragement to report concerns, active police engagement with a named ward link officer, and partnership working with the Trust's Equality and Diversity Lead to address and challenge unacceptable behaviours. Support is not only available for the substantive staff but also structure in place to offer support and post incident debrief, and supervision to bank staff.

There were 13 medication related incidents all reported as no harm. There has also been a significant reduction in self-harm incidents with 12 reported in the 6 month period, all reported as no harm/low harm.

Professional Judgement: PICU is a 10 bedded psychiatric intensive care ward. It is not a standalone unit and is a single level layout.

The workforce position has significantly improved, with the majority of vacancies now filled, a strengthened skill mix across all bands, and a dedicated psychologist in post, contributing to a more stable and therapeutic ward environment. The MDT is close to full establishment, with only minimal HCA and Band 5 vacancies remaining which is a substantial improvement from the previous year when staffing gaps were significant and risk registered.

The ward continues to experience staffing pressures linked to the complexity of the patient group, including high levels of assaults, verbal abuse, and incidents of racism towards staff; this has necessitated placement on an "at risk" register, with strengthened oversight and joint working with senior leadership, the Trust Equality and Diversity Lead, and police partners.

Additional workforce challenges include staff in preceptorship not yet undertaking shift leadership, a Band 5 secondment, and a period of long-term sickness at Band 7 level, although the team has remained engaged and supportive of initiatives to improve staff experience. Patient challenges reflect the acuity and complexity of need, including delayed discharges, extended Section 17 leave arrangements requiring ongoing outreach support, and frequent risk-related interventions such as seclusion and long-term segregation; there has also been a requirement to support acute physical health needs off-site.

Environmental constraints continue to impact care delivery, including limited line of sight and the need for ongoing refurbishment, though improvement works are underway. Planned enhancements including a new garden airlock, hot drinks station, and continued risk-managed access to kitchen facilities, are expected to improve both safety and patient experience once completed.

Financial position: The ward has demonstrated a strong improvement in financial performance, moving from a projected overspend of £103k at the last safer staffing review to an actual overspend of £36k at the end of the financial year, reflecting robust financial oversight, effective resource management, and driven by a reduction of bank and agency use.

Summary: The PICU continues to operate safely at the current safer staffing levels for a 10-bed unit, with an appropriate skill mix and gender balance across shifts to ensure safe and responsive care delivery. There is a clear focus on maintaining senior clinical oversight on all shifts, with Band 6 and Band 7 staff working within the numbers where required to support acuity and risk.

The team remains collaborative and flexible, acknowledging the need to redeploy Deputy Charge Nurse shifts at times of organisational pressure; however, this can create additional workload challenges locally.

Overall, there is good assurance that staffing arrangements remain appropriate and effective in supporting patient safety and care quality. Good level of assurance that the ward is safely staffed and that the current budgeted establishment supports the minimum staffing levels. No proposed changes or actions arising following this interim review. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

Progress update on previous actions/recommendations from full Safer Staffing Establishment review in November 2025:

Action	Update
With the on-going challenges with HCA recruitment, high use of temporary staffing and the increase in violence and aggression incidents the recommendation from this review is for the senior leadership team to consider the staffing model and review against NAPICU standards and guidance. This should be considered alongside the proposal for separating the ward into a female and male only PICU/HDU	Following a period of significant vacancy gaps highlighted at the last review, recruitment has been highly successful, with only 1 HCA and 1 RMN post currently vacant, representing a marked improvement in workforce stability. The staffing model remains unchanged, and the team now recognises the value of a fully established workforce in supporting patient safety and care quality. While the model may be subject to future review once the team is fully embedded, it is currently considered effective and sustainable
The team should conduct a deep dive into the incident data in relation to violence and aggression to inform these decisions based on quality and safety	A focused review of violence and aggression incidents identified that these were largely associated with a single complex patient whose presentation required a high level of risk management and specialist intervention. Senior leadership oversight, with a strong emphasis on staff support and maintaining safety during a particularly challenging period was maintained. The team worked cohesively, responding proactively to escalating risks, and supported the patient's transfer to a more appropriate medium secure setting, demonstrating effective multidisciplinary collaboration and commitment to safe, patient-centred care.
Consideration should be given to developing the HCAs which may improve recruitment and retention of staff.	A structured development approach is in place for HCAs, including targeted training to support competency development. Opportunities for growth are further

	enhanced through special interest groups and link roles, alongside continued support for all HCAs, particularly new starters, to complete the Care Certificate

Westlands	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	86%	98%	82%	101%	7.7	8.0	90%	25%	1%	10.3%
April 25 – Sept 25	91%	100%	86%	103%	5.9 *	8.5	88%	40%	0%	13.4%
Oct 24 - Mar 25	86%	97%	83%	107%	6.3	8.1	91%	30%	-2%	7.5%
April 24 - Sept 24	90%	94%	83%	108%	7.9	9.7	78%	35%	2%	7.8%
Oct 23 - Mar 24	79%	93%	78%	107%	8.9	9.8	79%	38%	13%	9.2%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	82%	94%	26	94	161
April 25 – Sept 25	89%	92%	17	142	282
Oct 24 - Mar 25	87%	90%	16	39	1023
Apr 24 - Sept 24	89%	95%	27	57	520
Oct 23 - Mar 24	85%	88%	22	53	734

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (generic) tool. Noted a slight increase in R- CHPPD (7.7) compared to the previous reporting period (5.9) however it was previously noted to have been a period of lower acuity and the R-CHPPD from this period is more reflective of the ward's dependency levels over time. At the point of data collection there was an average of 14.1 patients on the ward (18 bedded unit). Recommended WTE = 25.6. The target CHPPD is 8.0 and this was achieved over the 6 months average.

Nursing and HCA budgeted establishment is equal to 31.06 WTE (not including the Band 7). Within the wards budgeted establishment there are 2x Band 7s, 4x Band 6 nurses, 8x Band 5 nurses, 19.8x HCAs. The wider multi-disciplinary team (MDT) includes 2x Activity Co-ordinators, 1x APOT, 1x OT, 1x social worker, 1x psychologist Band 7, and 1x pharmacy technician. Minimal vacancies noted at the time of the review with 1x HCA recruited and pending start date.

There have been no changes to minimum staffing levels since the last review and the team have continued to operate on 5 on days (2 RNs) and 5 on nights (2 RNs) plus the twilight, which was initiated as a pilot in 2025. The pilot has been subject to a review, and the proposal is that this remains a permanent change.

Quality and Safety Indicators: Average sickness has reduced from 13.4% to 10.3% across October–March, with a further improvement to 6.8% by the end of the period, although this remains above target, long term sickness has improved from 5.2% in December to 2.1% by April.

While fill rates are occasionally below target, these are mitigated by team leader input and activity workers backfilling HCA gaps to reduce reliance on temporary staffing. Statutory mandatory training remains consistently strong. Clinical supervision was slightly under target for the reporting period which is a continued area of focus for the team.

From a safety perspective, there have been no moderate or severe harm incidents. There is a continued significant reduction in self-harm incidents with 161 reported in the 6 month period. Whilst this continues to be the units highest reporting category this is a reduction from 1023 in the same reporting period of 2024/25 demonstrating the significant impact and focus of the team on enhancing therapeutic and supportive engagements, supported by the strengthened MDT (including psychology input). All incidents of self-harm were reported as no harm or low harm. 93 violence and aggression incidents, which is a significant reduction from the previous reporting period however remains the unit's 2nd highest reporting category. All reported as no harm/low harm. 16 incidents involving aggression by a patient to a patient have been reviewed by safeguarding. There were 26 medication related incidents all reported as no harm and 20 incident reports related to patient absent without leave/absconsions, which continues to be monitored.

Professional Judgement: Westlands is an 18 bedded female only mental health inpatient unit. It is a stand-alone unit over two levels.

The ward experienced high sickness levels in December and January, though proactive management has led to improvements in Q4. Temporary reliance on agency staff to cover maternity leave, vacancies, and a non-patient-facing role is expected to reduce as the team reaches full establishment. The ward is now better established, with a strong skill mix including two Band 7 leaders in post, a full MDT (including two preceptorship nurses), and recent vacancies filled. 1x Band 6 remains on maternity leave, however Band 5 is currently acting into the Band 6 role. Encouragingly, staff engagement remains positive, with good attendance at reflective practice, safety huddles, and wellbeing initiatives.

Patient flow continues to be impacted by delayed discharges, particularly related to housing and legal processes. There has been a need for enhanced zonal observations to manage higher-risk presentations. Environmental challenges include ongoing legionella management, requiring additional risk assessment for admissions and transfers, and resulting in the temporary loss of seclusion facilities.

Financial position: The financial position at the end of the financial year 25/26 was an overspend of £75K. The year end projection had been significantly more than this and the team were commended for the improvements in the financial position since the last review which equalled 11 WTEs, compared to the most recent position of 4 WTE.

Summary: Westlands continues to manage high acuity safely, with most shifts filled and shortfalls effectively covered; staff feedback remains positive, with good engagement and benefit seen from the twilight shift in managing peak risk periods. Recruitment has been successful and contributing to improved workforce stability. Good level of assurance that the ward is safely staffed and that the current budgeted establishment supports the minimum staffing levels. No proposed changes following this interim review. Actions arising from this review are outlined below. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

Progress update on previous actions/recommendations from full Safer Staffing Establishment review in November 2025 :

Action	Update
Review impact of the twilight pilot – alongside incident data – QIA if this is to be a permanent change	The team introduced a twilight shift as a pilot in 2025 to consider if this would have a positive impact on temporary staffing requirements and patient safety. The team have reviewed the impact of the pilot and report a positive impact on safety and reduction in incidents occurring between 8pm and midnight. The decision has been made to make this a permanent change however **the team need to submit a QIA for approval**

Action arising from the Interim review
Strengthen recording practices on e-rostering to ensure that when Team Leaders or Activity Workers are utilised to backfill RMN or HCA shifts, this is accurately captured, enabling a more reliable reflection of true fill rates and workforce deployment.
Undertake a structured deep dive into absent without leave (AWOL) and absconsion incidents to identify patterns, contributory factors, and opportunities for learning, with findings informing targeted risk reduction and care planning improvements.

Children and Learning Disability Division – interim reviews on 8th May 2026

Townend Court	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RNs)	Sickness
Oct 25 - Mar 26	65%	87%	70%	79%	NA	37.2	33%	32%	25%	9.7%
April 25 – Sept 25	64%	96%	80%	90%	NA	34.1	39%	11%	14%	6.6%
Oct 24 - Mar 25	57%	94%	84%	100%	NA	37.7	37%	23%	13%	11.5%
April 24 - Sept 24	75%	139%	92%	120%	NA	44.8	33%	47%	17%	22.5%
Oct 23 - Mar 24	78%	102%	85%	100%	NA	34.2	38%	36%	23%	14.1%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	89%	93%	13	180	85
April 25 – Sept 25	86%	94%	22	176	112
Oct 24 - Mar 25	92%	95%	45	458	356
Apr 24 - Sept 24	86%	83%	19	422	459
Oct 23 - Mar 24	76%	93%	18	400	373

Acuity and Dependency Data and Staffing Establishment: There is no national recommended evidenced based tool for measuring acuity and dependence of patients within a learning disability inpatient unit from which to make a recommendations on staffing establishment or recommended CHPPD. In such circumstances professional judgement is used alongside review of quality and safety metrics.

Due to low bed occupancy (average 33%), actual CHPPD remains high, averaging 37.2% during this 6 month period.

Nursing and HCA budgeted establishment remains unchanged at 38.77 (excluding Band 7s).The budgeted establishment consists of 2x Band 7s, 6x Band 6s, 5.7x Band 5s, 1x Band 4, 26.07x HCA Band 3s. The wider MDT budget covers 0.2 pharmacy technician, 1x psychologist, and 1x OT. There is 1x APOT in post but no budget for this. They appears to be over recruited on Band 3 HCAs. Further clarification by senior leadership team is required on the current vacancies and budget lines for Band 3, APOT and Discharge co-ordinator.

There has been a recent recruitment into the vacant Band 7 post. 1x Band 6 vacancy at the time of the review. Slightly over-established on Band 5s with 6 in post, however 1 is currently unavailable for work due to HR process. 2x Band 5s on preceptorship. 2x HCAs on maternity leave and 1 currently unavailable for work due to

HR process. There is 0.8 x Band 6 discharge co-ordinator, but it was unclear if this is aligned to the TEC budget line which requires confirmation. Band 3 Activity worker included in the HCA budget.

Quality and Safety Indicators: Average sickness has increased from 6.6% to 9.7% across October–March, sickness peaked in December at 14.3% but has steadily improved since and by the end of this reporting period was down to 5.4% overall with 2.3% long term sickness (Level 3 report).

Following a temporary reduction in staffing noted at the last review, this has reverted back to the 8 on long days (2 RNs) and 7 on nights (2 RNs). Fill rates have continued to be inaccurately reflected within E-roster due to discrepancies with the demand template however work has been completed with the E-roster team and fill rates will be more accurately recorded moving forward. This has already had a positive impact with registered nurse fill rates in May reported as 108% on days and 100% on nights.

Overall statutory mandatory training compliance remains consistently strong. However, compliance with ILS has not been achieved and BLS has been below target for 5 of 6 months. The team report that staff have either now completed or are scheduled to complete training however this will require on-going review and oversight by the ward manager.

Clinical supervision averaged 89% for the period however 3 nil returns were noted due to gap in Band 7 oversight, this has now been re-established with supervision in May at 83.3%.

The increase in bank and agency use was noted to be impacted by increased sickness, vacancies and staff unavailable to work due to HR processes. Whilst the team reported a reduction in overall bank and agency use this is not evident as bank and agency use in March continued to be high at 44.2%. This requires further review and analysis by the services. All requests for agency staff is escalated for approval to the Deputy COO.

From a safety perspective, the incident profile remains stable, with notable improvements in both self-harm and violence and aggression incidents compared to 2024/25, and consistency with the previous reporting period. 84 incidents of self -harm were reported, with 83 no harm/low harm incidents. There was 1 moderate harm for which an Initial Incident Review was completed. Of the 180 violence and aggression incidents, 179 were reported as no harm/low harm. There was one incident of violence which led to the patient injuring themselves, reported as moderate harm, for which an Initial Incident Review was completed.

Strong safeguarding oversight is maintained, alongside proactive management of patient dynamics, including appropriate placement and movement between Willow and Lilac to ensure patients are cared for in the most suitable environment.

13 medication incident all reported as no harm.

No cancelled Section 17 leave. Incident categories that are emerging relate to inappropriate behaviour (n=43) and concerns for person (n=40) which require further review by the team. 2x moderate harm incidents reported with appropriate post incident review via Initial Incident Reviews.

Professional Judgement: Townend Court is a 14 bedded mixed sex assessment and treatment unit for people with a learning disability with additional mental health needs. The unit is split over two wards, Willow with 6 beds and Lilac with 8 beds.

The unit has experienced a period of staffing instability, largely related to winter sickness, long-term absence, and a number of HR processes affecting both registered nurses and HCAs. These pressures were proactively managed through strong leadership oversight, effective use of bank staff to maintain continuity, and support from the wider Learning Disability service. Recent recruitment across multiple roles, along with returns from maternity leave, has significantly strengthened the workforce

position, improving stability, skill mix, and resilience. Ongoing investment in training and development, including apprenticeships and preceptorship support, ensures a sustainable pipeline of skilled staff, with careful rostering to maintain appropriate supervision and support for less experienced team members.

Patient need remains high and complex, with a cohort requiring enhanced and, at times, long-term segregation (LTS) and increased observation levels. This includes patients with bespoke placement requirements and those without defined discharge pathways, contributing to sustained acuity and staffing demand. Positive progress has been achieved through improved discharge planning, increased Section 17 leave opportunities, and strengthened MDT input, resulting in reduced incidents and improved patient wellbeing. The team demonstrates a proactive approach to managing complex patient dynamics, underpinned by safeguarding advice, MDT collaboration, and a strong focus on personalised, least restrictive care.

Environmental challenges include the constraints of a mixed-sex ward layout, limited communal space, and the impact of the unit becoming more isolated following the closure of a neighbouring service. While there has been investment in improving the physical environment, further work is ongoing to enhance therapeutic spaces and ensure a more welcoming setting. Despite these limitations, risks are effectively mitigated through staffing presence, clear processes, and proactive management of safety incidents. Overall, there is good assurance that the unit continues to deliver safe, responsive care, supported by strong leadership, improved workforce stability, and effective multidisciplinary working.

Financial position: The financial position at the end of the financial year 25/26 was an overspend of £197K on staffing however the total overspend at year end was £161K (pay and non-pay) and this is offset against a £36K non-pay underspend.

Summary: The unit has experienced workforce pressures driven by sickness, HR-related absences, and vacancies; however, these have been effectively managed, with recent recruitment improving overall stability. Safer staffing levels have been maintained throughout, with additional staffing used as required to safely meet the needs of a complex and high-acuity patient cohort. Quality indicators remain stable, with improvements noted in self-harm and violence and aggression.

Ongoing focus is required on reducing reliance on temporary staffing, improving training compliance (ILS/BLS), and sustaining clinical supervision levels. Further review of establishment alignment and data accuracy will support financial sustainability. Overall, there is good assurance that the ward is safely staffed, with appropriate processes in place to manage risk and support continuous improvement. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

Progress update on previous actions/recommendations from full Safer Staffing Establishment review in November 2025:

Action	Update
Deep dive into the RN fill rates is required to identify and rectify discrepancies in planned versus actual hours.	A full review has taken place with the E-roster team and discrepancies have been identified and rectified for the staffing rota moving forward. These changes have recently been made and therefore will show a more accurate position at the next review.
Review of the minimum staffing levels to ensure a Quality Impact Assessment is completed before any permanent changes are made to shift patterns ensuring budgeted establishment and shift patterns remain sufficient should bed occupancy or patient acuity increase.	This was a temporary adjustment, and minimum staffing have reverted back to the agreed safer staffing numbers of 8 on days (2 registered nurses) and 7 on night (2 registered nurses). QIA therefore not required.

Actions arising for the interim review
Undertake a review of the budgeted establishment and current vacancies to ensure that HCA, APOT, and Discharge Co-ordinator roles are accurately aligned to the correct budget lines, providing clarity on the current workforce position and any gaps
Undertake a detailed review and analysis of bank and agency usage to identify key drivers of cost and implement targeted actions to reduce reliance and associated financial pressure

Granville Court	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RNs)	Sickness
Oct 25 - Mar 26	124%	107%	92%	103%	NA	21.0	64%	26%	-13%	8.9%
April 25 – Sept 25	135%	114%	98%	108%	NA	21.3	66%	24%	-15%	8.5%
Oct 24 - Mar 25	119%	104%	101%	106%	NA	19.5	71%	25%	-13%	12.7%
April 24 - Sept 24	108%	108%	106%	109%	NA	18.5	80%	29%	-1%	6.9%
Oct 23 - Mar 24	103%	108%	100%	107%	NA	17.5	84%	38%	2%	9.3%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Falls	Pressure Ulcers in our care
Oct 25 - Mar 26	90%	97%	14	9	0
April 25 – Sept 25	92%	98%	15	9	0
Oct 24 - Mar 25	91%	97%	13	5	0
Apr 24 - Sept 24	92%	94%	9	8	0
Oct 23 - Mar 24	93%	95%	13	11	0

Acuity and Dependency Data and Staffing Establishment: There is no national recommended evidenced based tool for measuring acuity and dependence of residents with complex needs within a nursing home from which to make a recommendations on staffing establishment or recommended CHPPD. In such circumstances professional judgement is used alongside review of quality and safety metrics. Actual CHPPD remains high, averaging 21 for this 6 month period, reflecting the need for higher resident to staff ratio.

The current budgeted establishment remains unchanged and is 1x Band 7 registered manager, 2x Band 6 registered nurses, 8.44 Band 5 registered nurses, 8x HCAs, 3.51x Social Care Assistant Grade 4 and 38.46x Band 2 Social care support workers with a total of 62.34 in the budget. This is to support the care of 11 permanent residents across the 3 bungalows. In addition, the service has 2 respite beds bringing the current occupancy to 13. An additional package of care has been agreed with the local authority for a resident requiring 1:1 care (HCA during the day and registered nurse on a night), whilst this cost will be charged to the local authority, additional staff have been brought in to offset this which bring the total registered nurses to 10.8.

The current staffing levels are 2x RN, 1x Band 3 Health Care Assistant and 7x Care workers on long days plus 2 x Care workers on an early and 2 on a late shift. The night shift is covered by 1x RN, 1x Band 3 HCA and 5x Care workers. This is an increase from the last review to support 2x residents requiring 1:1 support.

It was highlighted at the last review that some staff were rostered on to combined early and late shifts which is now not occurring. Staff work long days but not the early late combined shifts.

Quality and Safety Indicators: Average sickness has increased from 8.5% to 8.9% across October–March, with a peak in October at 10% but a recovered position of 3.8% in March 2026. The service report proactive management of sickness absence with support from senior leadership and HR support services.

Statutory and mandatory training compliance remains consistently high, averaging 97%, with ILS and BLS above target. Clinical supervision has also remained strong at 90%. The service have not used agency staff to support staffing shortages and where bank is used these are regular bank staff to supporting continuity in care and safety.

From a safety perspective, the incident profile remains the same with no moderate harm incidents reported during this period. Despite caring for residents with complex needs there have been no incidents of pressure damage for several reporting periods which was highlighted as an area of excellence. All other incident reporting categories remain low with only no and low harm incidents reported.

Professional Judgement: At the previous review the planned temporary move to Hawthorne Court was imminent, however this is no longer occurring. Revised plans for the estates work at Granville Court were being progressed at the time of the review in May but re-location of the residents to alternative accommodation was not currently planned. The current residents continue to be cared for within the 3 bungalows and as such staffing levels reflect the needs of the residents and the environmental layout of the current estate.

At the last review it was noted that the staffing model was based on historical service model of 20 beds. The services now operates on a maximum occupancy model of 15 permanent and 2 respite beds but the budgeted establishment has not altered with this reduction. No significant changes to staffing levels or budgeted establishment. The service reported having 2x Band 2 Care worker vacancies at the time of this review which they were actively recruiting to, however following further analysis of staff contracted and in post this is equal to 50.43 WTE suggesting a vacancies rate of 12 WTE. This requires review by the senior managers.

Whilst minimum staffing levels and skill mix remain unchanged, staffing is temporarily increased for respite residents who require 1:1 support, and this is reflected in the fill rates. Also noted that staffing was temporarily increased (RNs) to support the move to Hawthorne Court. The service report that this has reduced to nearer 100% (April). During this period additional support was provided for nurse preceptorship.

Financial position: The financial position at the end of the financial year 25/26 was an overspend of £150K on staffing. The year end projection was £152K.

Summary: Granville Court supports a cohort of residents with consistently high and complex care needs, requiring enhanced levels of staffing with the appropriate skills mix to ensure safe, responsive, and person-centred care. The configuration of the service across three separate bungalows necessitates sufficient staffing to safely cover each area at all times, maintain line of sight, and respond promptly to risks, which inherently increases the baseline establishment required.

While residents' needs may appear relatively static, in practice they fluctuate, often requiring dynamic adjustments to staffing to manage changes in physical health, behavioural needs, and safeguarding risks. The staffing model therefore reflects not only clinical and physical care requirements, but also the need to provide meaningful social engagement, maintain relational security, and uphold a least restrictive, dignified care environment for vulnerable residents. Whilst the establishment is considered appropriate and justified in the context of the complexity, layout, and risk profile of the service, this must be balanced with a clear focus

on maintaining financial discipline, ensuring that staffing is continuously reviewed against acuity, dependency, and quality indicators to support both safe care delivery and effective resource management. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

Progress update on previous actions/recommendations from full Safer Staffing Establishment review in November 2025 :

Action	Update
The current staffing establishment requires a systematic review involving the senior leadership team as there is evidence to support the current establishment is based on historic occupancy levels of 20 residents. There is no evidence based safer staffing tool for use in this care setting on which to make a recommendation on the number of WTE staff required and consideration needs to be given to the configuration of the staffing across the 3 bungalows and whether there is scope to more effectively manage care within two bungalows. It is acknowledged that this is a nursing home and requires careful consideration and consultation and should be considered alongside the imminent temporary move to Hawthorne Court.	At the last review the temporary move to Hawthorne Court was imminent however this will no longer be happening, and additional options are currently being explored. They are currently operating on a model of 15 permanent residents and 2 respite beds. The review of the staffing model has therefore not progressed and will require further consideration when the future plans for Granville Court have been confirmed. Work is on-going with the local authority following a recent Quality Assurance review to determine if there is a staffing tool which can be used within a residential care home of this nature.

Actions from the interim review
Undertake a structured review of the current staffing establishment, ensuring alignment between resident acuity, safety requirements, and the demands of the service layout, while strengthening financial oversight and budgetary control. This should incorporate ongoing triangulation of dependency, quality, and workforce data to ensure staffing remains both clinically appropriate and financially sustainable. Explore in conjunction with the local authority if there is an evidential tool that can be used within a nursing home setting to support review of staffing establishment requirements.

Inspire – Orion ward	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RNs)	Sickness
Oct 25 - Mar 26	106%	100%	92%	105%	NA*	23.9	61%	9%	1%	7.0
April 25 – Sept 25	88%	95%	107%	114%	27.8	26.8	61%	12%	-2%	5.2%
Oct 24 - Mar 25	99%	100%	112%	116%	27.7	34.0	50%	19%	-4%	5.8%
April 24 - Sept 24	93%	92%	102%	105%	30.4	20.6	74%	31%	-8%	14.1%
Oct 23 - Mar 24	93%	96%	104%	113%	21.6	26.6	61%	30%	-5%	12.0%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	90%	93%	17	71	229
April 25 – Sept 25	85%	93%	23	5	275
Oct 24 - Mar 25	91%	82%	27	15	167
Apr 24 - Sept 24	85%	89%	27	9	69
Oct 23 - Mar 24	89%	86%	38	26	94

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (CAMHS) tool however the ward was not at full occupancy during the data collection period. Wards with low bed bases do not produce meaningful or accurate data on which to make recommendations for staffing establishment or R-CHPPD. The average patient numbers during this period was 3.5 therefore a *R-CHPPD has not been included in this report. Bed occupancy was reduced considerably due to extensive estates work.

The target CHPPD of 10.3 is consistently achieved over time, supported by low OBDs (61% average over the 6 months)

Nursing and HCA budgeted establishment remains unchanged at 31.0 (excluding Band 7s). The ward's budgeted establishment consists of 2.5x Band 7s, 4x Band 6s, 7x Band 5s, 2x Band 4, and 18x HCA Band 3s. In addition there is an Inspire MDT budget which consists of 1x Consultant Psychiatrist (currently filled by locum), 1x Specialist Registrar, 2.2x Band 8a (Service manager and matron), 1x pharmacy technician, 2x activity workers, 1x Clinical Psychology 8c, 1x Assistant Psychology Band 4, 1x OT, 1x APOT, 1.4x Dietician, 0.4x pharmacist, 1x social worker, however some of these staff support patients across the pathway, not just inpatient services. There were no nursing vacancies at the time of the review, and the team continue to be over-established by 2x HCAs. 2x RMNs are currently in preceptorship.

The minimum staffing levels are 6 on long days (2 RNs) and 5 on nights (2 RNs) which remains unchanged.

Quality and Safety Indicators: Average sickness has increased from 5.2% to 7.0% across October - March, with fluctuations during the period; while sickness remained below the Trust target between November and February, it rose again to 6.2% in March. Despite this, workforce stability remains strong, supported by a fully recruited nursing establishment. Whilst the team is over established by 2x HCAs, this provides additional flexibility to meet patient need. The team is also progressing innovative workforce models, including hybrid HCA/activity roles and development of the day service, which is expected to further strengthen service resilience.

Statutory and mandatory training compliance remains consistently high, averaging 93%, with BLS and ILS training above target. Clinical supervision has also remained strong at 90%. Staffing levels and skill mix remain unchanged, with consistent fill rates above 90%, no agency usage, and the lowest bank usage across inpatient wards (averaging 9%), indicating effective workforce management and continuity of care.

From a safety perspective, self-harm incidents have reduced from 275 to 229, demonstrating progress, although levels remain high and continue to be actively monitored through structured reviews. There were 3 self -harm incident reported as moderate harm for which After Action Review (x1) and Initial Incident Reviews (x2) were completed to support learning and improvement. Incidents of violence and aggression have increased (n=71), predominantly verbal and patient-to-patient, which correlates with a cohort of young people experiencing delayed discharge; this has been proactively managed, including transfer to more appropriate care environments where required, and safeguarding oversight. All incident of violence and aggression were reported as no harm/low harm. There has been a reduction in medication related incidents down to 17, all reported as no harm. Overall, there is good assurance of a responsive and learning-focused service, maintaining patient safety alongside continuous quality improvement

Professional Judgement: Orion ward is a 9 bedded general admissions ward supporting young people between the ages of 13 and 17 who require inpatient care for their mental health. The unit is a single storey, standalone unit. There are 6 female beds, and 3 male beds commissioned. 1 is a high dependency area and can be used for either male or female. The ward also supports young people with eating disorders and provide care for patients as day cases who require intensive meal support. This impacts staffing availability and is not captured as part of the acuity and dependency data via the MHOST tool.

Inspire Ward continues to operate with a stable and experienced workforce, with no new or emerging staffing challenges identified. Staff retention remains strong, supporting consistency of care and a well-established skill mix across the team.

The patient cohort continues to present with episodes of violence and aggression, including patient-to-patient verbal incidents. All such incidents are appropriately managed and reviewed through established safeguarding processes, ensuring oversight, learning and continuous improvement in maintaining a safe environment.

The ward environment has been further strengthened through improved visibility and oversight by the ward manager, alongside ongoing environmental developments. This includes the planned relocation of NG feeding facilities onto the ward, which is a positive step in enhancing safety, responsiveness and patient experience. In addition, development of the day service is underway, supporting therapeutic engagement and recovery-focused care.

The ward manager and senior leadership team report that the ward is safely staffed, with an appropriate skill mix and strong staff retention. A regular pool of bank staff is utilised to support any staffing gaps, all of whom are appropriately inducted and trained to meet the needs of the young people. The multidisciplinary team continues to play a key role in supporting patient care, with safety consistently prioritised in all staffing and operational decisions.

Financial position: The service reported a year-end overspend for 2025/26 of £106k against a forecast of £108–109k, demonstrating close financial control against projected pressures. For 2026/27, the financial position has started positively, with April showing a marginal overspend of approximately £6k for the ward area and a small underspend within the MDT budget, indicating early signs of improved financial grip. The MDT overspend is largely attributable to the use of locum consultant cover, while the ward overspend reflects previous reliance on bank staffing to maintain safe staffing levels in response to acuity and workforce gaps. Notably, there has been significant progress in reducing temporary staffing usage, with bank usage now reduced to approximately 9%, reflecting effective workforce management actions that are expected to support ongoing financial recovery

Summary: Inspire continues to care for a highly complex and vulnerable cohort of young people, where risks related to self-harm and violence and aggression require intensive, responsive staffing to maintain a safe and therapeutic environment. While workforce numbers may appear higher than comparator services, this reflects the level of acuity, the need to provide enhanced care, and a commitment to delivering care in the least restrictive way, minimising restrictive practices through increased relational security and staff presence. The team is also managing additional pressures associated with delayed discharges, which prolong length of stay and sustain higher dependency levels, alongside supporting the development of the day service model. Collectively, these factors necessitate a workforce that is flexible, resilient, and sufficiently resourced to safely meet patient need, and provide strong assurance that current staffing levels are appropriate, justified, and aligned to the complexity of care being delivered. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review and has informed the recommendations within this report to ensure sufficient capacity to safely meet patient need and observation requirements.

Progress update on previous actions/recommendations from full Safer Staffing Establishment review in November 2025 :

Action	Update
There is an impact on resource in terms of having to now support up to 4 patients on 1:1 before additional funding can be applied for through the provider collaborative. Consideration should therefore be given to ensuring sufficient staffing resources if acuity increases and/or bed occupancy increases. The team would like to consider the addition of extra support from a Nursing Associate on a weekend and bank holidays when there are less available MDT for support. There is evidence to support an increase in staffing establishment	The weekend staffing model has been strengthened and is now delivered through a combination of Band 5, Band 6, and Nurse Associate (NA) roles, providing a more sustainable approach to workforce resilience and sickness cover. The team is exploring opportunities to recruit additional Nurse Associates as HCA vacancies arise, further supporting both ward and day service provision. Since the last review, there has been a significant reduction in the number of young people requiring 1:1 care, reducing pressure on staffing

based on the MHOST recommendation which doesn't consider day case resources. Further discussion are required with the provider collaborative to ensure quality and patient safety is not compromised and sufficient support is available should enhanced levels of care be required	resources. Senior leaders continue to maintain close dialogue with the Provider Collaborative regarding the emerging NHS England Children and Young People's Intensive Mental Health Service specification. Ongoing discussions are taking place to explore how future service developments can be supported and aligned with workforce requirements.

Actions form the interim review
To gather at ward level, more evidential and detailed information and analysis on Supportive Therapeutic Observations of Care (ETOC) to enable a deeper understanding of patient acuity and care needs, factoring in impact and challenges relating to delayed discharges and transfers of care.

Primary Care and Community Services Division – interim reviews on 7th May 2026

Malton Fitzwilliam Ward	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RNs)	Sickness
Oct 25 - Mar 26	87%	124%	84%	97%	NA	7.0	88%	11%	9%	4.4%
April 25 – Sept 25	87%	117%	83%	99%	7.05	7.6	82%	16%	8%	7.6%
Oct 24 - Mar 25	84%	111%	86%	101%	NA	7.2	87%	19%	2%	4.8%
April 24 - Sept 24	95%	109%	87%	100%	NA	7.4	88%	17%	5%	6.1%
Oct 23 - Mar 24	95%	118%	86%	98%	NA	6.8	93%	18%	-6%	5.2%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Falls	Pressure ulcers in our care
Oct 25 - Mar 26	100%	98%	6	10	3
April 25 – Sept 25	100%	89%	7	12	4
Oct 24 - Mar 25	100%	88%	17	17	4
Apr 24 - Sept 24	100%	86%	15	21	5
Oct 23 - Mar 24	100%	89%	10	23	5

Acuity and Dependency Data and Staffing Establishment: Previously there had not been a validated tool on which to make recommendations on staffing establishment or CHPPD, however, the Trust obtained the license for the updated Safer Nursing Care Tool (SNCT) in 2024 and following a period of training the community wards conducted the first dependency data collection in October 2025, and this has been repeated in February 2026 for a period of 30 days.

There were 8 patients during the data collection period in February that were clinical ready for discharge meaning the patient cohort was more stable compared to October, however the acuity is anecdotally reported to have returned to a similar position in March.

The SNCT makes recommendations on the number of WTE Registered Nurse and HCAs based on levels of dependency during the data collection.

The budgeted establishment has been provided by the finance manager and confirmed to be a total of 28.31 WTE nursing and HCAs within the budget (excluding Band 7) the breakdown of which is as follows; 15.88 WTE RNs (4.28 Band 6 and 11.6x Band 5) and 12.43 HCAs (9.43x Band 2s and 3x Band 3s). The SNCT recommended 12.39 RNs in October and 11.68 in February. The SNCT recommended 15.14 HCAs in October 25 and 14.27 in February 26. In conclusion, early data analysis indicates that whilst total nursing and HCAs establishment is adequate, the ward may be over established on RNs and under established on HCAs. However, given a notable difference in dependency scoring during February it would be prudent to conduct further review and analysis prior to making any proposed changes.

In addition to R-WTE, the SNCT did recommend Care Hours Per Patient Day. For the first round in October the R-CHPPD was 6.94. Since this date NHSE have re-published the SNCT tool (Feb 2026) and removed the R-CHPPD functionality. As a result, we are no longer able to provide a R-CHPPD. Average actual CHPPD remains consist over time (7.0 average for Oct-Mar) and aligns with the R-CHPPD from October 2025 (7.05)

The latest data from model health system remains limited with the provider median in September being 7.88 CHPPD (latest data from model health system accessed 16-06-26).

There have been no changes to minimum staffing levels or shift patterns since the previous review, with the demand template reflecting 7 staff on early shifts (3 RNs), 5 on late shifts (3 RNs), and 4 on night shifts (2 RNs).

Quality and Safety Indicators: Average sickness has significantly reduced from 7.6% to 2.6% across October–March, bringing the ward below the Trust target of 5% and reflecting improved workforce stability.

Due to HCA vacancies, Registered Nurses have continued to backfill HCA shifts, which is reflected in higher RN night fill rates (averaging 124% over the period); however, this position is expected to improve following recent successful HCA recruitment and return from long-term sickness.

Despite these pressures, bank usage has reduced to an average of 11%, with no use of agency staff, supporting both continuity and cost control.

Strong supervision compliance has been maintained at 100%, alongside high overall statutory mandatory training compliance. Quality indicators demonstrate a generally stable and well-managed service.

While incidents such as falls, pressure ulcers, and transfers to acute care reflect the complexity and frailty of the patient cohort, these are appropriately monitored with clear governance and oversight in place. The ward continues to benefit from strong MDT support, including Occupational Therapy and Physiotherapy, contributing to effective, holistic patient care. There were 6 medication related incident and 10 falls, all reported as no harm/low harm. There were 3 superficial pressure ulcers acquired in our care, all reported as low harm and reviewed by the Pressure Ulcer Review and Learning group. There were no moderate or severe harm incidents reported during this reporting period.

Professional Judgement: Fitzwilliam Ward continues to provide safe and responsive care within a changing and increasingly complex patient cohort, particularly linked to physical health deterioration, cognitive impairment and complex mobility needs. While transfers back to acute care and delayed transfers remain a feature of the service, these are actively managed, with improvements noted in clinical oversight, triage, and discharge processes, supporting patient safety and flow.

Staff capability and confidence have been positively strengthened through targeted training, including OSCI-style approaches, enhancing early recognition and management of deterioration. Although environmental constraints, such as limited line of sight, reduced therapeutic space, and the challenges of a standalone

unit persist, these are well understood and effectively mitigated through proactive risk management. Overall, there is good assurance that the ward continues to adapt and respond safely to patient need within these constraints.

Financial position: The financial position at the end of the financial year 25/26 was an overspend of £85K, largely reflecting the HCA vacancies and sickness, and the utilisation of RN backfill. An improved position for 26/27 is contingent on maintaining a fully established HCA workforce and continuing to manage sickness absence under the Trust target threshold. It was noted that previously the ward had over recruited as part of the international nurse recruitment, however following natural attrition this has gone back to the budgeted position.

Summary: The dependency profile aligns with the current staffing establishment when considered alongside professional judgement, indicating that the workforce model remains appropriate for the acuity of the patient group and supports consistent delivery of care hours above the required CHPPD. Workforce stability is improving, with reduced sickness levels and successful recruitment to HCA vacancies, further strengthening the team.

Fitzwilliam Ward continues to manage staffing safely and effectively, with the majority of shifts filled and any shortfalls appropriately mitigated. There is a good level of assurance that the ward is safely staffed and that the current budgeted establishment supports minimum staffing requirements. While there is potential to review the skill mix, including consideration of converting RN vacancies to HCA roles, this should form part of a wider, data-informed approach aligned to SNCT findings, professional judgement, and quality and safety indicators. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

The recommendation from this review is to develop a budget recovery plan to prevent a significant overspend for 26/27 however the senior leadership team within the division may want to review the E-roster template to ensure shifts are accurately recorded, assess the impact once the recently recruited HCAs are in post and develop a budget recovery plan. Caution should be applied before making any adjustments to the current skill mix and any subsequent proposed changes will require further discussion and formal approval of a quality impact assessment.

Progress update on previous actions/recommendations from full Safer Staffing Establishment review in November 2025 :

Action	Update
There is limited availability of HCAs on the bank and RNs are being used to backfill HCA shortfalls. This requires further exploration with the division's senior leadership team and the flexible workforce/HR teams to explore additional solutions	Recent recruitment to the HCA vacancies and a reduction in sickness absence has led to reduction in bank use however continue to review bank availability and progress recruitment to increase the number of HCAs on the bank.

Action arising from the Interim review
Work with the e-rostering team to update the demand template to accurately reflect long day shifts, ensuring planned versus actual staffing is aligned and supports improved rostering efficiency – **action completed 16-06-26, effective as of next roster period 31st August.**
Continue to progress recruitment and retention initiatives to address HCA capacity, reducing the need for RN backfill and supporting a more balanced and sustainable skill mix – review impact of HCA establishment following a period of stability
Develop and implement a targeted budget recovery plan, focusing on reducing reliance on temporary staffing, optimising workforce deployment, and ensuring alignment between staffing establishment, acuity, and available resources.

Whitby Memorial Ward	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RNs)	Sickness
Oct 25 - Mar 26	84%	100%	74%	96%	NA	7.8	88%	11%	10%	10.1%
April 25 – Sept 25	82%	103%	71%	100%	6.94	8.2	86%	10%	12%	6.9%
Oct 24 - Mar 25	82%	100%	82%	99%	NA	8.4	87%	5%	7%	6.0%
April 24 - Sept 24	85%	103%	82%	100%	NA	9.8	88%	2%	-8%	6.9%
Oct 23 - Mar 24	91%	101%	83%	100%	NA	8.4	90%	2%	-6%	8.5%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Falls	Pressure ulcers in our care
Oct 25 - Mar 26	94%	90%	14	11	0
April 25 – Sept 25	91%	93%	13	15	1
Oct 24 - Mar 25	86%	91%	14	24	1
Apr 24 - Sept 24	82%	94%	9	11	2
Oct 23 - Mar 24	100%	89%	16	12	7

Acuity and Dependency Data and Staffing Establishment: Similar to Fitzwilliam ward, there had not been a validated tool on which to make recommendations on staffing establishment or CHPPD for Memorial Ward, however, having obtained the SNCT license this is the second round of dependency data collection which was completed in February 2026 for a period of 30 days.

SNCT dependency data from October 2025 and February 2026 indicates a stable and predominantly low-acuity patient profile, with the majority of patients within Level 0, Level 1a and Level 1b categories and no higher-dependency patients recorded, as would be expected for a community rehab ward. While there has been a slight shift towards increased Level 0 dependency, overall acuity remains consistent and within the capacity of the current staffing model when considered alongside professional judgement.

The SNCT makes recommendations on the number of WTE Registered Nurse and HCAs based on levels of dependency during the data collection . The budgeted establishment has been provided by the finance manager and confirmed to be a total of 29.38 WTE nursing and HCAs within the budget (excluding Band 7) the breakdown of which is as follows; 12.74 WTE RNs (2.0x Band 6 and 10.74x Band 5) and 16.64 HCAs (12.84x Band 2s and 3.8x Band 3s). The SNCT recommended 10.63 RNs in October and 10.60 in February. The SNCT recommended 13.0 HCAs in October 25 and 12.95 in February 26. The ward is also budgeted for by 2x WTE Band 8a ACPs.

In addition to R-WTE, the SNCT did recommend Care Hours Per Patient Day. For the first round in October the R-CHPPD was 6.94. Since this date NHSE have re-published the SNCT tool (Feb 2026) and removed the R-CHPPD functionality. As a result, we are no longer able to provide a R-CHPPD. Average CHPPD remains consist over time and exceeds the R-CHPPD from October 2025 (6.94).

The latest data from model health system remains limited with the provider median in September being 7.88 CHPPD (latest data from model health system accessed 16-06-26).

In conclusion, the SNCT data suggests that the current budgeted establishment is slightly above the recommended levels however, this should be interpreted with caution. As a standalone unit, Memorial ward requires a degree of staffing resilience, and given this is early-stage data collection, no immediate changes are

recommended. A sustained period of workforce stability, including recruitment and skill mix optimisation, is needed before any adjustments to establishment are considered.

Quality and Safety Indicators: Average sickness absence has remained above the Trust target over several reporting periods, with a six-month average of 10.1% (October–March). While some improvement was observed in January, with reductions in both short-term (4.8%) and long-term sickness (0%), this has not been sustained.

There have been no changes to minimum staffing levels or shift patterns. Review of Level 3 performance data demonstrates that planned staffing hours have remained consistent over time. However, the senior leadership team has undertaken a review of the demand template, introducing a combination of early, late and long-day shifts to optimise staff deployment and increase capacity through overlap, particularly during the busy early evening period. It is anticipated that HCA fill rates from June onwards will more accurately reflect the true staffing position following these adjustments.

Bank usage has remained relatively static, largely reflecting the impact of vacancies and sickness absence. Workforce gaps have reduced, with 1.8x WTE HCA and 1x RN posts now recruited to and due to commence in September, alongside planned recruitment activity in July for both bank and substantive roles. Progress continues in relation to the Band 2 to Band 3 HCA uplift, led by the service manager following EMT approval in February.

A peak in admissions was noted in October, following bed closures in September and the redirection of patients to Malton, with lower bed occupancy maintained due to ongoing risks associated with the Langdale fires.

Overall statutory and mandatory training compliance remains consistently above target, however access to ILS and BLS training has been identified as a challenge; actions are in place to address this, including increased training capacity and monthly on-site delivery from the resuscitation team. ILS and BLS training compliance is currently under review Trust wide to support recovery planning in areas below the 85% target.

Clinical supervision compliance has remained above the Trust target over the six-month period, although one nil return was noted in February.

From a safety perspective, the incident profile remains stable over the reporting period. There were 14 medication incidents, all classified as no or low harm. There has been a sustained and positive reduction in falls, with 11 incidents reported compared to 24 in the same period in 2024/25; of these, one resulted in moderate harm and was subject to a Patient Safety Incident Analysis, with all others recorded as no or low harm. This improvement reflects the impact of ongoing quality improvement work focused on falls prevention, including enhanced risk assessment, targeted interventions, and proactive multidisciplinary oversight.

Professional Judgement: Whitby Community Ward continues to provide safe, effective care within a stable patient cohort, with no significant new patient-related challenges identified. Readmissions to acute care continue to be observed and, while not reflective of an optimal position, are recognised as a consequence of pressures within the wider health and care system impacting patient flow and community capacity. Delayed discharges have increased to approximately 25%, largely driven by external factors relating to social care availability. The average length of stay remains approximately 23 days, reflecting the rehabilitation focus of the service.

There is an increased organisational focus on sickness management, alongside proactive support for staff returning to work. This is complemented by a strong emphasis on team engagement and culture, with a local staff survey undertaken in February and plans to repeat this in June following implementation of targeted improvements, including enhanced support structures and induction of new team members.

Recruitment continues to present challenges due to the rural locality; however, a planned recruitment drive in early July aims to strengthen workforce stability. As a standalone unit, maintaining resilience remains a key consideration, with ongoing work to enhance ACP cover across both the ward and UTC to improve sustainability and clinical leadership.

Environmental improvements are progressing, including the introduction of a new call bell system, which is already demonstrating improved response times and a positive impact on patient safety. Further estates work, including enhancements to bathroom access and installation of handrails, will support safer care delivery, particularly for a patient cohort at increased risk of falls.

Finance: The year-end position reflects a staffing underspend of £64K, achieved despite an overspend of £32K across HCA, nursing and ACP staffing, which was offset by a significant underspend in GP expenditure and a budgeted Band 5 physiotherapy role that remained vacant.

Summary: Whitby Community Ward has demonstrated positive progress since the last review, with early signs of improvements in workforce stability, staff support and service delivery. While sickness absence remains an ongoing challenge, there is a strong and proactive focus from ward and service leadership to address this and support staff wellbeing.

Leaders report a positive trajectory of improvement and remain committed to sustaining this momentum. Key areas of focus include the remodelling of ACP provision across the ward and UTC to enhance resilience, progression of Band 2 to Band 3 roles to strengthen the HCA workforce, review of Freedom to Speak Up themes to identify and address any recurrent concerns, and continued emphasis on improving sickness absence and ILS/BLS training compliance.

The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

Progress update on previous actions/recommendations from full Safer Staffing Establishment review in November 2025 :

Action	Update
The deployment of staff across the shifts requires urgent review. Whilst flexible working is supported by the senior leadership team this needs to be balanced with the needs of the service to ensure patient safety and quality are optimised and staff are not feeling additional workload pressure which may result in staff feeling fatigued	The service manager has confirmed that the demand template has been reviewed, and additional capacity has been built in through shift overlap to support the ward over the busy early evening period.

Action arising from the Interim review
Progress the remodelling of ACP provision across the ward and UTC to improve resilience, optimise skill mix, and ensure sustainable clinical cover
Advance the Band 2 to Band 3 progression programme to strengthen the HCA workforce, enhance capability, and support career development
Undertake a review of FTSU themes to identify recurring concerns, implement targeted actions, and strengthen the speaking-up culture
Continue targeted interventions to reduce sickness absence, focusing on staff wellbeing, early support, and proactive management
Maintain oversight and targeted action to improve ILS and BLS compliance, ensuring all staff are trained to required standards

Forensic Services Division – interim reviews on 8th May 2026

Derwent	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	98%	103%	83%	104%	7.1	14.4	83%	10%	-5%	3.8%
April 25 – Sept 25	94%	105%	83%	130%	11.9	17.6	76%	31%	-3%	2.1%
Oct 24 - Mar 25	100%	101%	95%	140%	9.0	19.6	73%	34%	-6%	9.5%
April 24 - Sept 24	82%	103%	83%	110%	7.2	16.7	73%	32%	0%	4.9%
Oct 23 - Mar 24	95%	97%	86%	119%	10.1	17.1	80%	42%	8%	4.2%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	99%	96%	4	19	1
April 25 – Sept 25	96%	96%	13	59	4
Oct 24 - Mar 25	90%	96%	13	77	5
Apr 24 - Sept 24	96%	95%	4	26	1
Oct 23 - Mar 24	94%	95%	1	38	5

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (medium secure) tool. At the point of data collection there was an average of 8.1 patients on the ward (10 bedded unit). Recommended WTE = 13.3 and a Recommended CHPPD of 7.1. In cases where the ward has a low number of occupied beds and the tool does not recommend enough staff to safely cover the ward the MHOST guidance recommends professional judgement should be used. It is acknowledged that the fluctuations in dependency levels and R-CHPPD reflects the variation in episodes of seclusion, LTS over time. It should also be noted that despite a lower dependency profile identified through MHOST, the ward consistently delivers higher care hours per patient day (CHPPD), reflecting a proactive staffing approach. This enhanced staff-to-patient ratio enables meaningful therapeutic engagement, supports relational care, and contributes to the prevention of escalation, thereby positively impacting patient experience and safety outcomes.

The target CHPPD is currently set at 10.3. The ward averaged a CHPPD of 14.4 over the six month period.

Nursing and HCA budgeted establishment is equal to 28.6 WTE (not including the Band 7). Within the wards budgeted establishment there are 2x Band 7s, 3x Band 6 nurses, 5x Band 5 nurses, 1x Band 4 Nurse Associates, 18.6x Band 3 Health Care Assistants (HCAs). An activity worker is included in the ward budget however there is a central budget for the Humber Centre for the wider MDT including psychology, occupational therapy, physiotherapy, social work and speech and language. There are currently no registered nurse or HCA vacancies.

No changes to operational or staffing structure/shift patterns since the last review, with 6 on long days (2 RNs) and 4 on nights (1xRN).

Quality and Safety Indicators: Despite some peaks in sickness absence, the average sickness rate was 3.8% for this reporting period reflecting a stable workforce and strong performance in staff health, wellbeing, and absence management.

Bank use was noted to be consistently high at the last review however this has significantly improved from 31% to 10%.

Clinical supervision remains consistently strong. Statutory and mandatory training compliance remains consistently above Trust targets, providing assurance of workforce capability including ILS and BLS which were above 85% at the end of March.

From a safety perspective, there were no cancelled Section 17 leave episodes during the period. A total of 4 medication-related incidents were reported, all classified as no or low harm. There were 19 incidents of violence and aggression, predominantly no or low harm, including two patient-on-patient physical incidents, which were appropriately managed with safeguarding reviews completed. One self-harm incident was recorded as low harm, and there were no moderate or higher harm incidents reported, providing overall assurance of safe care delivery.

Professional Judgement: Derwent ward is a 10 bedded medium secure unit based at the Humber Centre, therefore not a stand-alone unit.

There are currently no significant staffing concerns, with no ongoing HR issues and sickness levels consistently below the Trust target, supported by robust and effective attendance management processes. This provides a stable workforce foundation and supports continuity of care.

Patient acuity during the period has required the use of seclusion and long-term segregation (LTS), necessitating increased staffing levels across the 24-hour period to safely manage risk and maintain high-quality care. Enhanced staffing requirements have been recognised and supported, with EPOC approval in place where required, ensuring that patient safety and staff support remain prioritised during periods of increased need.

Environmental developments are underway, including improvements to the seclusion area on Darley Ward to enhance facilities for managing seclusion and LTS safely and therapeutically. While the ward remains consistently safely staffed, there have been occasions where staffing has been flexed to support pressures in other areas, which can impact Derwent's reported safer staffing position; however, this is actively managed, with backfill provided where possible by the ward manager and senior nursing leadership to maintain safety and service delivery

Financial position: The 2025/26 year-end position reflects a £12k overspend, representing a significant improvement compared to the previous year (2024/25), which reported a £65k overspend. Performance strengthened notably from November onwards, with the ward consistently delivering an underspend driven by a substantial reduction in bank usage. Although initially forecast to close the year at a £22k overspend, the final position demonstrates improved financial control and effective cost management.

Summary: The ward remains safely staffed, with a stable workforce and effective staff deployment supporting consistent delivery of high-quality care. This is evidenced by strong quality metrics, sustained CHPPD performance, low levels of patient safety incidents, and excellent performance in both sickness management and budgetary control, providing a high level of assurance regarding safe and efficient service delivery.

No changes or recommendations made following this interim review. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

Update on previous recommendations/actions: No actions or recommendations were made at the Safer Staffing Establishment Review in November 2025.

Ouse	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	108%	116%	97%	108%	4.9	8.0	85%	24%	-1%	13.3%
April 25 – Sept 25	83%	114%	94%	100%	5.0	8.1	81%	23%	-1%	14.3%
Oct 24 - Mar 25	83%	109%	99%	116%	5.6	8.6	85%	27%	-5%	11.8%
April 24 - Sept 24	84%	106%	102%	134%	4.5	11.7	68%	31%	9%	9.5%
Oct 23 - Mar 24	86%	92%	89%	108%	5.3	9.4	69%	15%	8%	12.4%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	97%	97%	3	24	1
April 25 – Sept 25	99%	96%	10	18	0
Oct 24 - Mar 25	93%	94%	8	9	0
Apr 24 - Sept 24	93%	94%	6	6	2
Oct 23 - Mar 24	88%	94%	3	4	0

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (medium secure) tool. At the point of data collection there was an average of 13.2 patients on the ward (14 bedded unit). Recommended WTE = 15.2 and a Recommended CHPPD of 4.9.

The target CHPPD is currently set at 6.3. The ward averaged a CHPPD of 8.0 over the six month period.

Nursing and HCA budgeted establishment is equal to 23.44 WTE (not including the Band 7). Within the wards budgeted establishment there are 2x Band 7s, 3x Band 6 nurses, 5x Band 5 nurses, 1x Band 4 (trainee)Nurse Associates, 14.4x Band 3 Health Care Assistants (HCAs). At the time of the review there was 1x Band 6, and 3.36x HCA vacancies which are being actively recruited to.

No changes to operational or staffing structure/shift patterns since the last review, with shift patterns remaining 5 on long days (2x RNs) and 3 on nights (1x RNs).

Quality and Safety Indicators: Sickness levels have decreased slightly from an average of 14.3% to 13.3% across October–March, with peaks in October, December and March however this had reduced to 10.1% by April, largely driven by 4 staff members on long-term sickness throughout the period. This is being appropriate managed in line with the Attendance Management Policy.

Fill rates exceed 100% on nights for RNs which considers the additional duty manager.

Clinical supervision remains consistently strong. Statutory and mandatory training compliance remains consistently above Trust targets, providing assurance of workforce capability however ILS and BLS have fluctuated throughout the period with the end of March position reported to be 80% for ILS and 83.3% for BLS, just under the target threshold of 85%. This was impacted by new starters, maternity leave, long term sickness, and cancelled BLS sessions.

From a safety perspective, the ward maintained a positive safety profile during the reporting period. There were no episodes of cancelled Section 17 leave, demonstrating the ward's ability to safely facilitate patient leave arrangements. Five medication-related incidents were reported, all classified as no or low harm.

A review of the violence and aggression data identified some discrepancies in the initial reporting figures. Following validation of Datix records, 24 incidents were confirmed under the violence and aggression category (including all sub-categories). Whilst this represents an increase from previous reporting periods, the rise is less significant than initially anticipated. All incidents related to verbal aggression and resulted in no harm. 1x self-harm incident was reported and classified as low harm. There were no moderate or higher harm incidents during the reporting period, providing overall assurance regarding the safety of care delivery and management of patient risk.

Professional Judgement: Ouse Ward is a 14-bedded medium secure unit based within the Humber Centre and therefore benefits from being part of a wider inpatient service rather than operating as a standalone unit.

Overall, there are no significant staffing concerns; however, supporting patients on escorted leave can create additional workforce pressures due to the level of staff resource required. Sickness levels remain above the Trust target, primarily due to long-term absence, although this is being actively managed through established attendance management processes.

Patient acuity remains fairly stable, however there were periods of increased acuity with the use of both seclusion and long-term segregation (LTS) during the reporting period. The ward has also been managing risks associated with patients accessing others' bedrooms, which has been identified as a potential safeguarding concern. This has required increased zonal observations and additional staffing oversight to maintain safety while awaiting environmental improvements. Estates work to install a Magna lock has been escalated and is progressing, which will support longer-term risk reduction. Positive work has been undertaken to improve patient flow between Derwent and Ouse, supporting more effective bed management and patient placement.

While the ward is consistently safely staffed, staff are occasionally redeployed to support pressures elsewhere within the Humber Centre. These situations are actively managed, with ward leadership often providing additional clinical support to ensure safe staffing levels and continuity of care are maintained

Financial position: The forecast outturn for 2025/26 was a £33k overspend, with the year-end position closing slightly better than anticipated at £30k overspend. This represents a further improvement on the previous financial year, which ended with a £39k overspend, demonstrating continued progress in financial management and cost control. Further improvement is anticipated during 2026/27 as current vacancies are successfully filled, reducing reliance on temporary staffing and enabling a further reduction in bank expenditure, while maintaining safe staffing levels and quality of care.

Summary: Ouse Ward remains safely staffed and continues to deliver a stable service, with CHPPD above target and a low-harm incident profile. Despite ongoing challenges related to sickness, vacancies, and periods of increased patient acuity, effective staffing deployment and provide assurance that patient safety and care quality are being maintained. Financial performance has improved compared to the previous year, and further gains are anticipated as recruitment progresses and reliance on temporary staffing reduces. Overall, there is a good level of assurance that current staffing arrangements are safe and effective. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

Progress update on previous actions/recommendations from full Safer Staffing Establishment review in November 2025 :

Action	Update
Exploration required to determine what % of AHP central budget is being used to support the wards at the Humber Centre	Update not provided. Update via the monthly safer staffing meeting.
Whilst it is acknowledged that staffing levels have remained safe through this period and staffing has been managed flexibly to meet patient needs, there have been occasion when the have not been 2 RNs on shift and this need to be kept under review	This requires further exploration as the team report that they provide cover on occasion to other wards, however this is not reflected in this periods fill rates which are in a stronger position.

Action arising from Interim review
Escalate the fitting of the magna lock to the Head of Estates (action completed 02/07/26)
Undertake a review of occasions where staffing is redeployed from the ward to support pressures in other units, including the frequency of redeployment, destination wards, duration of cover, and any impact on the ward's staffing resilience, patient safety, and quality of care.
Exploration required to determine what % of AHP central budget is being used to support the wards at the Humber Centre

Pine View	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	90%	75%	99%	102%	5.3	9.1	90%	11%	16%	4.8%
April 25 – Sept 25	86%	82%	85%	95%	5.4	10.5	70%	18%	22%	8.2%
Oct 24 - Mar 25	93%	88%	78%	94%	5.3	10.1	68%	34%	6%	12.7%
April 24 - Sept 24	95%	85%	94%	95%	5.2	10.4	73%	28%	-2%	11.4%
Oct 23 - Mar 24	95%	59%	91%	93%	6.1	9.1	82%	27%	12%	8.4%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	99%	99%	19	96	1
April 25 – Sept 25	96%	98%	8	7	0
Oct 24 - Mar 25	99%	93%	5	6	0
Apr 24 - Sept 24	96%	95%	8	6	0
Oct 23 - Mar 24	99%	97%	14	2	1

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (low secure) tool. At the point of data collection there was an average of 16.1 patients on the ward (20 bedded unit). Recommended WTE = 20.1 and a Recommended CHPPD of 5.3.

The target CHPPD is currently set at 6.3. The ward averaged a CHPPD of 9.1 over the six month period.

Nursing and HCA budgeted establishment is equal to 31.6 WTE (not including the Band 7s). Within the wards budgeted establishment there are 2x Band 7s, 3x Band 6 nurses, 8x Band 5 nurses, 1x Band 4 Nurse Associates (currently 1xTNA), 19.6x Band 3 Health Care Assistants (HCAs). 1x Band 6 due to commence a 6 month secondment, which will be backfilled. Slightly over established on HCAs with 20.03 in post. There are currently 7 registered nurse Band 5s in post with one due to commence in September at which point the ward will be fully established.

No changes to operational or staffing structure/shift patterns since the last review, with 6 on long days (2 RNs) and 5 on nights (2xRN). Pine view has 2 RNs on a night shift as it is a standalone unit, with 1 RN on each ward at the Humber Centre plus duty nurse = 7 on nights in total. The 2nd RN does on occasion get moved to cover short falls at the Humber Centre which reflects in the fill rates. In addition, there were occasion when RN numbers were reduced due to vacancies and on occasion HCAs were utilised to support temporary staffing shortages. All shifts were covered by at least 1 RN.

Quality and Safety Indicators: Sickness levels have decreased from an average of 8.2% to 4.8% across October–March, which has reduced to below trust target by the end of this reporting period. Improved staffing numbers, and lower sickness rates have driven an improvement on the bank spend which seen a further reduction during this reporting period.

Clinical supervision compliance reduced during the period due to high acuity and ward activity, though a structured tiered approach remains in place and recovery is expected. Statutory and mandatory training compliance remains consistently above Trust targets, providing assurance of workforce capability however ILS did drop in March to 54% (4 staff members who have now completed).

From a patient safety perspective, there has been an increase in incidents relating to security challenges, reflecting changes in patient acuity and dynamics; one incident required an Initial Incident Review, providing assurance of appropriate governance and learning. There was one cancelled Section 17 leave episode during the period. A total of 19 medication-related incidents were reported, all classified as no or low harm.

There has also been an increase in violence and aggression incidents, aligned to a higher and more complex admission profile over the past 6–9 months, with bed occupancy averaging around 90%. While this has led to periods of instability, all incidents were reported as no or low harm, with one patient-on-patient incident appropriately managed with safeguarding oversight. The increase in reporting also reflects improved staff confidence and a positive reporting culture, addressing previous underreporting. One incident of self-harm was recorded, with no harm to the patient. There were no moderate or higher harm incidents reported during the period, providing overall assurance of safe care delivery.

Professional Judgement: Pine View (including Southwest Lodge) is a 20 bedded low secure unit (16 on Pine View and 4 on Southwest Lodge). Whilst on the site at Willerby Hill, it is separate to the Humber Centre. Pine View is a standalone unit requiring DMI team. Emergency response or additional support is provided from the Humber Centre if required.

Professional judgement indicates that the ward continues to operate safely within a context of sustained high occupancy and increasing patient complexity. Bed occupancy has remained consistently close to 100%, requiring careful coordination of patient flow and contributing to heightened acuity, which is effectively managed through proactive staffing allocation and close clinical oversight.

The patient cohort has presented with increased behavioural and security-related challenges, including a period of heightened risk associated with an individual requiring enhanced monitoring. The team has responded positively, strengthening relational, procedural, and physical security through close collaboration with security services, additional staff training, and reflective practice. This has supported staff confidence and resilience, ensuring a safe and therapeutic environment is maintained.

Workforce stability has improved following successful recruitment to Band 5 vacancies; however, occasional redeployment of staff to support wider service pressures introduces operational challenges, particularly given the stand-alone nature of the unit. These are mitigated through active leadership involvement and flexible staffing approaches, although this places additional demand on senior staff capacity and requires ongoing oversight.

Training compliance, supervision, and clinical competence remain strong, underpinning safe practice and effective response to patient needs. The environment continues to support safe care delivery, with no significant changes since the previous review.

Overall, there is good assurance that the ward is safely staffed and able to meet the needs of a complex patient group. Continued monitoring of staffing resilience, particularly in relation to cross-ward redeployment and sustained high occupancy, will be important to maintain this position

Financial position: The ward was forecast to deliver a £15k overspend for 2025/26, with the year-end position slightly higher at £20k, broadly in line with the previous year's financial outturn. However, the opening position for 2026/27 shows a positive trajectory, with an underspend on pay in the early part of the financial year, indicating improving financial control and a more favourable outlook.

Summary: Pine View continues to demonstrate a strong and improving position, with CHPPD consistently above target, reflecting a proactive staffing model that supports patient safety, therapeutic engagement, and relational security. Workforce stability is improving, with staffing nearing full establishment, reduced sickness levels now below target, and a continued reduction in bank spend.

While there has been an increase in reported violence and aggression incidents, analysis indicates this is linked to changes in patient acuity and improved staff confidence in reporting rather than increased harm, with all incidents remaining low or no harm. Overall, there is good assurance that Pine View is safely staffed and able to meet the needs of a complex and dynamic patient cohort; however, maintaining appropriate staffing levels remains essential to safely manage patient dynamics, risk, and support therapeutic interventions and leave.

No changes or recommendations made following this interim review. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

Progress update on previous actions/recommendations from the Safer Staffing Establishment review in November 2025 :

Action	Update
The ward managers need to monitor staff being able to take breaks and review the frequency with which this is occurring	At the last review, concerns were raised regarding staff not consistently accessing their breaks. Ward managers implemented enhanced monitoring and strengthened expectations around break allocation. Compliance has improved significantly, with staff now regularly taking their breaks as planned. This issue is considered resolved, with ongoing monitoring in place to ensure sustained adherence

Swale	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	107%	113%	96%	97%	5.3	11.0	76%	18%	11%	5.4%
April 25 – Sept 25	89%	102%	101%	108%	5.5	10.4	87%	27%	24%	2.5%
Oct 24 - Mar 25	92%	105%	92%	96%	5.3	9.2	88%	26%	6%	5.7%
April 24 - Sept 24	84%	110%	95%	93%	5.5	10.1	80%	24%	2%	5.4%
Oct 23 - Mar 24	71%	83%	90%	92%	5.1	10.8	72%	34%	31%	8.0%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	99%	99%	10	14	26
April 25 – Sept 25	95%	99%	16	36	15
Oct 24 - Mar 25	99%	99%	11	32	5
Apr 24 - Sept 24	95%	94%	9	4	2
Oct 23 - Mar 24	90%	92%	12	8	1

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (medium secure) tool. At the point of data collection there was an average of 11 patients on the ward (15 bedded unit). Recommended WTE = 13.8 and a Recommended CHPPD of 5.3. Dependency of patient remained fairly consistent during the data collection period with all patients in either level 1 or level 2 however it should be noted Swale is a dedicated Personality Disorder Unit for which there is not a specific MHOST tool. There is significant investment in managing relational risk through staff presence, however this is not reflected as formal 1:1 engagement and therefore not accounted for in the dependency data potentially resulting in a lower R-CHPPD. Where the tool recommends insufficient staff to safely manage the unit, professional judgment should be used.

Where the tool is recommending WTE that are not sufficient to safely staff a ward, professional judgment should be applied.

The target CHPPD is currently set at 10.3. The ward averaged a CHPPD of 11.0 over the six month period.

Nursing and HCA budgeted establishment is equal to 28.82 WTE (not including the Band 7s)

Within the wards budgeted establishment there are 2x Band 7s, 3x Band 6 nurses, 6x Band 5 nurses, 1x Band 4 Nurse Associates, 18.82x Band 3 Health Care Assistants (HCAs). The wider multi-disciplinary team (MDT) includes 1x Activity Co-ordinators and access to the wider MDT via the central budget.

Recently recruited a Band 3 HCA, so at the time of the review the ward had minimal vacancies equivalent to 0.83 WTE

No changes to operational or staffing structure/shift patterns since the last review, with 6 on long days (2 RNs) and 4 on nights (1xRN).

Quality and Safety Indicators: Sickness levels have increased from an average of 2.5% to 5.4% across October to March peaking in December and January, which was impacted by 2x staff on long term sickness however this has improved and the sickness at the end of this reporting period was 4.3%

Clinical supervision remains consistently strong averaging 99%. Statutory and mandatory training compliance remains consistently above Trust targets. ILS dropped below target across the October to December period due to new starters however this position has recovered with ILS compliance at 100%.

Bank usage has shown significant improvement overall; however, during the reporting period there were temporary increases driven by workforce vacancies (now recruited) and additional staffing pressures associated with patients requiring Supportive Therapeutic Observations of Care (ETOC). Further pressures were related to backfill requirements for staff development, including a Band 2 undertaking an apprenticeship and a Band 4 completing RN training. Additional staffing demand has also been required to safely support prison transfers, healthcare and dental appointments, and to facilitate Section 17 leave, all of which have contributed to short-term increases in bank utilisation.

From a patient safety perspective, the overall incident profile remains stable and low harm. A total of 10 medication-related incidents were reported, all classified as no or low harm. There were 14 incidents of violence and aggression, all resulting in no or low harm, including a small number of patient-on-patient physical incidents which were appropriately managed with safeguarding reviews.

There were 26 incidents of self-harm, primarily associated with three newly admitted patients, with a notable and sustained reduction to zero incidents by March, demonstrating effective management and therapeutic intervention. There were no moderate or higher harm incidents reported during the period, providing strong assurance of safe care delivery.

Professional Judgement: Swale is a 15 bedded medium secure forensic inpatient unit within the Humber Centre providing specialist care for patient with complex mental health/ personality disorders.

The ward is managing a range of staffing pressures, including a small number of vacancies, periods of both short- and long-term sickness, and individual staff members temporarily unable to undertake full patient contact duties. Additional demands are created through workforce development initiatives, including apprenticeships, preceptorship, and RN top-up training, which require protected study time and backfill. Increased staffing is also required to safely facilitate Section 17 leave, including supporting family visits in the community. These pressures are actively managed through the use of bank staff and flexible rostering to maintain safe care delivery.

Patient need remains complex, with staff required to manage dynamic and, at times, challenging group interactions within the ward environment. The patient cohort includes individuals with personality disorder, where emotional dysregulation and fluctuating presentation require a highly responsive and skilled approach to maintain safety and therapeutic engagement. Supportive Therapeutic Observations of Care (ETOC) have been required for some patients, including those with challenging behaviours and those transitioning back to custody, contributing to increased demand on staffing.

Environmental changes have been positive, with improvements including a new air conditioning system and redecoration of clinical and patient areas, enhancing the overall care environment. Despite the ongoing pressures associated with patient acuity and workforce demand, the ward remains safely staffed. Staff deployment is actively managed throughout the day, with clear escalation processes in place, and a strong emphasis on staff wellbeing through supervision, debriefs, and support systems. Overall, there is good assurance that patient safety is maintained and care is delivered effectively within current resources

Financial position: The forecast for 2025/26 was an overspend of £26k, with the year-end position closing slightly better at £24k overspend, representing a significant improvement compared to 2024/25, which reported an £84k overspend. This positive trajectory has been driven primarily by a sustained reduction in bank usage. Early analysis and projections for 2026/27 remain encouraging, with further improvements anticipated as financial controls and workforce efficiencies continue to embed.

Summary: Swale Ward demonstrates a strong overall position, with consistent quality and safety metrics, high clinical supervision compliance, and CHPPD delivery above target, reflecting a proactive and responsive staffing model. Financial performance has improved significantly compared to the previous year, driven by reduced bank usage, while early projections indicate continued positive progress.

However, the ward supports a highly complex patient cohort where relational risk, therapeutic engagement, leave facilitation, and management of dynamic behaviours require sustained staffing levels above those indicated by dependency tools alone. Maintaining this level of staffing is essential to ensure patient safety, manage risk effectively, and deliver meaningful therapeutic interventions, and should remain a key consideration alongside ongoing financial oversight.

No changes or recommendations made following this interim review. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review, with no additional staffing requirements or establishment changes identified.

Update on previous recommendations/actions: No actions or recommendations were made at the Safer Staffing Establishment Review in November 2025

Ullswater	Fill rates RN days	Fill rates RN nights	Overall Fill rates days	Overall Fill rates nights	Recommended CHPPD	Average CHPPD	Occupied bed days	Bank and Agency	Vacancies (RN)	Sickness
Oct 25 - Mar 26	97%	110%	115%	132%	14.9	25.5	52%	24%	-16%	8.9%
April 25 – Sept 25	103%	107%	139%	162%	17.4	20.2	78%	36%	-5%	7.6%
Oct 24 - Mar 25	94%	114%	127%	131%	14.7	15.1	90%	36%	-9%	13.6%
April 24 - Sept 24	91%	111%	132%	138%	13.5	17.2	69%	41%	-1%	13.5%
Oct 23 - Mar 24	99%	97%	119%	143%	12.9	17.1	67%	33%	-1%	7.1%

	Clinical Supervision	Stat/Mand Training	Medication incidents	Violence and Aggression incidents	Self-harm incidents
Oct 25 - Mar 26	92%	94%	8	130	14
April 25 – Sept 25	91%	97%	8	112	4
Oct 24 - Mar 25	93%	94%	13	95	8
Apr 24 - Sept 24	95%	89%	7	84	22
Oct 23 - Mar 24	88%	96%	2	82	6

Acuity and Dependency Data and Staffing Establishment: Data collection commenced on 30th March and was completed for 28 days using the MHOST (medium secure) tool. At the point of data collection there were 5 patients on the ward (10 bedded unit). 1 patient remained on a 2:1 during the full data collection period. Recommended WTE = 20.4 and a Recommended CHPPD of 14.9. In cases where the ward has a low number of occupied beds and the tool does not recommend enough staff to safely cover the ward the MHOST guidance recommends professional judgement should be used. Additional limitations include the specialist nature of the patient cohort for which there is not a specialist MHOST medium secure/learning disabilities tool.

The target CHPPD is currently set at 10.3. The ward averaged a CHPPD of 25.5 over the six month period, driven by a lower bed occupancy during this 6 month period. This followed a number of discharges resulting following which new admissions/referrals have been minimal.

Nursing and HCA budgeted establishment is equal to 26.13 WTE (not including the Band 7s). Within the wards budgeted establishment there are 2x Band 7s, 3x Band 6 nurses, 5x Band 5 nurses, 1x Band 4 Nurse Associates, 17.13x Band 3 Health Care Assistants (HCAs). At the time of the review, they were 2 Band 5 over established and 3.6 WTE vacancies for HCAs due to 4 HCAs leaving since January (various reasons).

No changes to operational or staffing structure/shift patterns since the last review. The minimum staffing levels are 5 staff on long days (2 RNs) and 4 on nights (1xRN), however this is temporality increased if the is an increase in patients on Supportive Therapeutic Observations of Care (ETOC).

Quality and Safety Indicators: Sickness levels have increased from an average of 7.6% to 8.9% across October–March, peaking in January at 11.8%**.** As a result, the requirement for temporary staffing via the bank has remained high, although it should be noted that despite these challenges bank use has reduced from 36% to 24% in this 6 month period. There are a proportion of staff actively being supported due to episodes of sickness absence. 2x episodes of long term sickness, both staff has resumed work.

Clinical supervision and overall statutory and mandatory training compliance remains consistently high however ILS has been below 85% from October through to February, recovering to 90% in March.

Average fill rates are strong, with periods of additional staffing needed for patients in 1:1.

From a patient safety perspective, the ward demonstrates a positive reporting culture, with an increase in incident reporting reflecting improved oversight and reporting practices. There were no cancelled Section 17 leave episodes and eight medication-related incidents, all classified as no harm. A total of 130 violence and aggression incidents were reported, all resulting in no or low harm. A significant proportion were associated with one particularly complex patient presenting with high levels of verbal aggression and racial abuse, with three patient-on-patient incidents appropriately reviewed through safeguarding processes.

Fourteen self-harm incidents were reported during the period. Overall, the incident profile remains low harm, providing assurance that risks are being identified, reported, and managed effectively.

Professional Judgement: Ullswater is a 10 bedded specialist forensic learning disability unit situated within the Humber Centre.

Ullswater Ward continues to operate within a highly complex clinical environment, supporting a small but significantly high-acuity patient cohort with learning disabilities, co-morbid mental health conditions, neurodivergence, and physical health needs. Patient presentations are often characterised by emotional dysregulation, trauma-related behaviours, and communication challenges, requiring consistent, skilled, and relational approaches from staff. The ward manages multiple patients requiring Supportive Therapeutic Observations of Care (ETOC), including 1:1 and 2:1 support and periods of seclusion or long-term segregation, which places sustained demand on staffing levels and skill mix.

Workforce pressures during the period have included fluctuations in sickness, workforce turnover, and a small number of staff requiring temporary adjustments to duties. These challenges were more pronounced during periods of heightened acuity and patient-related incidents, which impacted staff wellbeing. However, there has been a clear improvement in workforce stability more recently, with sickness levels reducing and staff returning to work. Compliance with mandatory training, including ILS, has also recovered following earlier capacity challenges, and overall staff capability remains strong.

The ward’s staffing model reflects the intensity of need, with a planned baseline of six staff on day shifts to safely manage high levels of Supportive Therapeutic Observations of Care (ETOC) and ensure safe delivery of care. At times, short-term absences can place pressure on the team, requiring staff to manage multiple

Supportive Therapeutic Observations of Care (ETOC) alongside routine clinical tasks, which reinforces the importance of maintaining establishment levels. When staffed as planned, the ward is able to safely meet patient needs, manage risk effectively, and provide consistent therapeutic engagement.

Environmental factors remain unchanged and continue to support care delivery; however, the primary drivers of risk are related to patient acuity and relational dynamics rather than physical environment.

Overall, there is assurance that Ullswater Ward is safely staffed when operating at its planned establishment, with strong clinical oversight, effective risk management, and a resilient team. Continued focus on workforce stability, staff wellbeing, and maintaining appropriate staffing levels is essential to sustain this position and support the safe management of a highly complex patient group

Financial position: The ward continues to experience financial pressures. However, the 2025/26 projected overspend was £124k with an actual year end position of £117K demonstrating better-than-expected financial control and a positive shift compared to 2024/25.

This improvement has been supported by careful financial management and a continued reduction in bank usage, with further gains anticipated if this trajectory is sustained. However, ongoing pressures remain, particularly where additional staffing has been required to maintain safety and EPoC approvals have not been secured, impacting the overall financial position.

Summary: Ullswater Ward continues to deliver safe care within a highly specialised and complex environment, supporting a small but high-acuity patient cohort. While occupancy remains low, this does not reflect the intensity of need, with sustained Supportive Therapeutic Observations of Care (ETOC) and relational risk driving CHPPD significantly above target and necessitating higher staffing levels. Workforce pressures have been present but are improving, with strong training compliance and supervision providing assurance of staff capability. Quality and safety indicators remain stable, with no high-harm incidents reported, and increased incident reporting reflecting patient complexity and a positive safety culture. Financial pressures remain due to the requirement for enhanced staffing; however, the year-end position improved against forecast, supported by better control of bank usage. Overall, there is good assurance that the ward is safely staffed, with ongoing focus required on workforce stability and financial sustainability. The impact of Supportive Therapeutic Observations of Care (ETOC) has been considered as part of this Safer Staffing Review and has informed the recommendations within this report to ensure sufficient capacity to safely meet patient need and observation requirements

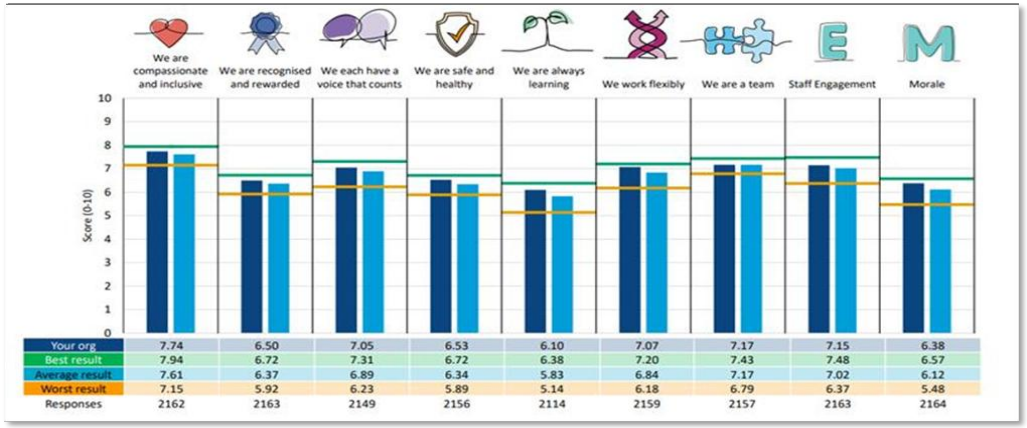
Progress update on previous actions/recommendations from the Safer Staffing Establishment review in November 2025 :

Action	Update
No changes to CHPPD or BE recommended however this needs to be kept under review	Following a rise in R-CHPPD at the last review, this review has produced results similar to previous data collection rounds although caution is applied due to reduced bed occupancy, however it does affirm that dependency over time is relevantly consistent.

Action arising from Interim review
Strengthen proactive staff wellbeing support by increasing engagement with the wellbeing team, ensuring early intervention, and embedding supportive approaches to reduce sickness absence

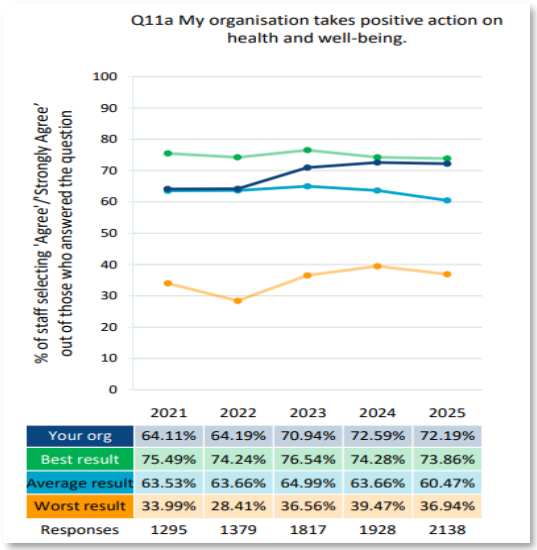
Accurately record Supportive Therapeutic Observations of Care (EToC) to develop a clear, evidence-based understanding of its impact on patient acuity and staffing requirements, and enhanced packages of care (EPoC) to support financial sustainability
Implement structured reflective debrief session/s following the discharge of a complex patients, to support staff wellbeing, learning, and resilience
Ensure that any proposed changes to admission criteria and increases in patient numbers are fully assessed in relation to staffing requirements, CHPPD, and risk, with a clear impact assessment to maintain safety and care quality

Staff survey results 2025:

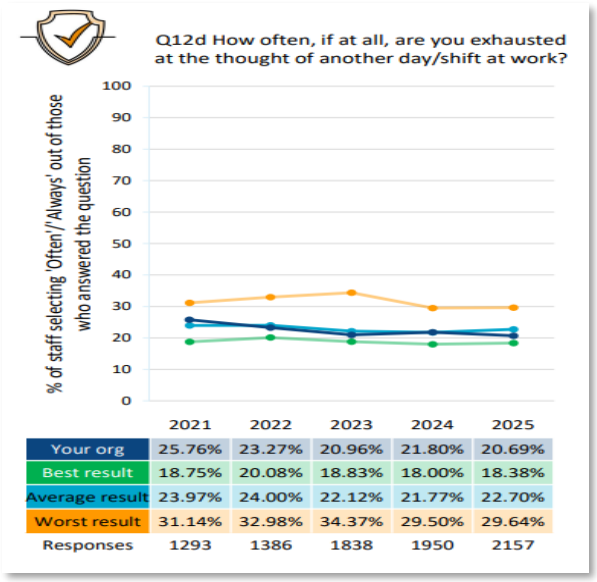


Your org	7.74	6.50	7.05	6.53	6.10	7.07	7.17	7.15	6.38
Best result	7.94	6.72	7.31	6.72	6.38	7.20	7.43	7.48	6.57
Average result	7.61	6.37	6.89	6.34	5.83	6.84	7.17	7.02	6.12
Worst result	7.15	5.92	6.23	5.89	5.14	6.18	6.79	6.37	5.48
Responses	2162	2163	2149	2156	2114	2159	2157	2163	2164

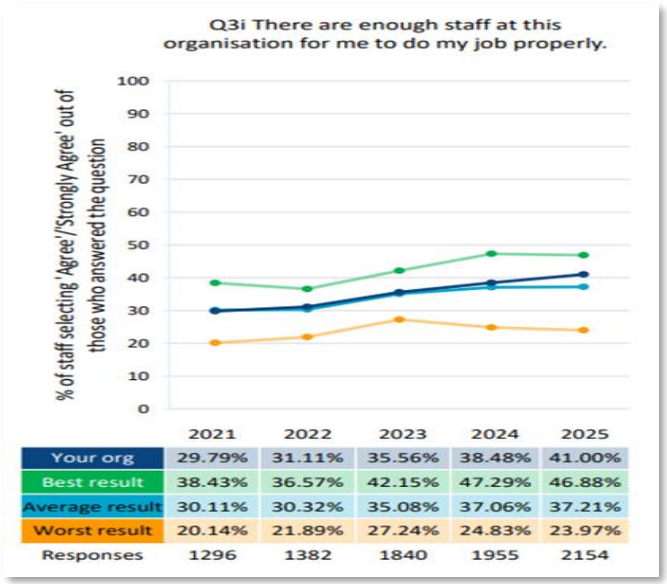
The 2025 National Staff Survey provides continued positive assurance regarding workforce experience across the Trust, with the highest-ever response rate (64%) and performance above the national average across all seven People Promise themes, and Staff Engagement, and Morale. Staff continue to report strong commitment to patient care, compassionate culture, inclusion, and teamworking. While overall results remain strong, the survey identified opportunities to further improve staff wellbeing, appraisal quality, confidence in speaking up, staff sense of feeling valued, health and wellbeing. These themes have informed Trust-wide improvement priorities and will continue to be monitored through established workforce and governance arrangements.



	2021	2022	2023	2024	2025
Your org	64.11%	64.19%	70.94%	72.59%	72.19%
Best result	75.49%	74.24%	76.54%	74.28%	73.86%
Average result	63.53%	63.66%	64.99%	63.66%	60.47%
Worst result	33.99%	28.41%	36.56%	39.47%	36.94%
Responses	1295	1379	1817	1928	2138



	2021	2022	2023	2024	2025
Your org	25.76%	23.27%	20.96%	21.80%	20.69%
Best result	18.75%	20.08%	18.83%	18.00%	18.38%
Average result	23.97%	24.00%	22.12%	21.77%	22.70%
Worst result	31.14%	32.98%	34.37%	29.50%	29.64%
Responses	1293	1386	1838	1950	2157



	2021	2022	2023	2024	2025
Your org	29.79%	31.11%	35.56%	38.48%	41.00%
Best result	38.43%	36.57%	42.15%	47.29%	46.88%
Average result	30.11%	30.32%	35.08%	37.06%	37.21%
Worst result	20.14%	21.89%	27.24%	24.83%	23.97%
Responses	1296	1382	1840	1955	2154

Summary of Assurance, Updates and Next steps:

Reporting period	Low assurance	Adequate assurance	Good assurance
Oct 2025- March 2026	0	0	18
Apr 2025 – Sept 2025	0	1 (Whitby inpatients)	17
Oct 2024- March 2025	0	0	19
Apr 2024 -Sept 2024	0	0	19
Oct 2023 - March 2024	0	0	19

Using the triangulated approach outlined in Developing Workforce Safeguards and the National Quality Board's guidance on safer staffing and having conducted safer staffing reviews on all 18 inpatient units we can conclude that there is sufficient assurance that our wards are safely staffed. All wards provided good assurance.

A number of service level recommendations have been made for actioning by the divisional senior leads, and these are outlined in the main body of the report and will be monitored via the monthly Safer Staffing meetings.

Only one unit had more than two red flags when reviewing the quality metrics six month averages. Townend Court had three red flags (RN fill rates, Overall Fill rates, and sickness). As noted in the report work has been completed with the E-roster team and fill rates will be more accurately recorded moving forward. This has already had a positive impact with registered nurse fill rates in May reported as 108% on days and 100% on nights.

Wards continue to utilise staffing flexibly to respond to changes in short term acuity. There has been some significant improvements in bank/agency use and minimal vacancies noted. Supervision and training compliance remains high.

High sickness rates have continued to be a challenge however there has been improvement in a number of areas with Pine View, Derwent, and Malton averaging below the 5% threshold for the 6-month period October to March.

Incident reporting continues to demonstrate a positive reporting culture with a high proportion of no harm and low harm incidents

Updates:

We have established a monthly Safer Staffing meeting under a formal Terms of Reference, ensuring clear reporting and escalation through the Quality and Patient Safety Group (QPAS).

In February and March, we participated in the national review of the MHOST tool being conducted by NHS England. Data was collected on two of our Mental Health inpatient wards, Maister Lodge and Mill View Court.

Progress report presented to EMT on Supportive Therapeutic Observations of Care (EToC). Significant progress has been made in respect of enhancing the governance and oversight of Supportive Therapeutic Observations of Care (EToC) as part of safer staffing. The maturity matrix shows improvements across most areas. Feedback from NHSE at the visit in May was positive regarding the robustness of arrangements for ETOC and Safer Staffing.

Work continues regarding the review of skill mix at Malton and Whitby with the Health Care Assistants Band 2 being uplifted to Band 3 as aligned to the clinical skills competency framework and role requirements.

Next steps:

Development and implementation of a divisional safer staffing dashboard, including monitoring of rule breaks and key workforce metrics, with oversight through the monthly Safer Staffing Group.

Pilot of Red Flag Shift reporting within the Mental Health Division to strengthen visibility of staffing pressures, operational risks, and the impact on care delivery.

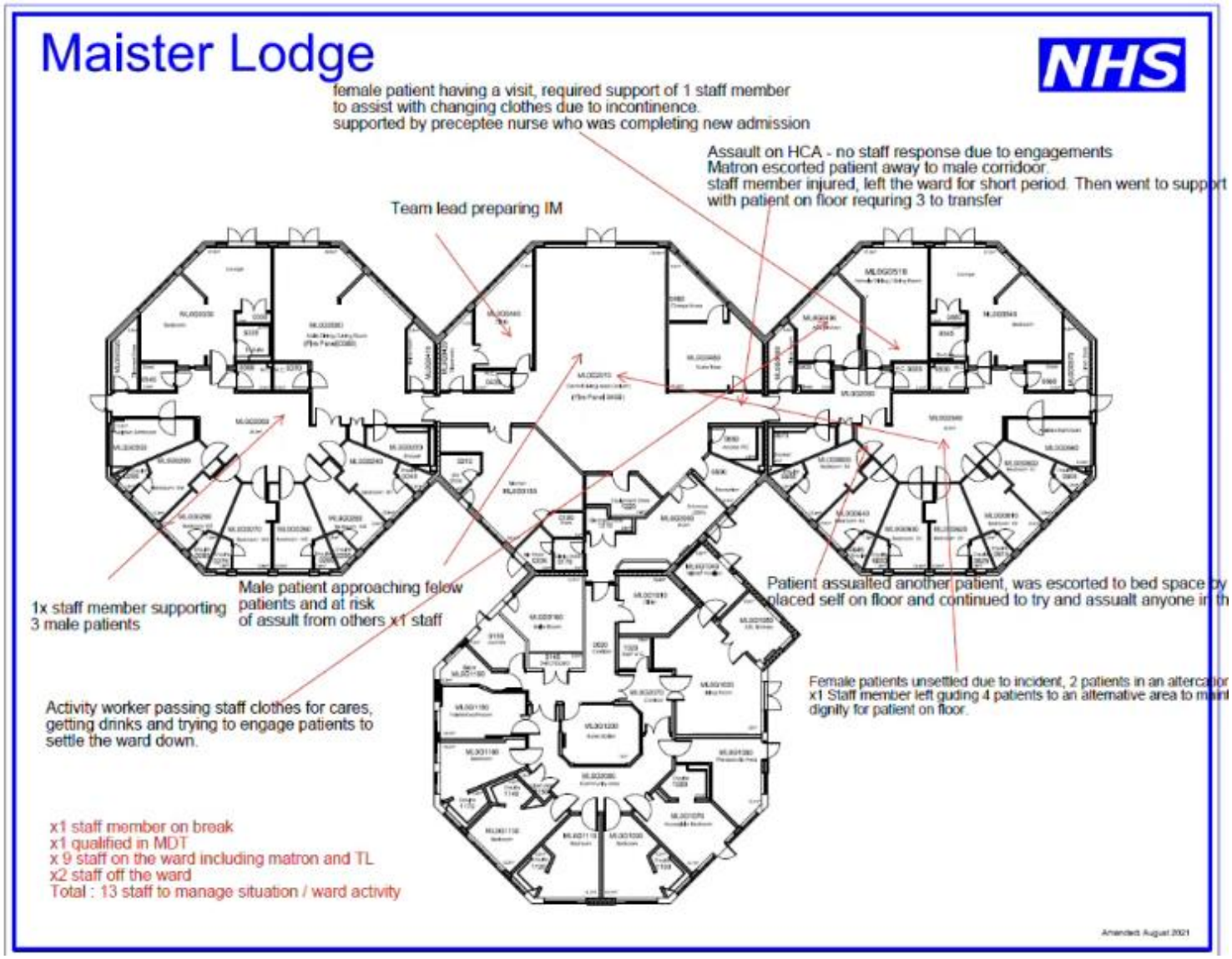
Develop a consistent approach to Supportive Therapeutic Observations of Care (EToC) data collection and reporting, including exploration of enhanced functionality within HealthRoster to support workforce planning, patient flow, and financial impact.

Share learning from the NHS England Chief Nursing Officer (CNO) Safer Staffing Programme and explore opportunities to further embed national best practice, including progression of the Head of Nursing's application for CNO Safer Staffing Fellowship.

Implement the revised resuscitation training plan, increasing access to ward-based training opportunities and reviewing opportunities to align PILS and ILS provision to improve accessibility and compliance. Proposal and progress to be reported through QPAS.

Explore opportunities for refresher training and external support through NHS England networks and safer staffing fellows, alongside continued Matron-led validation of staffing data and assurance processes.

Appendix 1:


Maister Lodge
NHS
female patient having a visit, required support of 1 staff member
to assist with changing clothes due to incontinence.
supported by preceptee nurse who was completing new admission
Assault on HCA - no staff response due to engagements
Matron escorted patient away to male corridoor.
staff member injured, left the ward for short period. Then went to support
with patient on floor requring 3 to transfer
Team lead preparing IM
1x staff member supporting
3 male patients
Male patient approaching felow
patients and at risk
of assult from others x1 staff
Patient assualted another patient, was escorted to bed space by
placed self on floor and continued to try and assualt anyone in th
Female patients unsettled due to incident, 2 patients in an altercatior
x1 Staff member left guding 4 patients to an alternative area to maint
dignity for patient on floor.
Activity worker passing staff clothes for cares,
getting drinks and trying to engage patients to
settle the ward down.
x1 staff member on break
x1 qualified in MDT
x 9 staff on the ward including matron and TL
x2 staff off the ward
Total : 13 staff to manage situation / ward activity
Amended August 2021

Humber Teaching NHS Foundation Trust

Agenda Item 10

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Patient and Carer Experience Annual Report (2025/2026) including Complaints and Feedback
Author/s:	Lorna Barratt (Patient and Carer Experience Manager) Mandy Dawley (Assistant Director of Patient and Carer Experience and Co-production) David Napier (Complaints and Feedback Manager)
Recommendation:	

To approve		To discuss	
To note		To ratify	√
For assurance			

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	To ask the Board to ratify the Patient and Carer Experience Annual Report (2025/2026) including Complaints and Feedback. A short film including highlights of the annual report will support this written document.

Key issues:

Positive Assurances to Provide:

Positive Assurances to Provide:

By listening to feedback, it is helping us to understand and influence our service provision as well as shape the services we deliver. Key highlights from the past year include:

- The Friends and Family Test (FFT) continues to provide valuable insight into patient experience, with 19,591 responses received and 91.3% positive feedback, demonstrating continued high levels of satisfaction with services. Improved access to the FFT dashboard has enabled teams to use real-time data to inform quality improvement.

- Significant progress has been made in embedding co-production through the Experts by Experience (EbE) programme,

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Community Mental Health Service User Survey 2025 results - Survey findings have been aligned with CQC improvement actions, with Trust and service-level groups overseeing delivery and PULSE surveys providing ongoing real-time feedback to monitor progress and identify emerging issues.

- Continued delivery of the Patient and Carer Experience Five-Year Forward Plan (2023 to 2028), embedding the themes of Our Care, Our Partnerships and Our Workforce and Organisation.

- Ongoing development and embedding of co-production, including expansion of the Experts by Experience programme and increased involvement in Quality Improvement activity.

which has grown to 61 individuals contributing to 36 projects, ensuring lived experience is central to service design and improvement. • The Trust has strengthened its "You Said, We Did" approach, particularly within mental health inpatient services, resulting in tangible improvements to environments, staff visibility, care planning, and therapeutic provision. • This year we launched the refreshed Patient Stories Framework providing a more structured, trauma-informed and inclusive approach to capturing lived experiences, supporting both learning and service improvement. • This year we refreshed our Panel Volunteer Framework, to ensure that staff are provided with the right tools to fully support patients, service users and carers when they volunteer to be involved in Trust recruitment activities. • Since its launch in 2021, 145 pieces of work have been awarded with the co-production logo stamp and during the past 12 months there have been 58 pieces of work awarded. The logo demonstrates the tremendous effort that goes on behind the scenes to co-produce work. • There has been continued focus on Equality, Diversity and Inclusion, including delivery against EDI priorities, strengthening engagement with diverse communities, and improving accessibility of services and information. • The Trust continues to demonstrate a strong link between staff experience and patient experience, with staff survey results improving further in 2025, and the Trust outperforming regional peers across NHS People Promise themes. • During the past year the Trust has responded to a total of 509 complaints: 166 formal complaints and 343 informal complaints. For the previous year, the Trust responded to a total of 502 complaints: 188 formal complaints and 314 informal complaints. Therefore, for the	• Implementation of Equality, Diversity and Inclusion priorities (2025 to 2027), including improving co-production with minoritised communities and embedding trauma-informed approaches. • Continued work to improve access to and utilisation of the FFT dashboard and feedback mechanisms to support local quality improvement. • A review of Trust-wide Patient and Carer Experience forums has been completed and changes to the structure, content and delivery model will be implemented during 2026/27 based on feedback received from forum members and communities.

period 25/26 there has been a decrease of 22 formal complaints compared to the previous year. • Of the 166 formal complaints responded to, 31 (19%) were upheld, 55 (33%) were partly upheld and 80 (48%) were not upheld. • 52 of the Trusts 129 clinical teams (40%) have not received any formal or informal complaints in the last twelve months. For the previous year, 47 (35%) of the Trusts 133 clinical teams did not receive any formal or informal complaints. • During this year compliments have increased significantly to 718 (a 63% increase on the previous year), reflecting the compassionate care and commitment of staff across the organisation.	
Key Risks/Areas of Focus: • Ensuring continued improvement in response rates and engagement across all services, particularly where FFT or feedback mechanisms are underutilised. • Maintaining momentum in embedding co-production and ensuring it is consistently applied across all areas of the Trust.	**Decisions Made:** None
Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	The annual report demonstrates the Trust's continued commitment to delivering care closer to home and strengthening community-based support. Examples include the development of peer support and recovery networks, social prescribing initiatives, community stroke support groups, enhanced partnerships with voluntary and community sector organisations, and increased involvement of patients and carers in the design and delivery of community services. Through co-production and stronger integrated working across Humber and North Yorkshire, the Trust is supporting people to access the right care, in the right place, at the right time.
Analogue to Digital	The report evidences increased use of digital tools to improve patient experience, engagement and service improvement. This includes significant uptake of digital Friends and Family Test feedback mechanisms, the Trust-wide FFT dashboard providing real-time intelligence for quality improvement, online surveys and pulse feedback tools, digital patient resources through the Connect website and Help Hub, survey landing pages, podcasts, and the use of digital platforms to support involvement, co-production and accessibility. These developments support the NHS ambition to use technology to enhance patient experience, improve access to information and drive continuous improvement.

Sickness to Prevention	The report reflects a strong focus on prevention, wellbeing and early intervention through partnership working, health promotion and engagement activity. Examples include learning disability cancer screening initiatives which have significantly increased screening uptake, safer inhalation programmes within addiction services, social prescribing support, wellbeing and recovery initiatives, domestic abuse awareness resources for young people, community health and wellbeing events, and work to address health inequalities across diverse communities. The Trust's approach to patient and carer involvement supports earlier intervention, improved self-management and healthier communities, aligning with the NHS ambition to move from treating illness to preventing it.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee	20.8.26	People & Organisational Development Committee	
Finance Committee		Executive Management Team	11.8.26
Mental Health Legislation Committee		Operational Delivery Group	27.7.26
Collaborative Committee		Other (please detail)	QPaS – 16.7.26

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	
Enhancing prevention, wellbeing and recovery	
Fostering integration, partnership and alliances	
Developing an effective and empowered workforce	
Maximising an efficient and sustainable organisation	
Promoting people, communities and social values	

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	

Public Exemption:

Is the report exempt from public disclosure	Yes/No

NHS
Humber Teaching
NHS Foundation Trust

Patient and Carer Experience

Annual Report (2025/2026) including

Complaints and Feedback



Caring, Learning
& Growing Together

PRODUCED IN COLLABORATION WITH LIVED EXPERIENCE

Contents

1.0 Executive Summary 3
1.1 Patient and Carer Experience Five Year Forward Plan (2023 to 2028) 5
2.0 Achievements during 2025-26 6
2.1 Trust-wide 6
2.2 Children's and Young People's Services 26
2.3 Community Services and Primary Care 31
2.4 Forensic Services 34
2.5 Learning Disabilities Services 38
2.6 Mental Health Services 40
3.0 Complaints and Feedback 43
4.0 Priorities for 2026/27 59

1.0 Executive Summary

As Medical Director for Humber Teaching NHS Foundation Trust, I'm pleased to share our Patient and Carer Experience (PACE) Annual Report (including Complaints and Feedback) for 2025/26. This report shows our ongoing commitment to putting patients, service users, carers and local communities at the centre of everything we do. It also highlights how listening to feedback and learning from it helps us improve the quality and safety of our care.

Over the past year, we have made good progress in delivering our PACE Five-Year Forward Plan (2023–2028). This plan focuses on three key areas: Our Care, Our Partnerships, and Our Workforce and Organisation. Together, these guide our aim to provide care that is personalised and shaped with the people who use our services.

Our Care: Listening and Acting on What Matters

We have improved how we gather and respond to feedback from patients. More people are sharing their views through the Friends and Family Test (FFT), with 19,591 responses this year – an increase of 3,182 completed surveys compared to the 16,409 received last year. We are pleased to share that over 91% of the respondents told us that they had a positive experience.

Just as important, we are using this feedback to make changes. Teams use our live FFT dashboard to identify themes to make improvements. We are strengthening our approach to act upon the feedback received using "You Said, We Did" ways of working; your feedback is leading to real improvements, such as better environments, more visible staff, and more involvement for patients in planning their care.

The Experts by Experience initiative has also grown significantly, with more than 60 people contributing to 36 projects. This means people with lived experience are increasingly helping to design, deliver and review our services.

We've also improved how we hear people's stories. Our updated and strengthened Patient Stories Framework helps us collect experiences in a way that is structured and person centred. This allows us to celebrate what works well and clearly identify where we need to improve.

Our Partnerships: Working Together to Reduce Inequalities

Working with partner organisations continues to be a strong part of our approach. Through programmes such as Veterans Aware, Equality, Diversity and Inclusion (EDI) work, and partnerships with community organisations, we are helping to reduce health inequalities and improve access to care.

Our engagement with different communities through forums, outreach and partnerships has helped us better understand the challenges people face. This has led to improvements such as more accessible information and resources that better reflect different cultural needs.

Our Workforce and Organisation: Supporting a Positive Culture

There is a strong link between staff experience and patient experience. Our 2025 staff survey shows continued improvements, including more staff feeling that patient care is the organisation's top priority.

We continue to perform well compared to similar organisations across NHS People Promise areas, reflecting a caring and supportive culture. Our Staff Champions of Patient Experience also play an important role in encouraging engagement and co-production across teams.

Quality Improvement work is closely linked to patient experience. More than half of our projects now involve patients and carers, showing that working together is becoming part of everyday practice which is leading to cultural change.

Complaints, Feedback and Learning

In 2025/26, the Trust responded to 509 complaints. The main themes were around patient care, communication and appointments. While the number of complaints has remained consistent compared with previous years, the feedback we receive provides valuable learning.

We are pleased to share that we have received a 63% increase in compliments, rising to 718 (compared to 440 received for the previous year), which reflects the kindness and dedication of our staff.

We have strengthened how we learn from feedback by putting clearer action plans in place, improving how we track progress and linking learning with patient safety data. Key areas we are focusing on include improving wait times, communication, and better co-ordination of care.

Looking Ahead

While we are proud of the progress we've made, we know there is more to do. We will continue to focus on strengthening co-production and clearly demonstrating outcomes as a result of "You Said, We Did" ways of working, reducing differences in experience between services

- improving timeliness, communication and coordination of care
- making services more inclusive and accessible
- embedding personalised and trauma-informed approaches

This report shows that listening to patients, service users, carers and communities is essential to providing safe and high-quality care.

Finally, I would like to thank our patients, service users, carers, partner organisations and staff for their ongoing support and commitment. Your continued dedication helps us to celebrate what is working well and where we need to continue to learn and improve to deliver better care.

1.1 Patient and Carer Experience Five Year Forward Plan (2023 to 2028)

The Patient and Carer Experience Five Year Forward Plan includes three outcomes (all of which underpin the six organisational goals) and are the focus for the Trust's patient and carer experience, engagement and involvement agenda. These include:



Outcome 1 – Our Care

Our care is informed by lived experience, involvement and engagement to ensure our diverse communities feel heard, valued and understood.

The Trust values the lives, opinions and experiences of everyone and is dedicated to developing services that are right for our communities to effectively meet everyone's needs, whilst addressing health inequalities they may experience. It is so important to make sure that individuals and those who support them are not only included in the care journey to make informed decisions, but are also provided with opportunities to influence, shape and improve healthcare services.

Outcome 2 – Our Partnerships

Our strong partnerships enable us to empower communities, address health inequalities and deliver integrated care that meets local needs.

Working together with our partner organisations to further strengthen existing relationships to understand and respond to the changing needs of our communities is a key priority for our Trust. We strive to continually improve our care by building strong alliances with our communities and partner organisations. We break down barriers to address health inequalities and ensure the best possible outcomes for our patient population.

Outcome 3 – Our Workforce and Organisation

Our staff are supported to involve our communities in all aspects of our work.

A happy workforce who are proud to work for the Trust is key to positive patient and carer experience and engagement. We equip our staff with the knowledge, skills and experience to genuinely co-produce services with our communities. Patient and carer experience and engagement informs our investments in services, estates and technologies to make sure no one is excluded.

2.0 Achievements during 2025-26

This report includes achievements made across the organisation to support the patient and carer experience and co-production agenda over the past twelve months. The achievements have been aligned to the three outcomes highlighted in the Trust's Patient and Carer Experience Five Year Forward plan (2023 to 2028) which link to the Trust's six strategic goals.

2.1 Trust-wide

Outcome 1 – Our Care

2.1.1 Trust Forums

The Trust continues to actively engage and involve the community by hosting face to face and virtual Trust Patient and Carer Experience forums across the geographical patch. The forums share the work taking place across the Trust and invite members to get involved with Trust activities. Forum members are given the opportunity to co-produce the agendas for each meeting. Please refer to our website for details of all our forums taking place: Patient and Carer Experience | Humber Teaching NHS Foundation Trust

In March 2026, a review of our forums was carried out to ensure that they were still meeting their purpose. "Your Voice Matters: Patient and Carer Experience Forum Marketplace and Event" sessions were held in Hull and East Riding, Scarborough and Ryedale and Whitby and District. Current forum members, along with members of the public who are not currently signed up to our forum membership, were invited to attend. Through varying forms of engagement including electronic surveys, tabletop discussions and paper-based feedback exercises, feedback determined that people felt that the forums would benefit from an update in terms of the strategic vision for the meetings, how they would operationally run moving forwards, what is information is provided and how often the meetings are held.

During 2026/27, changes to how the forums are delivered will be made based on the feedback received from all engagement activities.

Why This Matters (Positive Impact) …

The forums ensure that community voices are not only heard but acted upon. They help us deliver services that are shaped by real experiences, aligned with community needs, and provide opportunities for individuals to get involved with Trust activities.

2.1.2 Friends and Family Test

The Trust continues to collect feedback about all the services it provides using the Friends and Family Test (FFT) survey. The feedback we gather through our FFT offers valuable insight into people's experiences of our services. Our teams review the feedback to understand what is working well and to identify areas where improvements can be made.

A total of 19,591 completed surveys were received during this year, an increase of 3,182 completed surveys compared to the 16,409 received last year. Of the surveys completed this year, 91.3% confirmed they were happy with the overall service they received. 93.9% of respondents thought staff were friendly and helpful, 91.4% thought they were involved in their care and listened to, and 91.1% felt staff gave them enough information. The mode for completing the FFT survey was predominantly digital, with 92% of individuals completing the survey via the Trust website, and the remaining 8% completing a hard copy survey form.

All staff are able to access live FFT data for their teams through the FFT dashboard which shows how we are performing at an organisation, division and team level and includes:

- Number of survey forms received.
- Percentage of people who are satisfied with our services.
- Breakdown of positive, neutral, 'don't know' and negative responses.
- Qualitative feedback comments which are thematically analysed into one of ten themes and also divided into positive and negative sentiments.

Friends and Family Test Zero Reporting

The Trust continues to produce zero response reports for Friends and Family Test (FFT) every 6 months for each Division, asking for action updates for every zero-reporting team. This continues to provide assurance that an FFT approach for collecting feedback is embedded Trust wide.

The latest FFT zero reporting overall Divisional figures for the period October 2025 to March 2026 can be seen in the table below and highlights the continued improvement across the Trust in collecting FFT feedback.

Division	Number of Teams	No. of teams with zero FFT	% of teams with zero FFT responses
Children and Young People's Services	**48**	**6**	**13%**
Learning Disability Services	**7**	**4**	**57%**
Mental Health Services	**69**	**7**	**10%**
Community and Primary Care Services	**36**	**6**	**17%**
Forensic Services	**12**	**3**	**25%**
Trust wide	**172**	**26**	**15%**

During this latest reporting period of October 2025 to March 2026, there were only **26 teams out of 172 (15%)** who received no FFT response within that time period.

For the original pilot period of FFT zero reporting, which took place January to March 2024, of 176 teams with an FFT code, 93 teams (53%) did not receive any survey form responses. This means that in comparison to the pilot period, there has been a significant reduction of 38% in teams receiving zero responses to the FFT survey.

Work has now begun with each Division to ensure that access of the FFT dashboard is taking place across teams on a regular basis and that this is being utilised to identify Quality Improvement (QI) initiatives where negative themes are emerging.

Examples of QI projects because of FFT feedback include:

Addictions Services (East Riding Partnership):

- **You Said** "When I finish the Community Rehabilitation Programme, it would be nice to have extra after care with a Peer Mentor." **We Did:** We re-opened a building that gave us the opportunity to offer one-to-one peer support sessions that occur weekly for people leaving the programme after 12 weeks.

- **You Said** “Can you write a supporting letter for me? I am struggling to get to my current pharmacy for my prescription.” **We Did:** Arranged dispensing at other pharmacies for the service user’s convenience.

The examples above have led to positive change for individuals using our services including improved continuity of care through peer mentoring support after programme completion and increased flexibility in accessing medication through alternative pharmacy arrangements. These changes are helping to improve accessibility, support recovery, and respond more effectively to individual needs.

Why This Matters (Positive Impact) …

This work has strengthened how teams use patient feedback to make improvements. Regular use of the FFT dashboard is helping services identify issues more quickly and turn feedback into meaningful QI activity.

2.1.3 Mental Health Inpatient Survey

Last year, the Mental Health Division and the Patient and Carer Experience (PACE) team worked together to launch a new Mental Health Inpatient Care Services Survey. The aim of the survey is to gather views from those who have been cared for on our Mental Health inpatient units. The original Trust survey underwent significant review by a working group which consisted of Experts by Experience, Peer Support Workers, staff members from the Division and staff members from the PACE Team.

Since its launch in October 2025, the survey has seen a significant increase in response rates, with 26 responses being received during the first 3 months. For the first 6 months of the new survey being live, 42 responses to the survey have been received (in comparison to 7 responses received for the old survey for the previous 6 months). Since the new survey went live, the inpatient units have done a significant amount of work to act upon the feedback received, ensuring that the patient voice is heard and that improvements are made on the back of it.

Here is some of the positive feedback received through the Mental Health Inpatient Care Services Survey:

- Most patients said that staff were friendly, respectful and easy to talk to
- Patients felt that staff listened to them, understood them and took their concerns seriously
- Patients said the explanations were clear and staff kept them updated about care
- Many people felt involved in planning their care and making decisions

Here are some of the areas for improvement identified by the Mental Health Inpatient Care Services Survey:

You Said	We Did
Feedback was received about Avondale around the bookshelf in the small lounge and the books that were available.	A new, larger, bookshelf was ordered and a communications request for any unwanted books lead to many books being dropped off at Miranda House.
Feeback was received about Mill View Lodge around Allied health professionals not always being visible on the ward.	Occupational therapies team and the activities workers have moved their base on to the ward rather than having an office off the ward, making them more accessible and visible to patients.
The STaRS Community team received some feedback from a patient that they didn't feel our care plan was created collaboratively enough.	A care planning session has taken place in a key worker meeting, it has been discussed in business meetings and supervision has been updated to include more effective case load management.
Feeback was received about Mill View Lodge around a request for a safe and calming space for activities and therapies.	A new summer house is being built in the garden, this will be a fully decorated and furnished, space where staff and patients can have therapy sessions and it can also be used as a quiet space away from the ward.
Patients felt the food at Mill View Lodge was bland and uninteresting.	Meetings have been held with Hotel Services within our Trust and with staff at Castle Hill Hospital. Castle Hill are reviewing the meals they provide. It has been agreed that for a trial, on speciality food nights (such as Eid), food will be prepared at the Trust's Humber Centre and brought to the ward.
Feedback was received from one patient on Avondale for some self-help books.	A wish was requested and granted through the Trust's Health Stars for a self-help book which was ordered and received.
Patients didn't feel that they got appropriate debriefs following incidents.	A co-produced debrief model has been created (Supportive Engagement – Post Incident Reflection) to support in ensuring patients get a person centred debrief whether involved or witness to incidents.



Co-produced debrief model for patients following incidents.

Why This Matters (Positive Impact) …

The actions taken in response to patient feedback have delivered measurable improvements across our mental health inpatient services. Enhancements to ward environments, increased staff visibility, and more partnership care planning have strengthened the overall quality of care and improved patient experience.

Patients now benefit from more therapeutic spaces, better access to staff, clearer post-incident support, and more culturally appropriate food options. These changes have contributed to a safer, more responsive, and more person-centred service.

For the organisation, this work has reinforced a culture of listening and continuous quality improvement, strengthened patient engagement, and supported more effective multidisciplinary working. The "You Said, We Did" approach continues to demonstrate our commitment to acting on what matters most to the people who use our services.

2.1.4 Community Mental Health Service User Survey

Listening to and acting on feedback from people who use community mental health services remains central to the Trust's approach to quality improvement. The NHS Community Mental Health Service User Survey continues to provide the main source of nationally benchmarked patient experience data.

The 2025 results indicate ongoing challenges in how services are experienced. While some aspects of care remain in line with national findings, areas for improvement include access, continuity of care, and support for wider wellbeing needs. Feedback also suggests that some people do not feel fully informed or involved, with variation in experience across services.

Actions following the 2024 survey focused on improving care planning, involvement in decision making and communication. Some improvement has been seen, but this has not yet been experienced consistently.

An example of an action is as follows:

You said: You were not always asked for your views about the quality of your care.

We did: As part of action planning, we introduced regular pulse surveys, available in digital and hard copy formats, to provide more frequent opportunities for feedback.

Why This Matters (Positive Impact) …

This will enable more timely feedback and support services to respond more quickly, helping people feel listened to and involved in shaping their care.

Plans for 2026/27 focus on a continuation of action planning, to strengthen access, continuity, crisis support and wider wellbeing support, with progress monitored through routine feedback, including pulse surveys, and Trust governance processes.

2.1.5 Sharing of Patient, Service User and Carer Stories

This year we refreshed our Sharing of Patient, Service User and Carer Stories Framework, creating a clearer and more comprehensive toolkit to support staff and teams in listening to, understanding and learning from lived experience across the Trust.

The framework provides a structured and flexible approach to collecting and sharing experiences of care. By capturing both positive and challenging stories, it helps us identify what works well and where improvements can be made, supporting the Trust's involvement and engagement culture. The revised framework has been fully co-produced with people who have previously shared their stories, the staff who supported them, and teams who reflected on those experiences. Their experiences have helped create clearer guidance and stronger support processes for everyone involved in sharing or hearing stories. The framework embraces a wide range of ways people may choose to share their experiences. Its design ensures the approach is inclusive, trauma-informed and person-led, allowing individuals to choose what feels right and safe for them. All contributors are offered the chance to provide further feedback, such as testimonies or case studies, and are encouraged to take part in future involvement opportunities with the Trust.

Why This Matters (Positive Impact) …

Nikki's story – 18 months on

Nikki attended Trust Board in September 2024 to share their experience as a service user. Eighteen months later, Nikki returned to Trust Board to describe their progression, demonstrating the impact of sustained patient and carer involvement.

Following initial involvement as an Expert by Experience, Nikki has progressed into a Lived Experience and Co-production Lead role within the Mental Health division. This reflects both personal recovery and the benefits of structured involvement opportunities. Through contributions to initiatives such as culture of care and trauma-informed practice, lived experience has been further embedded within service development and decision-making.

Nikki's story provides a clear example of how lived experience involvement can support service improvement, strengthen the workforce, and ensure services are shaped by those who use them.

2.1.6 Experts by Experience

The Trust has continued to strengthen its commitment to meaningful involvement through the Experts by Experience (EbE) initiative, enabling individuals to contribute to service development in line with national guidance and with appropriate recognition of their time and expertise.

Over the past year, our EbE database has grown to include **61** Experts by Experience, with **41** individuals being reimbursed for **1,162** hours of work across **36** projects and activities Trust wide.

EbEs played a key role in the co-produced redesign of strategic frameworks, including the Panel Volunteer framework and the approach to sharing patient stories. Their input ensured processes are accessible, inclusive and grounded in real experience, resulting in clearer guidance and a more consistent approach across services.

This work has also supported staff to better understand the value of lived experience and increased confidence in co-production, particularly in relation to involving individuals appropriately and ethically.



Experts by Experience infographic

Why This Matters (Positive Impact) …

Three Humber Youth Action members, acting as Experts by Experience, supported a sensory audit at Inspire, the Children's Inpatient Unit. Using their lived experience, they assessed the building and suggested improvements across areas including classrooms, communal spaces, kitchen, bedrooms, and visiting areas.

"The three Experts by Experience had lived experience of neurodiversity, including ADHD and autism spectrum disorder, alongside varied experiences of CAMHS services across both community and inpatient settings. The Experts by Experience demonstrated strong passion and commitment throughout the process, with a shared dedication to improving services for young people. It is hoped that this work will contribute to meaningful improvements to the inpatient environment, making it more inclusive, supportive and therapeutic for young people with sensory processing differences, including those who are neurodiverse." **– Lydia, Advanced Occupational Therapist**

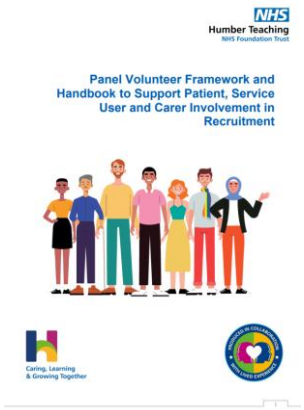
'Going on to inspire to do the sensory audit was a big step for me and something I feel really proud of. I feel thankful to have been given the opportunity to go back onto inspire after being a patient there to help the ward and make positive changes' – **Expert by Experience**

2.1.7 Panel Volunteer Framework

Within the last year we have refreshed our Panel Volunteer Framework, to ensure that staff are provided with the right tools to fully support patients, service users and carers when they volunteer to be involved in Trust recruitment activities. The revised framework provides a more comprehensive guide for staff to support Panel Volunteers through the process and also includes additional tools and resources that staff can use to ensure that our Panel Volunteers are as best informed as possible.

The revised framework, along with its new resources, have been fully co-produced with existing Panel Volunteers. Feedback was also sought from staff who have experience of supporting Panel Volunteers through the process. By co-producing with existing Panel Volunteers and listening to our staff, we have been able to strengthen the framework and produce a much clearer and concise guide.

The revised Panel Volunteer Framework was awarded the Co-production Logo Stamp in March 2026.



Panel Volunteer Framework

Why This Matters (Positive Impact) …

By providing staff with clearer guidance and improved tools, we are better equipped to support patients, service users and carers who volunteer to take part in recruitment activity. Co-production with existing Panel Volunteers and feedback from staff has ensured the framework is practical, accessible and aligned with real experience. As a result, volunteers are better informed and more confident in their role, and staff are supported to deliver a more structured, transparent and values-based recruitment process. This work reinforces our commitment to meaningful involvement and ensures that lived experience continues to shape how we recruit our workforce.

2.1.8 Co-production Stamp

The co-production stamp first launched in 2021; since then 145 pieces of work have been awarded the stamp across the Trust. The stamp demonstrates the tremendous effort staff put in to ensure that work is developed alongside patients, service users, carers and those with lived experience. The stamp is a fantastic way to add value and recognition, and to showcase where co-production has taken place. During the past 12 months there have been 58 pieces of work awarded the stamp. Pieces of work that are awarded the stamp are then entered into a prize draw that takes place three times a year during our Staff Champion of Patient Experience Forums.

The Trust's Social Prescribing Team for NHS England and NHS Trust trainees were awarded the co-production stamp for online drop-in sessions and podcast material produced to support the wellbeing of doctors in training (and their families) who arrive to the UK from overseas. The team support with a myriad of challenges that can include help with finding accommodation; overcoming loneliness and isolation; adjustment to language, culture and communication; feelings of anxiety and overwhelm, and much more. Following the success of the sessions, consent has been given by all who attended for the group to be made into a stand-alone episode of the team's podcast series. This will be shared amongst existing clients and stakeholders as well as being used to promote the service going forward. Debbie Blake, Project Officer and Senior Social Prescriber within the team, said "Due to the nature of the funding process, our service is commissioned on a 12 month fixed term contract. Therefore, it is fundamental that we do everything we can to strengthen our offer and to strive for innovation and development in order to secure this essential support for our service users. Having the endorsement of the co-production stamp helps to support future contracts and the longevity of the service."

Why This Matters (Positive Impact) …

The co-production logo stamp strengthens the credibility of projects, increases transparency, and demonstrates our commitment to embedding lived experience in service design. The stamp also supports teams by adding recognised value to their work by reinforcing a culture of meaningful involvement across the Trust.

2.1.9 Evaluating the Impact of Lived Experience Involvement

Internal and external surveys, co-produced with Experts by Experience, have been introduced to better understand the impact of lived experience involvement across the Trust. Feedback is gathered from staff, volunteers and service users involved in EbE activity, panel volunteering and the sharing of personal stories.

Why This Matters (Positive Impact) …

Findings indicate a positive impact across staff practice, patient and carer experience, and organisational development. Staff report increased understanding of lived experience and greater confidence in co-production. In inpatient settings, this is reflected in a shift towards more recovery-focused approaches, with one staff member noting:

"Just having EbE's in the service challenges the culture, staff begin to see EbE's as people rather than just patients. This creates a recovery focussed environment where service users are given back choice and autonomy."

Patients and carers involved in EbE activity and panel volunteering report feeling listened to, valued and able to influence change. This is reflected in feedback from a panel volunteer:

"It was good to be a part of the process and to see how inclusive it was. Everyone had an equal voice in the room."

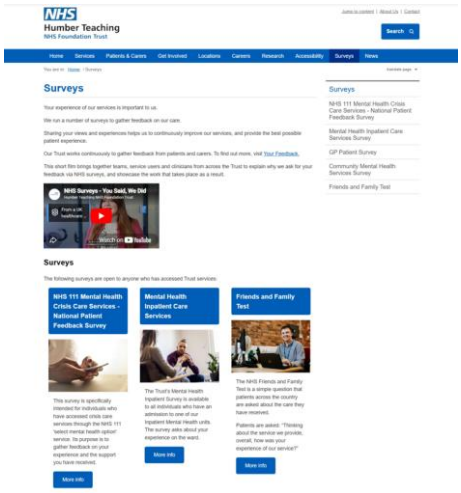
At an organisational level, lived experience has informed the development of key frameworks, improving clarity and consistency in practice and embedding patient voice within governance and service improvement. As one Expert by Experience reflected:

"The framework was truly co-designed and co-produced throughout…"

2.1.10 Survey Landing Page

The Trust continues to maintain and promote its Survey Landing Page, which provides a central, easy-to-navigate hub for all patient, service user, and carer surveys. This established resource supports our ongoing commitment to gathering meaningful feedback that informs service development and enhances the overall experience of those accessing our care.

By bringing all current surveys together in one accessible location on the Trust website, the Survey Landing Page helps individuals understand the purpose of each survey and how their views contribute to continuous improvement. Its ongoing use supports consistent collection of valuable insights, enabling teams across the Trust to identify areas for development and ensure services remain responsive to the needs of our communities. The Survey Landing Page remains a routine and vital tool in our approach to listening, learning, and improving care in partnership with patients, service users, and carers.



Survey Landing Page on Trust website

2.1.11 Experience of Care Framework

The Experience of Care Framework is a national NHS tool that helps organisations understand how people experience care and where improvements can be made. It focuses on listening to patients, service users, carers, staff and communities. The framework includes 88 questions across key areas such as leadership, organisational culture, feedback and learning, helping the Trust to reflect on what is working well and where changes are needed to improve experiences.

Over the past year, the Trust carried out a detailed review of all 88 questions, assessing how well we are doing in each area. This showed that we are performing strongly in most areas, with around 80 areas assessed as achieving or excelling. We identified 8 key areas where further improvement is needed, and these have become our priority actions. To ensure a joined-up approach, we are bringing together this work with our Improving Patient Care Together (IMPACT) programme within our new Quality Improvement (QI) Five Year Plan. We will take forward a detailed workplan aligned to six pledges, with the 8 priority Experience of Care actions fully embedded to drive meaningful improvements for patients, service users, carers and our communities.

Why This Matters (Positive Impact) …

This work will help us continue to improve the care and support people receive by making sure we listen carefully to what matters most to patients and carers. By looking closely at feedback and experiences, we can better understand where we are doing well and where we need to make changes. The areas we have identified for improvement will help us focus on making care more inclusive, responsive and joined-up.

By bringing this work together into one clear improvement plan, we will be able to make changes more effectively and show how feedback is leading to real improvements. Over the next few years, patients, service users and carers should see continued improvements in how we listen, involve people in decisions about their care, and ensure everyone's experience is consistently positive and person-centred.

Outcome 2 – Our Partnerships

2.1.12 Veteran Aware Healthcare Alliance

VETERAN AWARE

The Trust is a Veteran Aware Healthcare organisation. We were originally accredited in May 2020 and were re-accredited in 2023 where we met standards laid down by the Veterans Covenant Healthcare Alliance (VCHA).

We continue to support the Armed Forces Community by working towards our Veteran Aware Principles to enhance career opportunities and support for the Armed Forces Community and increase awareness and understanding within the Trust of the needs and contributions of the Armed Forces Community. Our principles demonstrate the Trust's strong commitment to making a positive difference to fulfilling the Armed Forces Covenant and supporting the wider Armed Forces Community.

In 2025, we are proud to have achieved Silver accreditation with the Armed Forces Employer Recognition Scheme, and have begun working towards achieving Gold.





Armed Forces Covenant Silver Award Ceremony October 2025 at York Racecourse

Why This Matters (Positive Impact) …

Maintaining our Veteran Aware status through the VCHA ensures that attention remains focussed on this important community of patients, service users, carers, staff and the wider community, and provides additional drive to quality improvements for the cohort. The VCHA process requires executive-level oversight, which comes from our Medical Director.

Being part of the Veteran Aware programme helps us recognise and support veterans and Armed Forces families more effectively across our Trust. It makes sure their needs are understood and considered when we plan and improve services. This work helps us provide fairer, more personalised care by listening to veterans and their families and involving them in shaping services. It also means our staff are better trained and more confident in supporting people from the Armed Forces community. We are committed to being a supportive employer for veterans and their families, creating an inclusive culture where they feel valued. Overall, this helps us improve care, experience and support for both patients and staff, while showing our commitment to the Armed Forces community.

2.1.13 Accessible Information Standard

The Accessible Information Standard (AIS) Guidance aims to ensure people who have a disability, impairment or sensory loss can access information in a format they can understand and receive any communication support they need to access Trust services. The AIS has been updated and republished in June 2025, to incorporate statutory changes since its initial publication in 2016. The Trust AIS guidance has been reviewed and updated in line with AIS June 2025.

One of the key changes in the guidance is the requirement that patient communication needs are reviewed, to recognize that these may fluctuate, or change over time.

For the period April 2025 to March 2026, the Trust received and responded to 1 formal complaint, 0 informal complaints, and 0 compliments relating to people with a communication need under the AIS.

2.1.14 Equality, Diversity and Inclusion Priorities for Patients, Service Users and Carers (April 2025 to March 2027)

The Trust held the Equality, Diversity and Inclusion (EDI) Event in May 2025.The keynote speaker was Sarah Regan of the Hull and East Yorkshire Centre for the Deaf, who spoke and signed about some of the work carried out at the centre which has been empowering the local Deaf British Sign Language-using community for 170 years. She gave the audience a fascinating glimpse into the life, needs and challenges faced by this community, and shared some guidelines on communicating with Deaf people.

The audience were treated to a performance by the Hull Visual Choir, a signing adult choir aimed at bringing the Deaf and hearing community together which uses a mixture of British Sign Language and artistic license to make beautiful songs accessible to the Deaf people who have never experienced the power of song.



Hull Visual Choir Performing at the EDI Event

The Trust has made good progress to deliver on our four EDI priorities which were co-produced with patients, service users, carers, staff and partner organisations in a workshop in May 2023. The table below highlights a few examples of work undertaken.

You Said Your Priority from April 23 to March 25 was	We Did in 2025/26
1. To strengthen patient demographic data collection to tailor care that meets individual needs.	• The Trust has implemented a new Electronic Patient Record across all areas which has enabled more consistent data collection and refreshed reporting processes. This includes a more visual dashboard to highlight where information is not complete.
2. To further enhance our faith offer to ensure inclusivity.	• Trust Chaplain, Reverend Eve Rose, continues to host services throughout the year, bringing people together virtually and physically for spiritual and pastoral support. • The Chaplain participated in the Lord Mayor's Celebration of Interfaith Working across Hull and the East Riding, at Hull's Guildhall. This supported the aim of strengthening relationships with other faith leaders and was a wonderful opportunity to learn more about community support offered in the area. • The chaplain has invited faith leaders to record podcasts discussing faith and spirituality. The first of these can be accessed through the Recovery Club Podcasts via the Recovery College which is open to anyone (free account login required). Topics covered to date include the Chaplain's path into her role, and a conversation with Imam Abid Salik which explored life as a Muslim and the importance of Ramadan. • From January 2026, a Faith and Spirituality Calendar of Events booklet is available to complement the Caring for People of Different Faiths booklet. This outlines key festivities and observances to support inclusivity and cultural awareness.
3. To continue to build and sustain relationships with our diverse communities to fully understand the challenges people face	• The Patient and Carer Experience (PACE) Team have been building links with the Humber All Nations Alliance (HANA) to improve understanding of the needs of communities who form part of this alliance.

and how we can support to overcome them.	• The PACE team has attended events such as the HANA International Fashion Show, the Peel Project Health Fair, and the Lord Mayor's Celebration of Interfaith Working across Hull and the East Riding as part of this work. • The Trust has worked to improve service for British Sign Language users and other Deaf people by working closely with the Hull and East Yorkshire Centre for the Deaf. This work continues into 2025/26.
4. To introduce cultural celebration weeks to educate and support people to understand cultural differences.	• Podcasts are now being recorded (see 2) with a range of interviewees. This will provide a bank of resources for reference as needed.



Faith and Spirituality Calendar 2026

Why This Matters (Positive Impact) …

Priority 1 - The change has moved the Trust from inconsistent and incomplete demographic data to a more standardised, visible, and actionable system, enabling better insight, more equitable care, and stronger decision-making.

Priority 2 - This work has strengthened the Trust's approach from a traditional chaplaincy offer to a more visible, inclusive, and community-connected faith and spirituality service, helping ensure care is respectful, culturally aware, and responsive to diverse needs.

Priority 3 - This work has moved the Trust from limited engagement to a more proactive, relationship-based approach, resulting in better insight, improved accessibility, and services that are increasingly shaped around the needs of diverse communities.

Priority 4 - This work has started to shift the approach from planned cultural events to a more sustainable, accessible learning model, helping build ongoing awareness, cultural competence, and a more inclusive culture across the Trust.

At the Equality, Diversity and Inclusion Event in May 2025, participants co-produced new priorities for the period 2025 - 2027.

Priority	We Did in 2025/26
Priority 1: Demonstrate how the Trust incorporates feedback and co-production, with increased use of "you said, we did"	We co-produced our Equality, Diversity and Inclusion (EDI) priorities at a Trust-wide event in May 2025, ensuring people with lived experience directly shaped our priorities. Experts by Experience were actively involved in developing key policies, including the Reasonable Adjustments policy, with a draft produced and further materials in development. These activities strengthen how feedback and co-production are embedded and visible across the Trust.
Priority 2: Increase co-production, particularly with minoritised groups	We strengthened co-production by working in partnership with diverse communities and people with lived experience. This included ongoing engagement with groups such as Humber All Nations Alliance, Hull and East Yorkshire Centre for the Deaf, Peel Project and Bora Shabaa, helping us better understand barriers to care. We reviewed and refreshed key resources (such as the "Why Ask?" booklet) with input from Experts by Experience and applied health literacy principles. We supported the procurement of improved interpretation and translation services, reflecting service user feedback. We promoted co-production across the organisation through events, conferences and targeted outreach, and expanded resources through the Recovery and Wellbeing College, including podcasts and materials on faith and cultural awareness. Work to improve support for people with communication needs included Deaf awareness resources, strengthened links with the Centre for the Deaf, and embedding these considerations into the Reasonable Adjustments policy.
Priority 3: Inclusive trauma-informed policies and training	We expanded trauma-informed practice by providing access to training through our Electronic Staff Record (ESR) and targeted programmes within services. The Trust's Culture of Care programme delivered significant trauma-informed training across inpatient wards and more widely. Additional learning opportunities were introduced, including sessions addressing identified gaps such as understanding shame. This work has strengthened staff awareness and supports more compassionate, inclusive care for patients who have experienced trauma.

Why This Matters (Positive Impact) …

Co-producing our EDI priorities and involving Experts by Experience in policy development has ensured our work is informed by lived experience meaning that the policies put in place meet the needs of the people using our services.

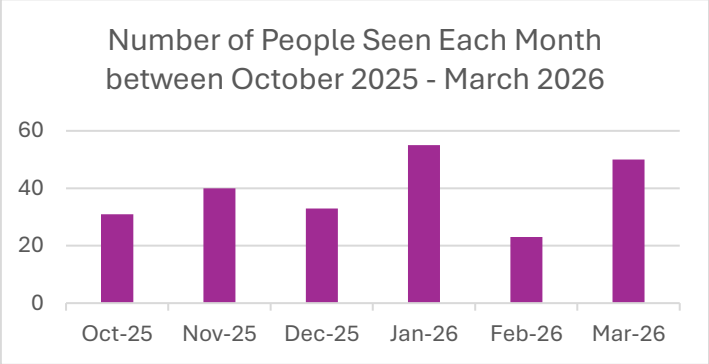
Strengthening co-production with diverse communities and Experts by Experience has improved understanding of barriers to care and led to more accessible, culturally appropriate resources and services. This includes better interpretation support, improved health information, and stronger recognition of communication needs.

Expanding trauma-informed practice through targeted training and the Culture of Care programme has increased staff awareness and understanding of trauma, enabling more compassionate and responsive care. This supports staff to better recognise and meet the needs of patients who have experienced trauma.

2.1.15 Chaplaincy at Fitzwilliam Ward – Malton Community Hospital

On 1st August 2025 an enhanced chaplaincy service offer began its provision by York and Scarborough Teaching Hospitals NHS Foundation Trust. The service aims to provide pastoral, spiritual and religious care services to our patients, carers and staff at the Fitzwilliam Ward, Malton Hospital. This service is an enhancement to the Trust's current chaplaincy offer, and feedback from staff since the service went live is that the service is being very well received.

During the six-month period of October 2025 to March 2026, **89 new referrals** were received into the Chaplaincy service at Fitzwilliam Ward, **201 visits were made to referred patients**, and **232 people were seen in total** (including family members). Activity levels fluctuated month-to-month but demonstrated an ongoing demand for chaplaincy presence within the ward.



Across the six-month period, chaplaincy support consistently focused on:

- **Pastoral listening and emotional support**
- **Prayer and blessings**
- **Support for families**, often alongside patient visits
- **Sacramental ministry**, including Holy Communion
- **Occasional end-of-life support**

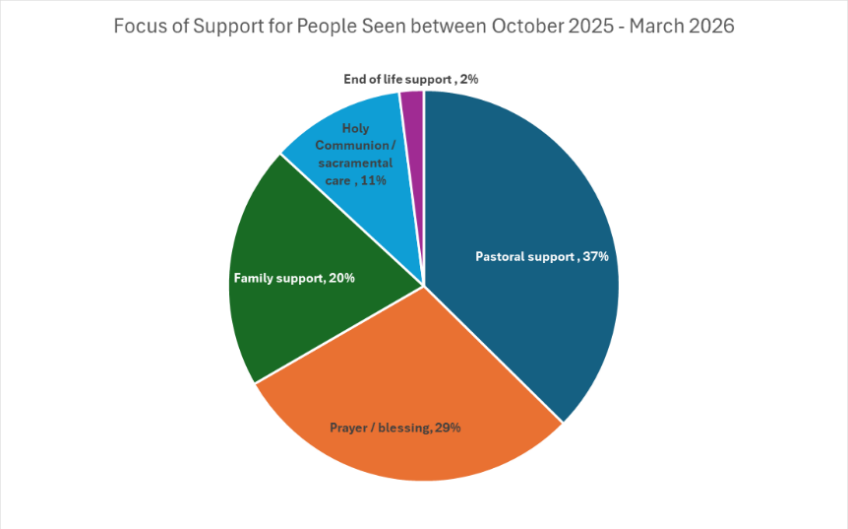


Chart - Focus of Support for People between Oct 2025 and March 2026

Why This Matters (Positive Impact) …

The introduction of this chaplaincy provision on Fitzwilliam Ward at Malton Hospital has strengthened the Trust's existing chaplaincy services by offering consistent pastoral, spiritual and emotional support to patients, their families and, where appropriate, staff. The service supports individuals from a wide range of faith and belief backgrounds and makes an important contribution to addressing emotional and spiritual needs alongside clinical care.

There is clear evidence of a sustained and significant demand for chaplaincy support on Fitzwilliam Ward, with high levels of engagement throughout the reporting period and the number of visits frequently exceeding the number of referrals received.

"A Chaplain now comes onto the ward every Friday and goes round the patients, completing a form about what and who they have seen. The patients appreciate their input, some just like someone to talk to and some want specific chaplaincy support. We have good reports about them; very understanding and helpful and show a lot of patience. They have also seen patients on request and spoken to relatives (some lengthy conversations). Previously, the ward did not have any input from a chaplaincy service and it was difficult to access anyone to come. Now this is not a problem and they are available 24/7." – **Nurse Manager – Malton Ward**

Outcome 3 – Our Workforce and Organisation

2.1.16 Staff Champions of Patient Experience

The Trust has an established network of around 200 Staff Champions of Patient Experience (SCoPEs) across all services, whose role is to ensure the voices of patients, carers, and service users are heard and to promote good practice in patient experience.

Following feedback gathered at a SCoPE Forum in October 2024, a working group was formed in 2025 to review and strengthen the role. Through positive discussions, the group clarified expectations, benefits, and

commitments, explored whether the role name reflects its purpose, and began shaping future training offers in collaboration with SCoPEs.

This work has resulted in the development of a new promotional poster to better define the role, support recruitment, and improve understanding among existing members, with further co-produced improvements planned.



SCoPE Poster

Why This Matters (Positive Impact) …

The work carried out has made the following difference to SCoPEs:

- **Clearer and more consistent SCoPE role –** Discussions clarified expectations, responsibilities, and benefits, leading to a more consistent understanding of the role across the Trust.
- **Stronger engagement and co-production -** Involving SCoPEs in shaping the role increases ownership, motivation, and alignment with what staff need to be effective champions.

2.1.17 Staff Experience alongside Patient Experience

There is an intrinsic link between colleagues' workplace experiences and the direct impact on patients and the standard of care they receive. If colleagues enjoy a positive work experience, feel part of a trusted and safe team and work together with patients to make a real difference, we know we have the right culture and that the Trust is a great place to work. A compassionate culture makes a real difference to how our patients, service users, their families and loved ones perceive the care we provide, and our staff survey is a meaningful way for us to measure whether we are getting this right and to frame our actions to be even better in the future.

Delivering outstanding patient care is always our top priority. We are particularly pleased that our 2025 score for the question, "Care of patients or service users is my organisation's top priority", has improved again and is now at its highest level to date. Although our scores on these measures have improved, scores across our benchmark group of similar trusts nationally have declined. This has strengthened our relative position and means we are now outperforming many comparable organisations. We are proud to be a leading Trust and we recognise that this is built on commitment and professionalism of our colleagues every day.

Building on these results, it's important to recognise just how strongly we continue to perform compared with other Trusts in our region. This year, we scored higher than other providers in our ICS region across every NHS People Promise theme and sub theme, at a time when the overall national picture has declined in almost every area. Our Advocacy score, which reflects whether colleagues feel patient care is the organisation's top priority, would recommend us as a place to work, and would be confident in the care provided to friends and family, remains one of our greatest strengths. When looking across the wider Northeast and Yorkshire region, including all ICS, Humber and North Yorkshire, North East and North Cumbria, South Yorkshire and West

Yorkshire, our overall Advocacy score placed us third out of 31 Trusts. These results underline the pride colleagues take in the care we provide and the confidence you have in the work we do together every day.

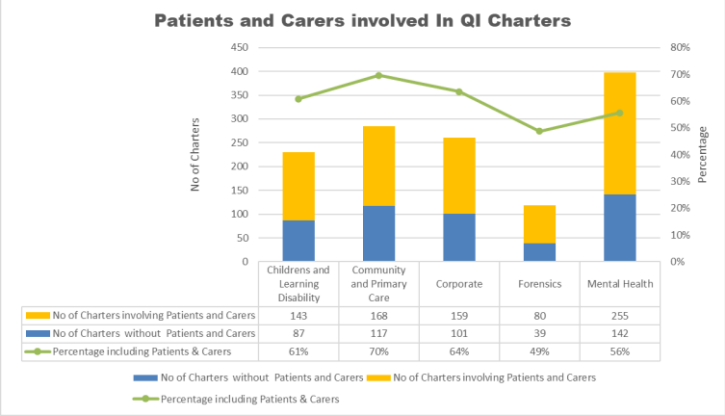
Question/Statement	2018	2019	2020	2021	2022	2023	2024	2025
Q6a. I feel that my role makes a difference to patients/service users	84.7%	87.8%	88.8%	86.87%	87.35%	88.25%	87.68%	88.30%
Q25a. Care of patients/service users is my organisation's top priority	64.1%	65.7%	75.6%	73.87%	75.58%	80.14%	80.87%	81.71%
Q25b. My organization acts on concerns raised by patients/service users	67.4%	66.4%	72.7%	74.5%	73.44%	77.50%	79.04%	80.72%
Q25c. I would recommend my organisation as a place to work	47.6%	49%	61%	59.45%	62.83%	66.98%	68.99%	70.45%
Q25d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	60.5%	58.4%	66.8%	65.41%	65.25%	69.64%	71.66%	72.95%

2.1.18 Patient Experience to inform Quality Improvement

Quality Improvement (QI) and Patient and Carer Experience continue to work closely together. The Joint Strategy Group continues to ensure that both our patients, service users, carers and staff are fully involved in both agendas.

The QI charter continues to provide tracking of patient and carer involvement within QI activities across the Trust. The Trust achieved 54% for all teams and 70% for operational teams to co-produce activities with patients and carers - a 6% increase for all charters across the Trust.

The chart below breaks down the charters for each Division and Corporate Services into those activities which were developed with our patients and carers and those which were not.



In contrast, 97% of open and completed activities have indicated that the activity would benefit our patients, service users and carer

Why This Matters (Positive Impact) …

Here are some examples of the difference made:

Innovate Brand and Hub Development
A number of our Patients and Carers supported the development of our Innovate brand and what they would like to see on the Innovation Hub.

Improvement Training
To raise awareness of the importance of including patients and carers in improvement activities, A short video of Staff, Peer Support Worker and an Expert by Experience talking about the benefits of including the Patient and Carer Voice in QI initiatives. This will form part of the new training offer that will be available in Quarter 1 of 2026-27. We currently have a working group supporting the development of a new animated film for Outcomes, Outputs and Benefits that will be available on both the Trust Innovation Hub and the Recovery College. A full review of all the QI training will be undertaken in Quarter 1 of 2026-27 and will include Patients and Carers.

Service User Expert by Experience Reps Forensic Services, Forensics
The project was established to develop a consistent process for identifying which service users are able to support different pieces of work. A task-and-finish group, made up of service users, designed the initial pilot and the documentation required to recruit the first cohort of representatives. This included the Service User Involvement Authorisation Form, which is used when an involvement opportunity is advertised at Humber Voices (the patient council meeting). The form enables service users to take ownership of their involvement by outlining why they wish to be involved, any potential difficulties they may experience, and how these could be managed. Service users then take the completed form, which includes full details of the opportunity, to their MDT meeting. This allows clinical staff to assess and manage any risks associated with the proposed involvement and formally sign off the activity.

Co-production of training for the Sensory Outreach Service, Childrens and Learning Disability
An expert by experience collaborated with the Outreach Service team to co-produce and deliver a comprehensive training package and create accompanying materials to educate school staff about understanding and supporting sensory differences in students. Our expert will provide lived experience of sensory differences at school and share strategies which have supported them.

2.2 Children's and Young People's Services

Outcome 1 – Our Care

2.2.1 Dynamic Support Register Animation, in collaboration with the Humber and North Yorkshire Dynamic Support Keyworker Service

Our Humber and North Yorkshire Dynamic Support Keyworker Service received feedback from service users who said that they often struggled to understand how the Dynamic Support Register (DSR) works, who is eligible and how it supports children, young people and their families. Keyworkers, together with three Humber Youth Action Group (HYAG) members recruited as Experts by Experience co-produced an animation for the Connect website that explains how the DSR works for children, young people and their families.

The animation is now publicly available on the Connect website, improving understanding for children, young people and their families. Service users now have a clearer, more engaging resource that supports informed involvement in their care and the DSR process.



Dynamic Support Register Logo

Why This Matters (Positive Impact) …

Feedback identified that children, young people and families did not clearly understand the Dynamic Support Register (DSR). In response, the Humber and North Yorkshire Dynamic Support Keyworker Service co-produced an animation with Experts by Experience to explain the DSR.

The animation being available on the Connect website, has improved understanding of the DSR, reduced confusion, and enabled service users to feel more informed and confident in engaging with their care and the DSR process.

"I really like the new animation. It seems to hit just the right balance of realism, emotion and practical information. Congratulations to all involved."- **Lived Experience co-worker Health Improvement Team NHS England**

2.2.2 Co-produced Humber Youth Action Group Logo and Visual Identity and Values

In January 2025 the Humber Youth Action Group shared that they would like to review the groups' visual identity and formulate some shared values. During the year, a new logo and set of values was co-produced for the group which better reflects the group's current identity. A new induction process has also been created to provide stronger support for young people joining the group, this involves a one-to-one meeting with the group's facilitator to better understand each young person's individual needs and lived experience helping to better match them to meaningful projects.

Humber Youth Action Group Logo

Why This Matters (Positive Impact) …

The new logo and values have given the group a clearer identity and helped young people feel more connected and included. The new induction process means young people get better support when they join, helping them feel understood and matched to projects that suit them. Overall, this has made the group more welcoming, supportive and engaging for its members.

2.2.3 Domestic Abuse Information Resources for Children and Young People

Feedback from young people told us that they would like more inclusive resources to support them to recognise the signs of unhealthy and abusive relationships. The Humber Youth Action Group (HYAG) co-produced along with our Trust's Safeguarding Team a set of posters that was shared within the community. Community Vision secured funding in 2025 to print the digital resources, enabling wider distribution across local schools, colleges, youth groups and Trust waiting areas.

In addition, HYAG members shaped the design and content of online resources on "The Help Hub", a resource on the Connect website, to ensure the webpage is accessible, relevant and young-person-friendly.



Information resource poster

Why This Matters (Positive Impact) …

Young people now have clearer information to help them recognise unhealthy and abusive relationships. The posters, shared in schools, colleges and community settings, have reached more young people and raised awareness. The online Help Hub resources are now more accessible and relevant because they were shaped by young people themselves.

Overall, this work has improved awareness, made support easier to understand, and ensured resources better meet young people's needs.

2.2.4 Connect website – Help-Hub

When developing the Connect Website, which hosts our Children's and Adult Learning Disability Services, service users told us it was important to support our community in finding the right service and/or resource at the right time. Service users helped design the "Help Hub," which is a unique digital tool on the Connect website that provides signposting to a wide range of health topics. The resource includes links to Trust

services, information hosted on Connect, and external websites and online support tools. From June 1st 2025 to January 31st 2026, The Help Hub has had 1983 sessions and 1639 active (unique) users. Training has been provided to teams across the division so they can confidently signpost service users to this resource.

Why This Matters (Positive Impact) …

The Help Hub has made it easier for people to find the right support when they need it, all in one place. It has been widely used, with nearly 2,000 visits and over 1,600 individual users, showing strong engagement. Staff training has also helped ensure more people are signposted to the resource. Overall, this has improved access to information, helped people get support more quickly, and made it easier to navigate services.

Outcome 2 – Our Partnerships

2.2.5 Humber NHS Cadet Programme

The Humber NHS Cadet Programme which is run in partnership with St John's Ambulance, gives young people the opportunity to access a tailored programme which aims to reach a diverse range of young people who have barriers to entering volunteering and/or a career in healthcare. As NHS Cadets, young people develop key skills, boost their self-confidence, and get to explore careers in the healthcare sector.

Why This Matters (Positive Impact) …

Thirty young people graduated the third cohort in December 2025, many reporting that they feel more prepared and motivated to pursue a career in the NHS after engaging with staff and guest speakers from our Children's and Learning Disability Division.

"I thoroughly enjoyed Humber NHS Cadets, it was very interesting and highlighted topics such as manual handling that you wouldn't usually think about much but are quite important. Personally, I enjoyed learning about the variety of carers in the NHS and having the guest speakers join sessions and feel this really helped when exploring my options in further education. It was also excellent to meet the others participating in the sessions and the coordinators. In fact, I feel just working in this group helped me to develop my skills as I was able to see how others dealt with situations for example how the coordinator managed their time in a session. Overall, it is a fantastic programme and I would recommend it to anyone thinking of a career in healthcare or anyone who is unsure about what they would like to do after leaving education." - **Humber NHS Cadet Graduate**

"I want to thank every guest speaker who has attended, as their presence on our NHS Cadets Programme session is inspiring to the young people makes a significant impact. They're currently considering various roles within NHS, and having a good variety of backgrounds provides versatility on the roles across many fields. For example, having two different speakers covering mental health gave young people an insight that no role is fixed, but can have various people doing similar work. In addition to this, by having a Volunteer Manager, it highlighted that there are non-clinical roles within NHS England and can go for other roles if the clinical field was not an interest. Furthermore, the attendance of a Career Development Specialist will be even more impactful. Therefore, I would like to send the whole team's gratitude to the Trust for being proactive and supporting us on the NHS Cadet Programmes."-**Regional Lead - Humber NHS Cadet Programme**

2.2.6 Hull University Teaching Session with Humber Youth Action Group

Hull University invited the Humber Youth Action Group (HYAG) to support the delivery of training for third-year mental health nursing students. The session focused on sharing young people's experiences of accessing Child and Adolescent Mental Health Services (CAMHS) and wider mental health services and explored how nurses can adapt their practice to better support young people and their families.

Having the HYAG supporting the delivery of the training gave nursing students direct insight into young people's experiences of CAMHS and mental health services, improved students' confidence and skills in engaging with young people and helped students identify practical ways to adapt their practice to better support young people and families.

The collaboration also helped to build a stronger partnership between HYAG and Hull University and supported members to develop confidence, facilitation and co-design skills.



Photos from the teaching session

Why This Matters (Positive Impact) …

Having the HYAG supporting the delivery of the training gave nursing students direct insight into young people's experiences of CAMHS and mental health services, improved students' confidence and skills in engaging with young people and helped students identify practical ways to adapt their practice to better support young people and families.

The collaboration also helped to build a stronger partnership between HYAG and Hull University and supported members to develop confidence, facilitation and co-design skills

"I really can't understate how much of an impact (positively!) days like today have. Knowing that I can use what happened to me to try to reduce the likelihood of other young people being impacted in the same way has quite honestly done more for me than any therapy ever has. It allows me to chip away at the narrative that my head has formed around the intentions of professionals and gives me back my voice so that even if I couldn't speak then, I can now and I know that I will be heard. That is a hugely liberating, hugely impactful thing. Thank you for facilitating that and for allowing me the time to build up to feeling able to give my thoughts and opinions without fear of being wrong or speaking out of turn." – **Humber Youth Action Group Member.**

Outcome 3 – Our Workforce and Organisation

2.2.7 Sensory Processing Service- Outreach Service

The Sensory Outreach Service is an extension of the Sensory Processing Service and is aimed at supporting students and staff in schools with sensory differences.

Grace (Expert by Experience) has been working with the service since September 2025 and has co-designed and co-produced Sensory Champions Training and Whole School Training and has provided guidance to the service on the recommendations they can make for young people with sensory processing differences. Whole School Training Sessions are a 1 hour session to give staff a practical overview of sensory processing and how it can shape the way children experience school. Sensory Champions Training is a more in-depth, 6-hour training for staff who will take on the role of "Sensory Champion" within their school. Champions will develop a deeper understanding of sensory processing and how it affects children's learning, behaviour, and wellbeing.



Grace presenting

Why This Matters (Positive Impact) …

"I am an Expert By Experience with the Sensory Outreach Team. As an Expert By Experience, my role is to support the service and bring ideas based on situations that I have personally experienced. This allows for the support to be specific and helpful, as it focuses on real difficulties that other students may face in schools. I personally think that the Outreach Service will support numerous children who struggle with sensory difficulties in schools. it also allows me to gain valuable experience and learn more about sensory processing. I really enjoy advocating for others based on my experiences and am hopeful that I can make a significant difference to children in schools." – **Grace, Expert by Experience**

"Working with an Expert by Experience has been brilliant for the Sensory Processing Service and Sensory Outreach. Grace has been working with us to review website content, and to deliver our training packages to teachers. She has reviewed the content of our Sensory Champions training and has also presented at some of the training sessions.
Having an expert by experience makes our training so much more powerful; teachers are able to directly ask Grace about her school experience, which helps them to understand sensory differences. Grace also sheds light on how simple adjustments can have a tangible impact for pupils, which hopefully inspires teachers to leave our training motivated to make their learning environments as inclusive as possible.Our co-production work with Grace is ongoing. She is currently developing an animation to illustrate the impact of sensory differences in school, which will be published on the Connect website. We are also planning to co-produce resources specifically for teenagers and to collaborate with Grace on environmental support. This will involve Grace visiting schools alongside Occupational Therapists to help identify practical ways to make learning environments more sensory-friendly. It has been a pleasure working with Grace. She has provided many insights that have strengthened the work delivered by the Sensory Services and enriched our understanding of how sensory differences affect pupils." – **Staff Member – Sensory Outreach Team**

2.2.8 Fundraising for Health Stars

The Humber Youth Action Group (HYAG) expressed an interest to start fundraising for Children's Services to help improve health outcomes and care for children, young people and their families. There are seven HYAG members registered as charity champions who co-produce fundraising initiatives with the Charity Manager and Engagement Lead to support our children's services. Since August 2025 we have hosted two fundraising events which have raised over £1500 for the Trust's Children's Services. These funds will support the redesign of Rivendell House, our East Riding Core Children and Adolescent Mental Health Services (CAMHS) building which is currently undergoing a major transformation which the HYAG are supporting alongside Experts by Experience.

Why This Matters (Positive Impact) …

Young people are now more actively involved in raising funds to improve children's services. The fundraising events have generated over £1,500, which is helping to improve environments like Rivendell House. By working alongside staff as charity champions, young people have had a real say in how funds are raised and used.

Overall, this has increased young people's involvement, supported service improvements, and helped create better spaces and care for children and families.

"It was such a fun and meaningful experience, meeting new people while supporting a good cause that really matters. It was both enjoyable and rewarding, it felt great to have a good time while making a difference, with so many people willing to give and hear about what it was for." – **HYAG Member**

2.3 Community Services and Primary Care

Outcome 1 – Our Care

2.3.1 GP Practice Patient Information Booklets

Patient Participation Groups (PPGs) fed back that some patients needed a non-digital way to access information about GP services. In response, the Patient and Carer Experience Lead worked with practice staff and PPG members to update and improve a practice information booklet at Market Weighton, making it more detailed and tailored to local needs. This approach was then used to create similar booklets for other practices.

Although GP services are transferring to new providers, editable versions of the booklets will be shared so practices can continue to adapt them with their new teams.

Why This Matters (Positive Impact) …

Patients who are not online now have a clear and accessible way to find information about their GP services. The booklets provide more detailed, locally relevant information, helping patients better understand what support is available and how to access it.

By involving PPGs, the resources better reflect patient needs and experiences.

2.3.2 Sharing a Patient Story – "A Message of Hope"

East Riding Partnership service user Karl was invited by the Trust's senior management team to present his story to the Board in September 2025.

In his presentation, Karl reflected on his life, care experience and journey—from living with addiction to becoming a dedicated Peer Mentor. His story highlights that addiction can affect anyone and that recovery is always possible with the right support, determination and willingness to seek help. He shared his experience to inspire others and to showcase the vital work of the Drug and Alcohol Service.

Why This Matters (Positive Impact) …

Karl is now an active volunteer Peer Mentor with the Trust, providing hope, encouragement and recovery support to people using Drug and Alcohol Services. He raises awareness of available support by sharing his lived experience and is exploring work with the Recovery and Wellbeing College, including developing podcasts for a wider audience.

2.3.3 East Riding Partnership – Peer Mentorship

The following feedback was received from service users of the East Riding Partnership:
"When I finish the Community Rehabilitation Programme it would be nice to have extra aftercare with a peer mentor."

Why This Matters (Positive Impact) …

In response, the Addictions team reopened a building to provide weekly one-to-one peer support sessions for those completing the 12-week programme.

The East Riding Partnership "You Said… We Did" initiative shows our commitment to listening to service users, valuing their feedback and making meaningful improvements. It ensures services are shaped by user views and continue to evolve based on what matters most to the public.

2.3.4 Scarborough Stroke Warriors

The Stroke Warriors Support Group was launched in September 2025 by Andrea, a patient of the Community Stroke Team. After experiencing a number of strokes, Andrea was determined not to let the experience define her. She sought to create a new focus after her stroke which meant she was no longer able to work. She identified a gap in local peer support in Scarborough. With guidance from the team, and in collaboration with the Divisional Patient and Carer Experience and Involvement Lead, Andrea established a local stroke support group. This included development of branding, promotional materials, a social media presence, and securing a venue.

Why This Matters (Positive Impact) …

"In 2024, at the age of 52, I had four mini-strokes and an MCA infarct stroke, which affected my ability to communicate. Recovery was frightening and isolating, and I often felt self-conscious trying to speak to others. When I couldn't find a local support group, I realised one was needed. With the support of the Community Services Stroke Team and the Patient and Carer Experience and Involvement Lead, I set up a group to support other stroke survivors who are facing the same challenges."

2.3.4 Market Weighton Practice Patient Participation Group Health and Wellbeing Awareness Event

The division piloted a printed information booklet with Market Weighton Practice, which was then co-produced with the Patient Participation Group Action Planning Group to better meet local needs. This approach was extended to other practices, with editable, unbranded versions shared so they can continue to be adapted during the transition to new providers.

As an extension to the production of the information booklet, a community event attracted over 200 attendees, who explored local health and wellbeing services and took part in activities for all ages. Workshops and digital support were offered, including help with using the NHS App, accessing online consultations, and the launch of the updated booklet.

Overall, the event brought together services and the community to promote health, wellbeing and awareness in a welcoming, inclusive way.

Why This Matters (Positive Impact) …

More patients can now access clear, useful information about their GP services. The booklet and event helped people better understand what support is available and how to access it, including digital options like the NHS App. The event brought together services and the community, increasing awareness of local health and wellbeing support and encouraging people to take a more active role in their health.

"The hosts were exceptionally friendly and welcoming. We attended with our two children and found everyone incredibly accommodating. The Cress Heads craft activity was a wonderful addition, keeping the children happily engaged while we explored the health and wellbeing stalls. It was a fantastic event that truly brought the whole community together." ***– Event Attendee***

2.3.5 Safer Inhalation Devices Awareness Project

The Safer Inhalation Pipes and Devices Awareness Project was launched with dedicated funding to promote safer inhalation practices. Free safer inhalation kits are provided through Addiction Services keyworkers, supporting safer substance use and reducing the risk of respiratory infections and blood borne viruses linked to shared or unsafe equipment. The initiative also acts as an engagement tool, encouraging access to health advice, support and treatment pathways. Staff have received specialist training in harm reduction, safe distribution and brief interventions, including safer use guidance, respiratory awareness and overdose prevention. Patients are also offered optional health checks, Blood Borne Virus (BBV) testing and referrals.

Equipment is issued on a one-per-person basis to minimise sharing risks, improve engagement, and strengthen connections with harder-to-reach groups. The project collects non-identifiable data on distribution, demographics, staff and patient feedback—already showing increased engagement.

Following evaluation, the project will work with service users and peer volunteers to co-produce awareness materials to encourage wider engagement with

Why This Matters (Positive Impact) …

This project has made people safer by reducing injuries and the spread of infections. It has helped more people access support, especially those who may not have used services before, and allowed staff to offer advice, testing and referrals earlier. It has also built trust with harder-to-reach groups. Feedback has been positive, and what people have said is helping shape future improvements and awareness work.

Addiction Services.

Outcome 3 – Our Workforce and Organisation

2.3.6 Enhancing our Lived Experience Workforce

Across the division, Experts by Experience and volunteers are actively contributing to service design and improvement through co-produced projects, forums and community partnerships. At the same time, staff are being supported to lead this work through dedicated engagement leadership, structured quality improvement approaches and practical tools to gather and act on feedback.
Initiatives such as the Friends and Family Test quality improvement programme and the consistent use of "You Said, We Did" highlights how staff across the division are embedding patient experience into everyday practice, strengthening partnership working and supporting a culture where co-production is everyone's responsibility.

Why This Matters (Positive Impact) …

Involving people with lived experience compliments our workforce and brings another dimension to enable the organisation to be more person-centred. Having a dedicated Senior Patient and Carer Experience Involvement Lead enables staff to feel more confident and supported to listen to feedback and act on it, which has improved how services respond to patients and carers. Overall, this has led to improved patient experience, stronger relationships with our communities, and a more engaged and motivated workforce.

2.4 Forensic Services

Outcome 1 – Our Care

2.4.1 Service User Expert by Experience Ward Rep Pilot

Service users told us that they would like to refresh the role of the Service User Rep by developing a safe and supported paid Service User Rep role with clear responsibilities and role description. To support this they also wanted to include a fair interview process and T-shirts to identify reps when attending external events and carrying out the role within the service. As well as the development of the role, service users also told us that they would like more paid opportunities within the service.

In response to the feedback, we have now developed and implemented a fair and safe recruitment process, training and support structure. There are now nine paid Service User Reps across our forensic inpatient wards who are supporting the Humber Voices co-production group and bringing service user feedback from

ward to board. Our Health Stars charity have enhanced the role through providing reps with T-shirts and notepads which help to identify them.

An induction and training session was delivered to the first cohort of paid reps, one of whom is now paid to deliver the training to newly recruited Service User Rep

Humber Voices logo

Why This Matters (Positive Impact) …

This has made the role clearer, fairer and paid, giving service users real opportunities to be involved. The nine paid reps receive training, support and are easier to recognise, which helps them feel more confident and valued. It has also created more chances for service users to develop, including helping to train new reps. Some service users told us how they feel about the refresh of the role:

"I feel more confident and less paranoid"

"It's helpful to keep busy rather than sat in my room ruminating"

"This seems to be just what I need"

"Being a rep allows me to reintegrate into the wider community and gain contacts with services that can help me in the future"

"It keeps me busy at times when there's 'nowt to do"

"I'm getting used to getting involved with other people"

2.4.2 Ward Entrance Project

Service users told us that they would like to make the entrance to the Humber Centre look more inviting. As a result of this feedback, a service user with artistic skills was paid as an Expert by Experience to paint ward entrances making their living space feel less clinical and improving their experience of care.



Artwork from The Humber Centre

Why This Matters (Positive Impact) …

This has made the environment feel more welcoming and less clinical, improving the look of ward entrances and helping service users feel more comfortable in their living space. It has also given a service user the chance to use their skills and be paid for their contribution, helping them feel valued and involved.

2.4.3 Implementation of Service User Involvement Authorisation Form

Feedback from service users told us that they wanted a better system in place for taking involvement opportunities through Multi-Disciplinary Team (MDT) meetings. As a result, a new form has been created to support the authorisation of service user participation in involvement opportunities ensuring involvement is supported and safe for all.

Why This Matters (Positive Impact) …

This process is providing service users some autonomy where they can take opportunities that they would like to participate in, such as attending an external event to their MDT for approval. These opportunities are building confidence and supporting recovery.

Outcome 2 – Our Partnerships

2.4.4 Service User Led Events Group

During this year, a service user led events group was launched as a result of service user feedback showing that service users wanted to be involved in improving their seasonal events. The events group brings together staff and service users who work together to deliver fun engaging events across the service.

Service users have hosted an Armed Forces Appreciation Day which included a sponsored step challenge, a 10k sponsored walk to Risby Park and are working on a 'Humber's Got Talent' Event for Summer 2026. These fun and engaging events are improving service user experience, providing social opportunities and boosting morale across the service while raising money for our Health Stars charity.



Armed Forces Charity Event Poster

2.4.5 Humber Voices Newsletter

Why This Matters (Positive Impact) …

This has improved service users' experience by giving them a voice in planning and running events they enjoy. It has created more social opportunities, helped people feel more connected, and boosted morale across the service. It has also supported teamwork between staff and service users, while raising money for charity.

Based on what service users told us they would like, a monthly newsletter, which is co-produced by services users and staff, is now distributed across the service.

Service users now feel better informed about involvement opportunities, events and service updates, such as new staff members in our recent addition of a 'meet the staff' section. The co-production group allows service users extra time to socialise with others while being creative. Each month they find a theme, jokes, facts and puzzles to include.



Humber Voices Newsletter

Why This Matters (Positive Impact) …

This helps service users feel more informed about what is happening across the service, including events, opportunities and new staff. It has also created a space for people to come together, be creative and socialise, which supports wellbeing. By working together with staff, service users feel more involved and have a stronger voice in shaping the newsletter.

Outcome 3 – Our Workforce and Organisation

2.4.6 Refresh of the Staff Champion of Patient Experience role in Forensic Services

A Staff Champion of Patient Experience Relaunch Event was held and we have recruited nine additional staff members to the role to support with Involvement and Co-production across the service. This strengthens links to the strategic Patient and Carer Experience Team and helps to ensure that involvement, engagement and co-production are properly embedded in the service.

Why This Matters (Positive Impact) …

This has strengthened involvement and co-production by increasing the number of staff supporting this work. It has improved links with the Patient and Carer Experience Team, helping to ensure that engagement and co-production are a consistent and embedded part of the service.

2.5 Learning Disabilities Services

Outcome 1 – Our Care

2.5.1 Experts by Experience

The Learning Disability service is placing co-production at the centre of its work, ensuring people with lived experience help shape services. This includes introducing a trust-wide approach to reasonable adjustments, working with children's services to create accessible infant feeding resources, and co-producing and delivering sign language training.

So far, eleven Experts by Experience have supported seven projects, contributing nearly 100 hours. This has strengthened inclusive practice, improved accessibility, and ensured services better meet the needs of people with learning disabilities and their families.

Why This Matters (Positive Impact) …

This has helped to make services more inclusive and better tailored to people's needs by putting co-production at the centre. Because of collaborative work on specific projects there are now more usable resources for parents with learning disabilities, and better communication through sign language training. Involving Experts by Experience has ensured services are shaped by real insight, leading to more practical and meaningful improvements for service users and their families.

2.5.2 Co-production Group for Learning Disabilities Division

A weekly Patient Voice Group and a Community Co-Production Group have been set up in response to feedback from inpatients and the Learning Disability service. These groups provide a safe and supportive space for people to share their views, contribute ideas and work with staff to improve services.

Together, they have helped establish clear group values, agreements and a standard way of working. Around eight people with learning disabilities are now involved, taking part either one-to-one or in group depending on their needs. This has strengthened co-production, ensuring service users feel heard, involved and able to influence changes in their care.

Why This Matters (Positive Impact) …

This has given people with learning disabilities a safe and supportive space to share their views and feel listened to. It has increased confidence and involvement, helping service users have a real say in their care and how services are run. The groups have strengthened co-production with staff, leading to clearer ways of working and more service improvements shaped by patient feedback.

Outcome 2 – Our Partnerships

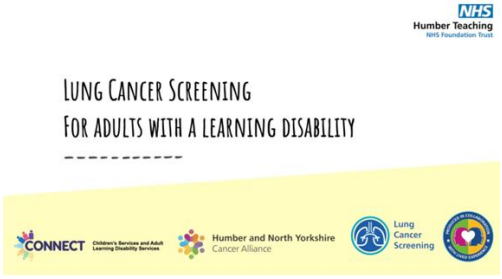
2.5.3 Learning Disabilities Cancer Screening Project

Patients with learning disabilities are less likely to attend important health screenings, increasing their risk of poor health outcomes. In response, this project created four accessible, co-produced videos on bowel, breast, cervical and lung screening, alongside awareness sessions for staff and resources to reduce anxiety at appointments.

Why This Matters (Positive Impact) …

Since launching in October 2024, screening uptake in Bridlington has significantly improved, with bowel screening rising from 7 to 43 participants, breast from 0 to 26 participants, and cervical from 2 to 19 participants by September 2025.

The project has been widely recognised for its impact, including a Health Service Journal (HSJ) Award shortlist, a high commendation for championing the patient voice, a partnership award at the Humber NHS Staff Awards, and selection as a case study by the Humber and North Yorkshire Cancer Alliance.



Lung Cancer Screening for Adults with a Learning Disability

Outcome 3 – Our Workforce and Organisation

2.5.4 Staff Champions of Patient Experience

Seventeen staff members have been recruited as Staff Champions of Patient Experience within the Learning Disability (LD) division, with representatives from each team. A survey helped shape how the group runs,

including meeting times, topics and frequency. The group meets every two months, led by the engagement lead, and focuses on co-production, sharing ideas, learning from guest speakers and offering peer support. Staff have also co-produced the group's values, helping to create a supportive and collaborative network across the service.

Why This Matters (Positive Impact) …

This has created a stronger network of staff who are more confident and skilled in co-production and involvement. It has improved communication and sharing of ideas across teams, ensuring more consistent approaches within the LD service. Regular meetings and peer support have helped staff feel more connected and supported, leading to better engagement with service users and more meaningful involvement opportunities.

2.6 Mental Health Services

Outcome 1 – Our Care

2.6.1 Inpatient Voices Group and Inpatient Survey

Patients accessing care on our inpatient units wanted clearer processes for providing feedback. We developed a new inpatient survey that would be easier for patients to complete, reducing the number of questions whilst continuing to gather meaningful feedback about aspects of care that are important to our patients. The survey is adapted from one of the Culture of Care surveys which were co-produced with those with lived experience.

We also launched a new inpatient voice group, running once a month with participation encouraged from all wards across unplanned care.

Feedback received through the inpatient survey has increased with a plan in place to promote engagement with the survey across all wards in the division.

The inpatient voices group was launched in February 2026 with attendance from 5 wards at the first meeting. Direct feedback was heard from patients currently accessing care, enabling actions to be taken where possible.

Why This Matters (Positive Impact) …

It is now easier for patients to give feedback by introducing a simpler survey that focuses on what matters most to them. As a result, more feedback is being collected and used to improve care. The new inpatient voice group has also given patients a direct way to share their experiences. Overall, it has strengthened patient voice and made it easier for services to listen and respond.

2.6.2 Culture of Care Initiative

The NHS England Culture of Care initiative aims to improve the environment on mental health inpatient wards for patients, carers and staff. Two wards have taken part in a quality improvement project, where staff are working with patients and Experts by Experience to develop and test ideas for change. Feedback has been collected through surveys, with positive responses to the changes being made.

Why This Matters (Positive Impact) …

The Culture of Care initiative is strengthening trauma-informed practice by increasing staff knowledge, confidence, and consistency in responding to trauma. This is leading to more compassionate, person-centred care, improved patient experience on inpatient wards, and a more supportive and reflective staff culture that recognises and responds to the impact of trauma.

2.6.3 Support Groups – Homeless Mental Health Team

The Peer Support Worker in the Homeless Mental Health Team identified the need for a space for service users to come together and receive support from each other based on feedback from those known to the service. The individuals felt that more informal support in a group setting may be beneficial outside of clinical appointments.

As a result, two support groups have been set up; one for pre/post discharge support and one for housing sustainment support, running monthly. These groups are facilitated by Peer Support Workers currently supported by the Lived Experience Co-ordinator.

Why This Matters (Positive Impact) …

Feedback from those accessing the groups have shared that attendance is enhancing their recovery, building confidence and social skills as well as supporting new connections.

The pre-post discharge group started out with only a few attendees and now has consistently high attendance. Those accessing the group have also been keen to get involved in other activities e.g. sharing an experience of care.

Outcome 2 – Our Partnerships

2.6.4 Hull University Teaching Sessions for Clinical Psychology Doctoral Students

Feedback received from students on the DClinPsych (doctoral degree to become a qualified clinical psychologist) was that by including Experts by Experience (EbEs) in teaching supported their learning. Three teaching sessions led by the Complex Emotional Needs Service (CENS) were co-delivered by those with lived experience. Feedback received on the teaching was very positive and specifically referenced the benefit of involving those with lived experience to bring the topics to life.

Why This Matters (Positive Impact) …

Feedback shared by students included:

"EbEs were really helpful to make a tricky topic appear more 'real' and accessible."

"I found it really helpful having the experts by experience in for this session and felt that their insights into how these things feel in practice were really important to consider."

"Lived-experience perspectives as well as clinical insight were brilliant and provided a rich understanding."

Outcome 3 – Our Workforce and Organisation

2.6.5 Trauma-informed Communications Guide for Staff

Staff asked for support to embed trauma-informed principles within written communications with patients, service users and carers. Workshops were held with patients, service users and carers to discuss their experiences of when communication felt safe/unsafe and to make suggestions for how staff can be more trauma-informed in their communication.

Why This Matters (Positive Impact) …

The outcome of this project is a communications guide for staff covering suggestions for written and verbal communication accompanied by real experiences. The guide is still in the final stages of being developed.

3.0 Complaints and Feedback

During the past year (1 April 2025 to 31 March 2026), the Trust has responded to a total of 509 complaints: 166 formal complaints and 343 informal complaints. For the previous year, the Trust responded to a total of 502 complaints: 188 formal complaints and 314 informal complaints.

Of the 166 formal complaints responded to, 31 (19%) were upheld, 55 (33%) were partly upheld and 80 (48%) were not upheld. For the previous year, the Trust responded to 188 formal complaints of which 43 (23%) were upheld, 70 (37%) were partly upheld and 75 (40%) were not upheld.

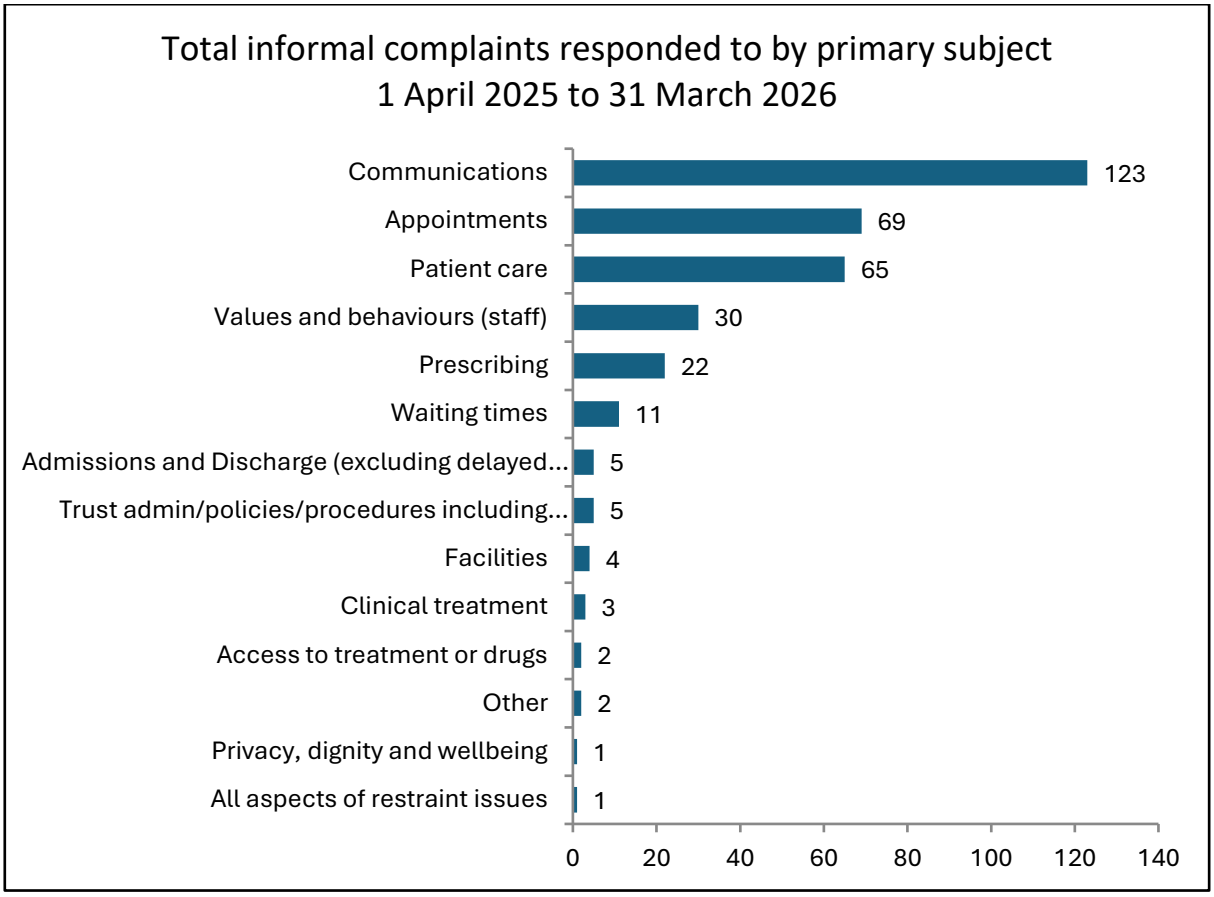
On comparing the 2 years there has been an overall increase of 7 complaints (formal and informal complaints) and communications and patient care are the top primary subjects.

The Trust implements actions because of formal complaints responded to which are upheld/partly upheld and lessons are learnt from feedback.

3.1. Informal Complaints

For the period 1 April 2025 to 31 March 2026, the Trust responded to 343 informal complaints. The primary subjects/themes are highlighted in Graph 1. For the previous year, the Trust responded to a total of 314 informal complaints.

The primary subjects/themes for informal complaints responded to for the period 1 April 2025 to 31 March 2026 are highlighted in Graph 1.



Graph 1

3.1.1 Informal Complaints Escalated to Formal Complaints

For the period 1 April 2025 to 31 March 2026, a total of 8 informal complaints have been escalated to formal complaints. For the same period last year, an identical total of 8 informal complaints were also escalated to formal complaints.

Here is a detailed analysis of informal complaints escalating to formal complaints for the past year.

Community Services and Primary Care – Humber Primary Care Practice
Primary subject: **Prescribing**
Reason for escalation: The complainant originally raised concerns regarding their mother's medication being stopped by the practice without prior warning. Following the sad death of their mother, the complainant escalated this to a formal complaint along with numerous other concerns regarding her care and treatment over an 18 month period.

Planned Care Mental Health Services – Hull Community Mental Health Team
Primary subject: **Waiting times**
Reason for escalation: The complainant originally raised concerns regarding the lack of allocated care coordinator support for their mother from the service, for which she had been waiting 18 months to date. Following a lack of acceptable response and resolution from the service, the complainant requested escalation to a formal complaint.

Unplanned Care Mental Health Services – PICU Ward
Primary subject: **Values and behaviours of staff**
Reason for escalation: The complainant originally raised concerns regarding their care and treatment on the ward, including the behaviour of multiple staff members. The service was subsequently unable to resolve these issues informally to the complainant's satisfaction, and they requested escalation to formal complaint.

Unplanned Care Mental Health Services – PICU Ward
Primary subject: **Prescribing**
Reason for escalation: The complainant originally raised concerns regarding the timely administration of medication while on the ward. The service was subsequently unable to resolve these issues informally to the complainant's satisfaction, and they requested escalation to formal complaint.

Planned Care Mental Health Services – PSYPHER
Primary subject: **Values and behaviours of staff**
Reason for escalation: The complainant originally raised a concern that their family member was informed of their discharge from the service when they had not given their consent for this information to be shared. The service was subsequently unable to resolve these issues informally to the complainant's satisfaction, and they requested escalation to formal complaint.

Community Services and Primary Care – King Street Medical Practice
Primary subject: **Communications**
Reason for escalation: The complainant originally raised concerns regarding their recent interactions with the practice, including the attitude of a staff member towards them, a delay in receiving test results and an alleged breach of their confidentiality. Following receipt of a letter sent directly from the practice, the complainant did not feel the issues had been sufficiently resolved and wished to escalate to a formal complaint.

Community Services and Primary Care – Market Weighton Practice
Primary subject: **Prescribing**
Reason for escalation: The complainant originally raised a concern that their medication had been stopped by the practice without prior warning. Although the issue was initially addressed by the practice and the

complainant was happy to close the complaint as informal, they subsequently requested escalation to a formal complaint as the promised resolution had not happened.

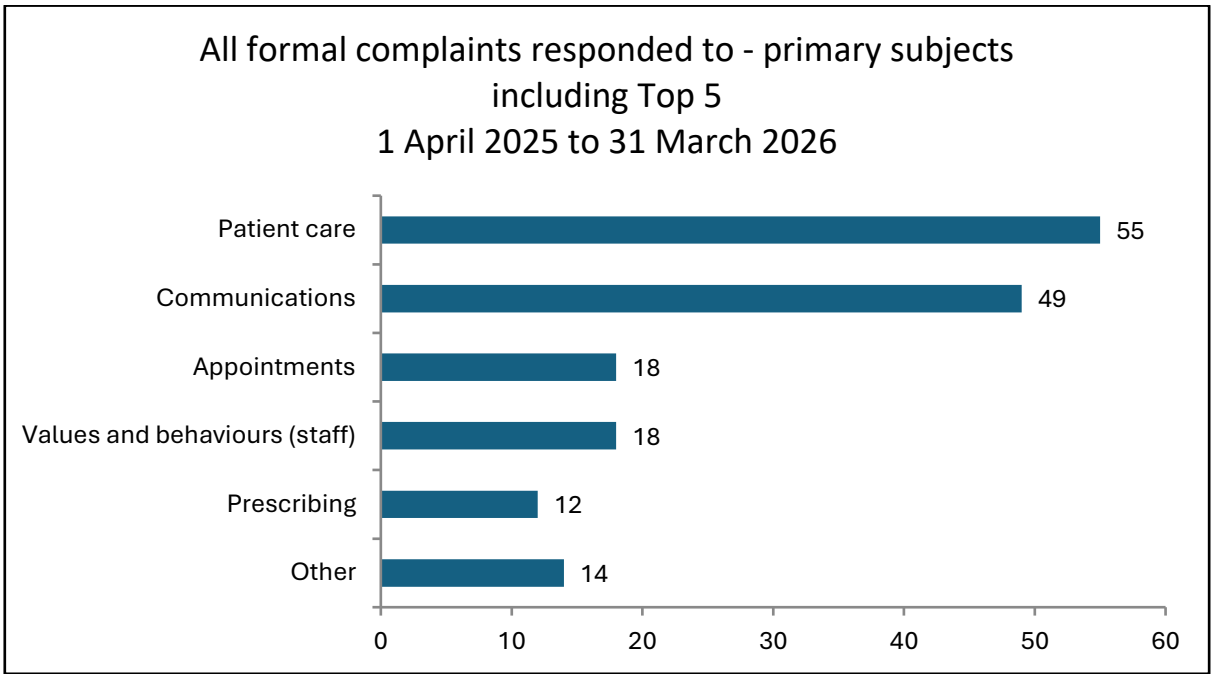
Planned Care Mental Health Services – Hull Community Mental Health Team
Primary subject: **Communication**
Reason for escalation: The complainant originally raised concerns over a lack of communication from the service. The service was unable to resolve the issues to the complainant's satisfaction on an informal basis, and they requested escalation to a formal complaint.

3.2 Formal Complaints

During the past year (1 April 2025 to 31 March 2026), the Trust received 204 formal complaints compared to 193 for the previous year.

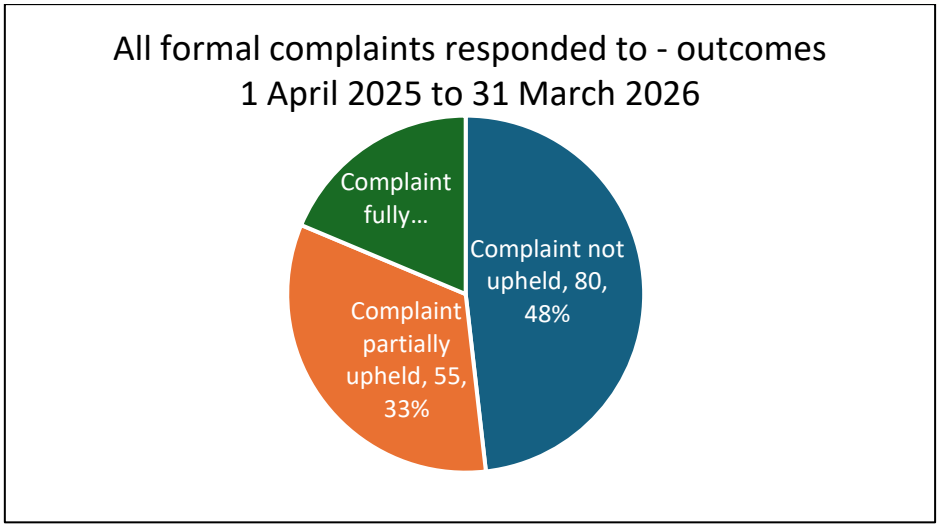
The Trust responded to **166** formal complaints which compares to **188** for the previous year (a decrease of **22** formal complaints). The Complaints and Feedback Manager considers that this position is due to both a continued overall reduction in complaints for Primary Care, and challenges in meeting the demand of an increase in complaints for the Mental Health Division, which have resulted in a backlog of complaint responses for approval.

The primary subjects/themes are highlighted in Graph 2.



Graph 2

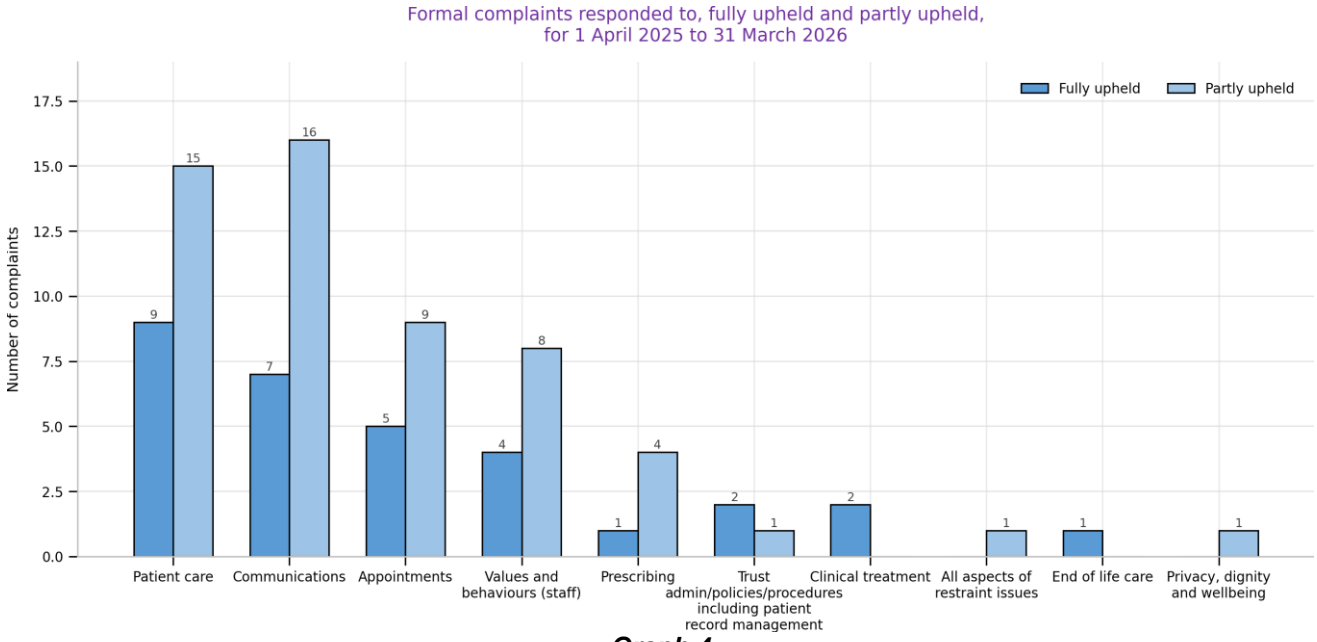
Of the **166** formal complaints responded to, **31 (19%)** were upheld, **55 (33%)** were partly upheld and **80 (48%)** were not upheld. For the previous year, the Trust responded to **188** formal complaints of which **43 (23%)** were upheld, **70 (37%)** were partly upheld and **75 (40%)** were not upheld. The outcomes are highlighted in graph 3.



Graph 3

3.2.1 Themes and Trends

On analysis of the total number of formal complaints responded to during the twelve-month period from 1 April 2025 to 31 March 2026 where the outcome was either upheld or partly upheld, Graph 4 shows that patient care is the highest complaint subject for the Trust, followed by communications and then appointments.

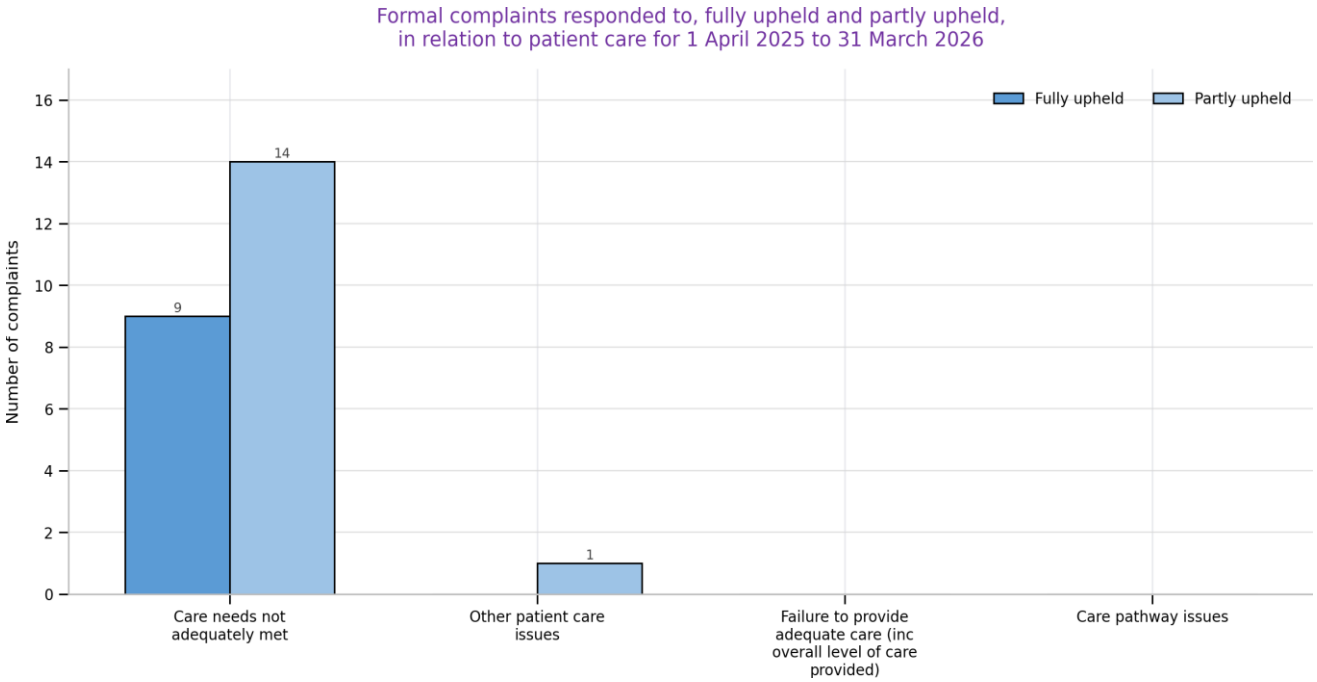


Graph 4

Analysis: Patient care: On closer review of the leading subject of patient care, Graph 5 (below) shows that care needs not adequately met continues to be the dominant sub-subject for the Trust. During the twelve-month period, there were 55 formal complaints responded to with patient care recorded as the primary subject. Of these, 9 were fully upheld and 15 were partly upheld following investigation, with the remaining 31 not upheld.

Of the 24 complaints that were fully or partly upheld, 9 (38%) related to Planned Mental Health Services, 6 (25%) to Community and Primary Care, 5 (21%) to Unplanned Mental Health Services, and 4 (17%) to Children's and Learning Disabilities Services.

Of these 24 fully and partly upheld complaints, 23 related specifically to care needs not adequately met. The strongest recurring issues within this group concerned delays in follow-up or review, uncertainty about who was responsible for ongoing care, and concerns that the level of support or intervention provided did not fully meet need. There was one further upheld complaint recorded as other patient care issues; therefore, no additional trend was identified from that complaint on its own.



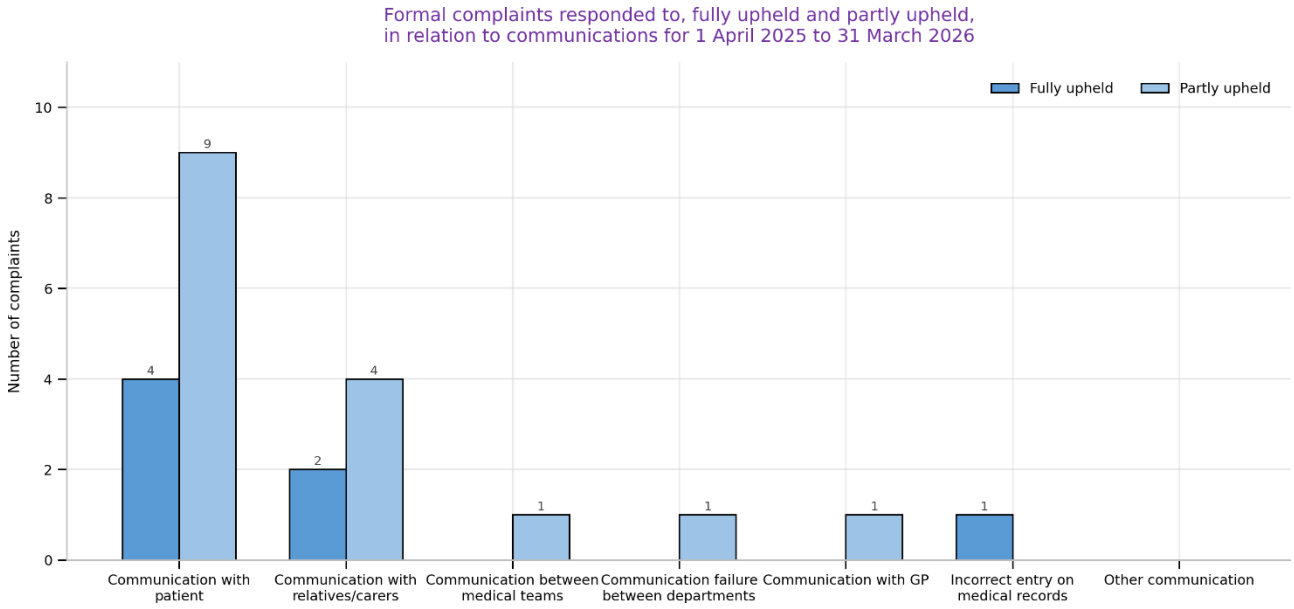
Graph 5

Analysis: Communications: On closer review of the second highest subject of communications, Graph 6 shows that communication with patient is the main sub-subject within this category, followed by communication with relatives/carers. During the twelve-month period, there were 49 formal complaints responded to with communications recorded as the primary subject. Of these, 7 were fully upheld and 16 were partly upheld following investigation, with the remaining 26 not upheld.

Of the 23 complaints that were fully or partly upheld, 10 (43%) related to Planned Mental Health Services, 5 (22%) to Unplanned Mental Health Services, 4 (17%) to Community and Primary Care, 3 (13%) to Children's and Learning Disabilities Services, and 1 (4%) to the Medical Directorate.

The main sub-subject trends show that 13 complaints had a sub subject of **communication with patient**, with common concerns about lack of timely updates, unclear explanations of care or next steps, and calls or messages not being returned promptly. A further 6 complaints related to **communication with relatives/carers**, most often where families felt they had not been kept informed or had difficulty obtaining clear, timely information.

The remaining upheld complaints were isolated across communication between teams, communication failure between departments, communication with GP, and incorrect entry on medical records, so no further consistent trend was observed.

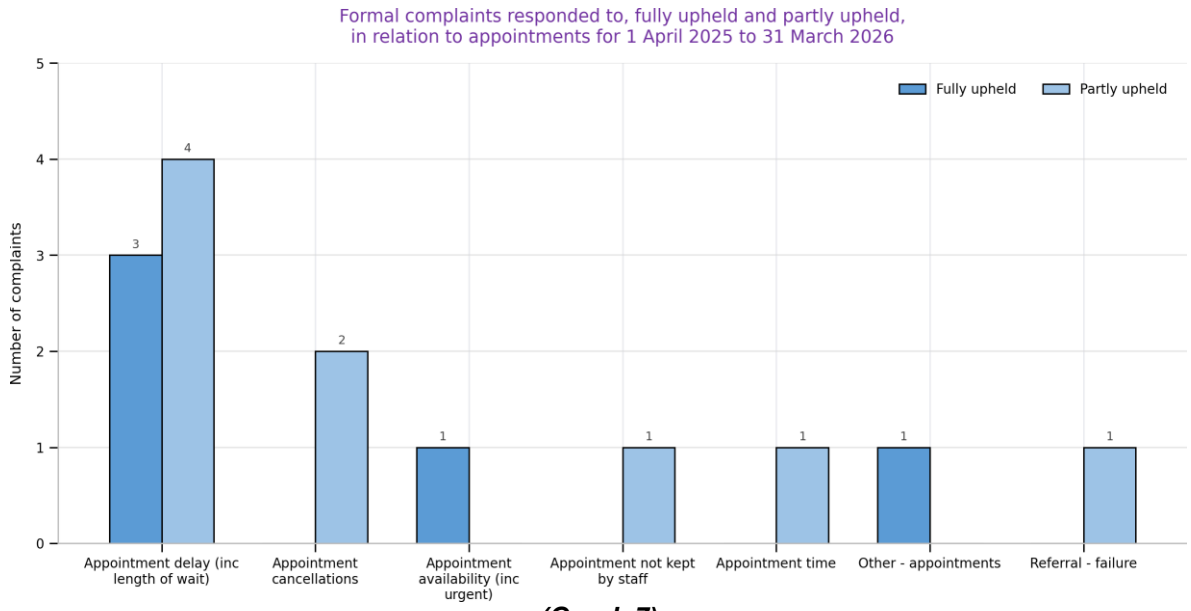


Graph 6

Analysis: Appointments: On closer review of the third highest subject of appointments, Graph 7 shows that **appointment delay (including length of wait)** is the leading sub-subject for the Trust, followed by appointment cancellations. During the twelve-month period, there were 18 formal complaints responded to with appointments recorded as the primary subject. Of these, 5 were fully upheld and 9 were partly upheld following investigation, with the remaining 4 not upheld.

Of the 14 complaints that were fully or partly upheld, 7 (50%) related to Planned Mental Health Services, 6 (43%) to Community and Primary Care, and 1 (7%) to Unplanned Mental Health Services.

The main sub-subject trends show that 7 complaints related to **appointment delay, including length of wait**. These complaints most often concerned long waits for assessment, treatment or follow-up appointments. A further 2 complaints related to **appointment cancellations**. The remaining upheld complaints were spread across isolated issues relating to appointment availability, appointments not kept by staff, appointment time, other appointment concerns and referral failure; therefore, no additional pattern was evident.



(Graph 7)

3.2.2 Learning Responses

Each complaint presents a new opportunity for learning and improvement in the Trust. For every formal complaint that has been either fully or partly upheld, an action plan is produced by the Investigating Manager and submitted with the final documentation; all actions are then moved onto an action tracker which is monitored by each division to ensure continuous improvement and transition into the day-to-day business of patient care.

The following are some of our learning responses because of the complaint and the subsequent investigation during the past year.

Theme 1: Patient care

Issues upheld	Learning responses
Planned Mental Health Services – The complainant did not receive clear follow-up after completing a 12-week programme and requests for medication review and therapy updates were not progressed, leaving uncertainty about next steps and available support.	The service has implemented an MDT tracking system for medication review requests, with urgent reviews flagged to the Consultant, Non-Medical Prescriber or Pharmacist. Service users also now receive written confirmation of waiting list placement and anticipated timescales.
Unplanned Mental Health Services – The complainant raised concerns that basic care needs, including support with personal hygiene, were not consistently reflected in care planning and that family concerns were not documented clearly enough.	The service has strengthened care planning standards so that personal hygiene needs and required staff actions are clearly documented. Where there are concerns about capacity in relation to personal care, mental capacity assessments are completed and recorded clearly, with the learning reinforced through team business meetings and documentation reviews.
Planned Mental Health Services – The complainant experienced delay and uncertainty because clinic correspondence was not uploaded in a timely way and referral tracking did not consistently identify a named clinician or clear pathway for follow-up.	The service has reinforced mandatory timescales for completion and upload of clinic letters, supported by administrative tracking and escalation for overdue correspondence. Referral tracking systems have also been strengthened so that a named clinician and pathway status are recorded on the electronic patient record for all active cases.

Theme 2: Communications

Issues upheld	Learning responses
Children's and Learning Disability Services – There was an inconsistent level of communication with the complainant from the service, particularly around the allocation of keyworkers and updates regarding changes to the external partner.	The service has developed and implemented a new multi-agency escalation process to support with the management and communication of clinically complex cases.
Planned Mental Health Services – The complainant's family repeatedly raised concerns about deterioration in mental health, but communication and handover arrangements were not robust enough when the allocated worker was absent.	The service has reviewed the structure and recording of its safety huddles to ensure continuity of discussion and action for patients presenting with risk or relapse concerns. The standard operating procedure for staff absence and caseload review has been reinforced to improve handover, monitoring and communication with families.

Unplanned Mental Health Services – The complainant felt that the practical implications of attending specialist psychotherapy, including access arrangements and treatment expectations, had not been clearly communicated at referral and acceptance stage.	The service has developed clearer patient and carer information about treatment options, practical access considerations and what the service offers. Updated information for referrers has also been introduced so that expectations and practical implications are discussed fully before a referral is accepted.

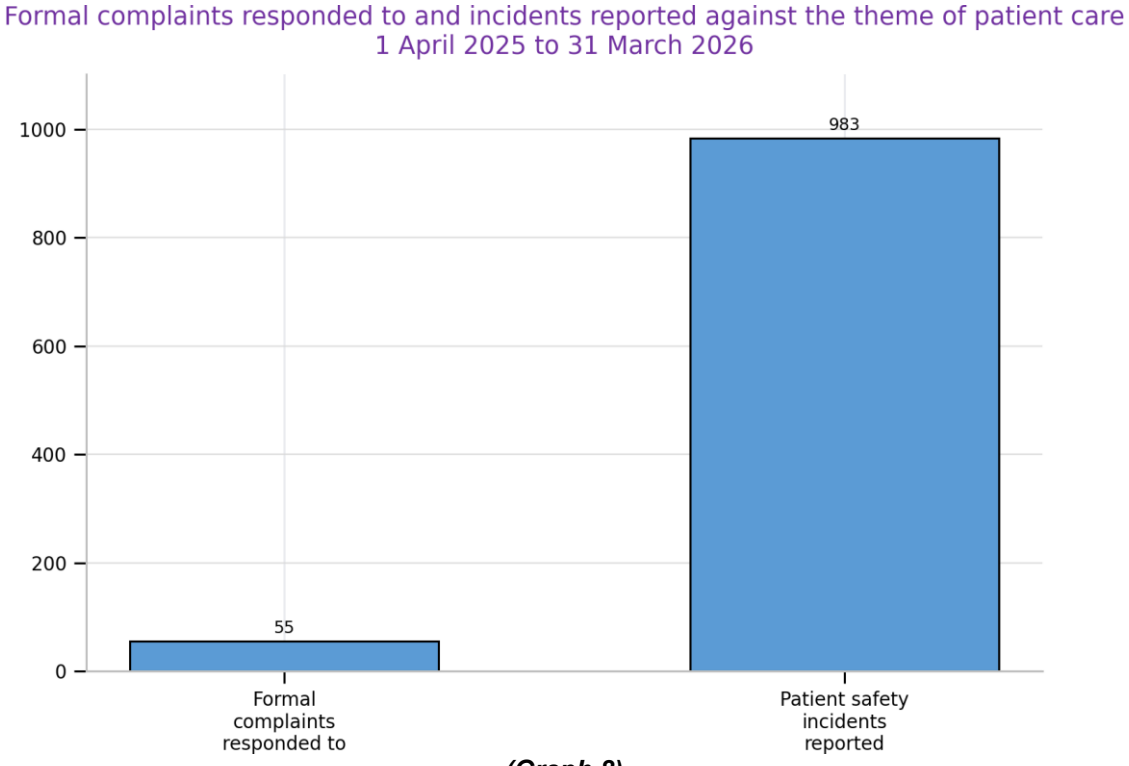
Theme 3: Appointments

Issues upheld	Learning responses
Planned Mental Health Services – The complainant experienced delay in completion of assessment and diagnosis because a radiology re-report request had not progressed efficiently and patients were not kept clearly informed about the next step in the pathway.	Requests for imaging re-reporting are now reviewed at a scheduled weekly meeting between the Consultant Psychiatrist and Clinical Lead, with the request completed by a clinician. A patient letter is issued following formulation to explain the next stage in the diagnostic pathway, and an action tracker has been added to meeting agendas and notes to monitor outstanding actions.
Unplanned Mental Health Services – The complainant attended for an appointment only to find there was no record of it, following cancellation and rearrangement issues which had not been communicated clearly.	To improve reliability of appointment management, the service now contacts patients by telephone as well as by post when planned appointments are rearranged. The cancellation process and associated learning has been reviewed through the service business meeting, and the service's written and online information has been updated to explain the referral journey, service offer and appointment arrangements more clearly.
Primary Care – The complainant's child's vaccination appointments were delayed and repeat delays were not escalated quickly enough within the practice workflow.	The practice has strengthened oversight of time-critical appointments by adding any vaccination delays to the daily workflow and reminding the administration team of the urgency attached to childhood immunisation appointments. This is designed to support earlier escalation and reduce the risk of avoidable delay when clinic capacity changes at short notice.

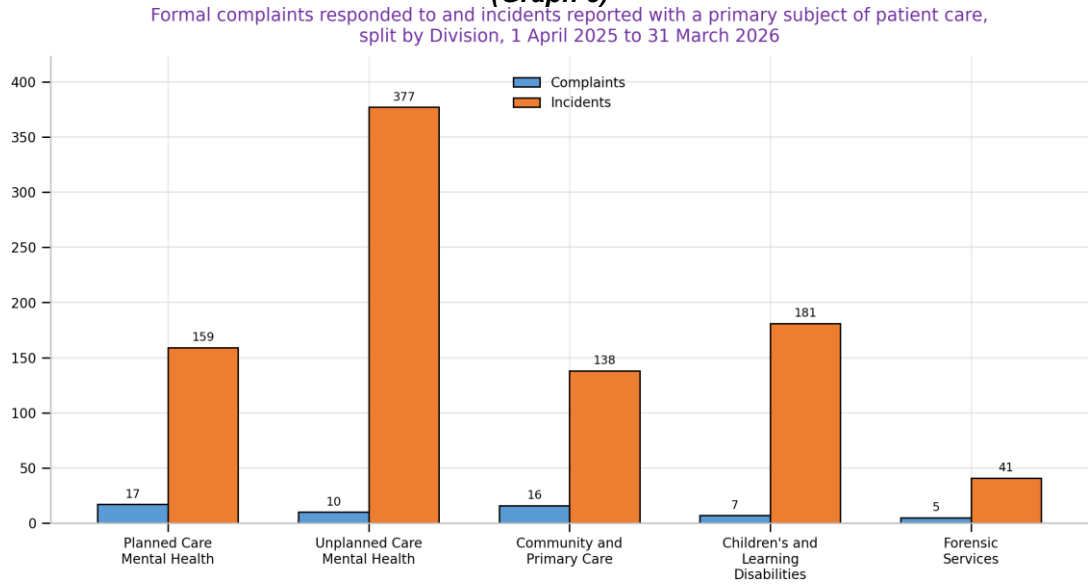
3.2.3 Thematic Review of Patient Care Aligned to Patient Safety Incidents

To gain a more joined-up understanding of the top theme of patient care, we have undertaken a closer look at these complaints alongside patient safety incidents received for the same theme. This category is recorded for incidents as “Patient Care Problem”.

The total number of formal complaints responded to and incidents reported against the theme of patient care for 1 April 2025 to 31 March 2026 are compared in Graph 8 below, whilst Graph 9 demonstrates this split by clinical division.



(Graph 8)



(Graph 9)

Analysis

Formal complaints with a primary subject of patient care – On critiquing the top subject of patient care, **care needs not adequately met** is the highest sub subject for the Trust during the period, with 23 formal complaints upheld or partly upheld. There was 1 other upheld complaint across the category, which was **other patient care issues**.

Of the 23 formal complaints upheld or partly upheld with the sub-subject of care needs not adequately met: 16 complaint narratives related to a lack or omission of care, follow-up or support provided by the services in question. 18 complaint narratives related to a delay in accessing care, review or support. 20 complaint narratives related to a care decision, pathway decision or discharge/treatment planning issue which the complainant was unhappy with. It must be noted that some formal complaints include more than one theme.

Patient safety incidents with a primary subject of patient care – On critiquing the top subject of patient care, **Delay in Patient Care / Treatment** is the highest sub category for the Trust during the period, with 177 incidents reported, followed by **Care Problem/Error - Other** with 111 incidents reported.

Of the 111 patient safety incidents with the sub-subject of Care Problem/Error - Other: 11 related to a delay in follow-up, monitoring or review; 43 related to missed appointments, referrals, visits, allocation or tasking processes; and approximately 7 were concerns raised by services regarding patient risk, behaviour or safeguarding issues rather than direct care provision. A number of incidents included more than one of these themes.

Of the 177 patient safety incidents with the sub-subject of Delay in Patient Care / Treatment: 16 related to shorter-term delays in review, follow-up or response; 10 related to longer-term waits, waiting list pressures or backlog themes; and approximately 5 referred to delays where contact, capacity or patient factors also affected progression of care. It must be noted that some incidents include more than one theme.

Summary

On comparing complaints and incidents against the theme of patient care more closely, two trends emerge consistently across both; a lack or omission of care, follow-up or support from the service(s) involved and/or a delay in receiving care, treatment or review. Although the totals of each are different, the broad themes remain closely aligned.

The Mental Health Division (Planned and Unplanned Care) accounts for the majority of formal complaints responded to and incidents reported on this theme. Within the complaints dataset, these two divisions account for 49% of patient care complaints. Within the incident dataset, using the amended Care Group field and excluding Corporate records from the clinical division comparison shown in Graph 9, the same two divisions account for 60% of patient care incidents.

The majority of complaints and incidents regarding delays in care continue to relate to mental health pathways, particularly around follow-up, allocation, review, community response and progression through treatment or assessment processes. Community and Primary Care Services also account for a significant proportion of activity, particularly where appointment, visit or referral processes have led to avoidable delay.

There remains a significant difference between the overall number of complaints responded to (55) and incidents reported (983) on this theme. This appears to be due in part to the fact that the incident dataset includes operational patient safety events across all care groups, including 87 incidents recorded under Corporate, whereas the complaint dataset relates only to complaints responded to.

3.2.4 Complaints and Feedback Complainant Survey

Following the closure of each complaint, the Complaints and Feedback Team send out a feedback survey to all formal and informal complainants. This anonymous questionnaire gives complainants an opportunity to comment on their experience of the complaint process and to provide insight into how we are doing from a patient/carer/public perspective. The survey is provided in a variety of formats including web link, hard copy and SMS text message.

During 2025/26, 26 responses were received to the survey (13 for formal complaints and 13 for informal complaints). This compares to 43 responses received during 2024/25 (22 for formal complaints and 21 for informal complaints), which is a decrease of 17 responses (40%).

Formal complaints:

- **77%** of respondents felt that making their complaint was a simple process.
- **38%** of respondents felt that their complaint was taken seriously and handled fairly.
- **54%** of respondents felt that the response was personal to them and specific to the nature of their complaint.
- **46%** of respondents felt that the response was clear and understandable and addressed their concerns, even if they did not agree with the outcome.
- **31%** of respondents felt that the learning/actions identified were appropriate to the outcome of their complaint.

Informal complaints:

- **77%** of respondents felt that making their complaint was a simple process.
- **54%** of respondents felt that their complaint was taken seriously and handled fairly.
- **62%** of respondents felt that the service listened to them and took their personal preferences into account.
- **69%** of respondents felt that the service addressed their concerns appropriately, even if they did not agree with the outcome.

Feedback during 2025/26 suggest that respondents valued ease of access to the process, prompt follow-up and personalised responses where these were provided. The main areas of challenge remained timeliness, clarity about outcomes, visible evidence of learning, and confidence that concerns would lead to meaningful change. All but one of the results across both surveys show improvement compared with last year's results; however, this should be interpreted in the context of a lower response rate.

We will continue to draw on this feedback to inform service improvement, complaints training and the ongoing development of the complaints process.

**A further question was introduced into the survey this year, which asks respondents whether they felt the response was compassionate and respectful of their viewpoint, regardless of the outcome. The data for this question has not been included due to being only a partial data set.*

3.3 Parliamentary and Health Service Ombudsman (PHSO)

Of the 166 formal complaints responded to from 1 April 2025 to 31 March 2026, 1 of the complainants have, to date, had their case considered by the Parliamentary and Health Service Ombudsman.

There are currently 2 further cases being considered by the Ombudsman which were closed during 2024/25.

1 detailed investigation by the Ombudsman, relating to a complaint from 2022, was closed during 2025/26 with the concerns not upheld following investigation. There are currently no other cases under detailed investigation by the Ombudsman.

3.4 Zero Informal and Formal Complaints

The total number of teams across the Trust where no formal or informal complaints were received during the reporting period (1 April 2025 to 31 March 2026) is 52 (40%) (out of 129 teams in scope). For the same period last year, 47 teams out of a possible 133 teams in scope (35%) did not receive any formal or informal complaints. This is an increase of 5% on the previous year.

The table below provides a further detailed analysis of the number of teams last year which received no formal or informal complaints.

Division	Teams in Scope	No. of Teams with zero Complaints	% of Teams with zero complaints
Children's and Learning Disabilities	40	23	58%
Community and Primary Care	28	12	43%
Corporate	4	1	25%
Forensic Services	8	3	38%
Mental Health Planned Care	24	4	17%
Mental Health Services Central	1	0	0%
Mental Health Unplanned Care	24	9	38%
Total	**129**	**52**	**40%**

3.4.1 Actions to Address Zero Complaints

To ensure our teams are communicating the complaints process to everyone as effectively as possible, whilst acknowledging an effective local resolution, here are some of the actions taken by the organisation during the past year to address where teams may have received zero complaints.

Working with services – The Complaints and Feedback Manager meets regularly with senior divisional and clinical staff as part of the oversight and approval processes for complaints and suggestions for improvements are identified and acted upon.

Training and presentations – As part of the Trust's complaints training package (see 3.6), staff are made aware of the zero complaints reporting process and the importance of the Trust complaints process being visible to patients and the public. The Complaints and Feedback Team has also given presentations on the complaints process at Trust stakeholder meetings and participated in the Trust Patient and Care Experience Forums. The team is scheduled to present at further meetings into the future.

Posters and leaflets – The Complaints and Feedback Team have worked directly with clinical teams and services to ensure that the Trust's complaints posters are available and on display across community and inpatient sites. The posters are designed to strengthen the local resolution process, ensure that positive feedback is also encouraged, and provide clear contact details for the different ways in which people can make a complaint, as well as signpost free and confidential support available from Independent Health Complaints Advocacies.

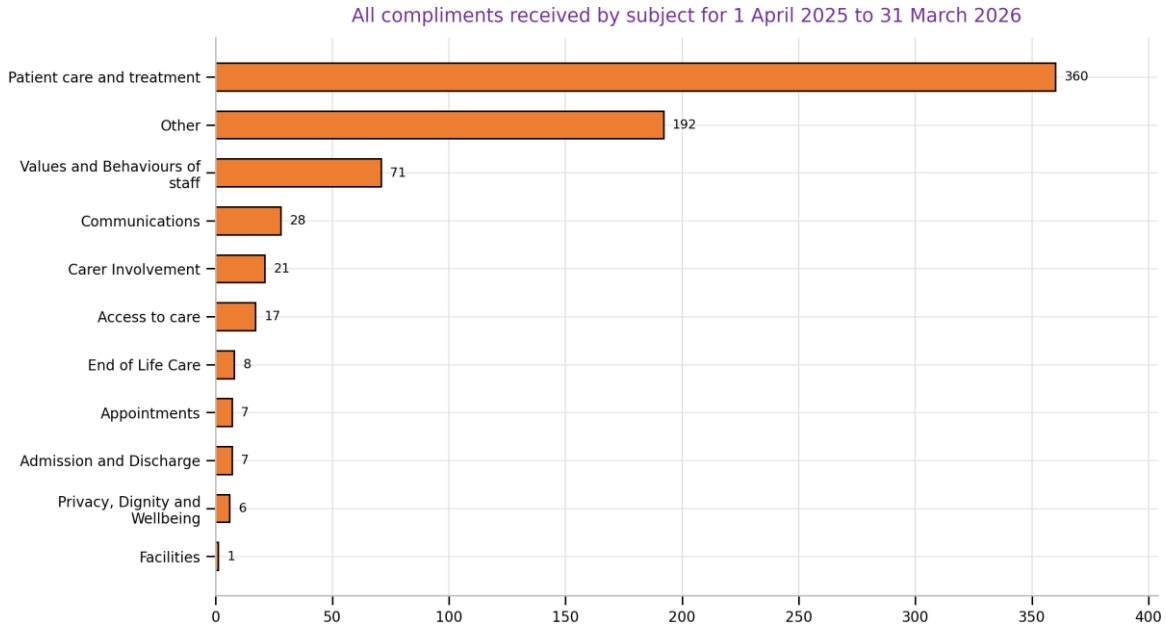
Peer reviews – Complaints are one of 8 performance indicators in peer reviews relating to stakeholder feedback and there is a question regarding complaints information for patients (environment/site visit), staff, team leaders and as part of the closed culture metrics. An estimated 105 reviewers have responded to these in last year's peer review cycle.

Accessible literature – The Complaints and Feedback Manager has received assurance from the Learning Disabilities division that easy read leaflets for making a formal complaint to the Trust are currently available within the Learning Disabilities community and inpatient settings. The division employs an Engagement Lead with a clinical background in Learning Disabilities who is working with patients and families to ensure they have a good understanding of the complaints process and to assist with resolving issues locally.

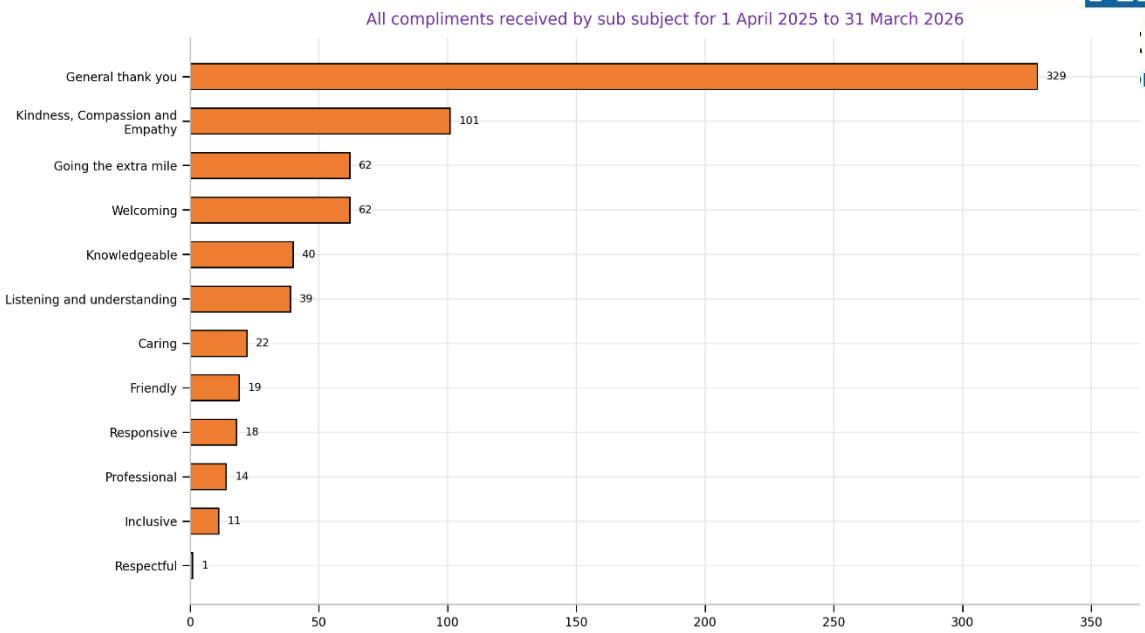
3.5 Compliments

Patients, service users, carers and families sometimes compliment our staff offering their gratitude and thanks for the wonderful services they provide. The Trust received 718 compliments for the period 1 April 2025 to 31 March 2026, which compares to 440 compliments received for the previous year – an increase of 278 compliments. Graph 10 below informs on the type of compliment received and Graph 11 demonstrates this further by compliment sub subject.

The Complaints and Feedback Manager attributes this significant increase in compliments received to improvements made to the systems for recording and reporting feedback across the Trust, as well as continuing to encourage the recording of compliments amongst staff, including publicity material, internal communications, and training resources.



(Graph 10)



(Graph 11)

Analysis

Patient care and treatment is the highest compliment subject for the Trust during the period, with 360 compliments received. This is followed by Other with 192 compliments, then Values and Behaviours of staff with 71 compliments.

On reviewing compliment sub subjects, General thank you is the highest recurring theme for the Trust with 329 compliments received. This is followed by Kindness, Compassion and Empathy with 101 compliments. Going the extra mile and Welcoming were the next most common sub subjects, each with 62 compliments.

By division, Planned Mental Health Services received the highest number of compliments with 189 recorded, followed by Children's and Learning Disabilities with 146 and Unplanned Mental Health Services with 140. The Humber Recovery and Wellbeing College, which now sits under the Patient and Carer Experience Team within the Medical Directorate, also received a high volume of compliments with 125 recorded, reflecting the sustained positive feedback for the service's activity throughout the year. Compliments relating to the Recovery and Wellbeing College particularly emphasised inclusivity, confidence building, skill development and a welcoming atmosphere.

Across the compliment narratives, the strongest recurring themes are compassion, emotional support, staff listening and understanding, and practical help that made a meaningful difference to patients, carers and families. There is also a notable trend of compliments recognising staff who went above and beyond, alongside consistent feedback about welcoming and inclusive environments.

A number of compliments highlighted specific staff by name, often recognising continuity of care, person centred support, teamwork and the positive impact of tailored interventions.

Overall, the 2025/26 compliment dataset shows a marked increase of 278 compliments compared with the previous year (63%), with especially strong themes around patient care and treatment, kindness and compassion, and staff going the extra mile.

3.6 Complaints and Feedback Training Offer

The Complaints and Feedback Team are now offering an enhanced two-tier staff training package, designed to ensure that staff are informed with regular and up-to-date information about the complaints

process, and to ensure they are equipped with the necessary knowledge and skills to handle complaints and concerns as they arise.

The **Complaints Awareness Training** course is a 30-minute session held over Microsoft Teams which was launched in September 2023 and runs on a bi-monthly basis. It is aimed at all staff in the organisation and is bookable via the Trust's e-learning system. The objective of the course is to provide staff with good awareness of the following:

- The different types of complaint.
- The different ways in which individuals can make a complaint.
- The complaints investigation process and how this works, including The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
- The importance of local resolution, wherever this is possible.

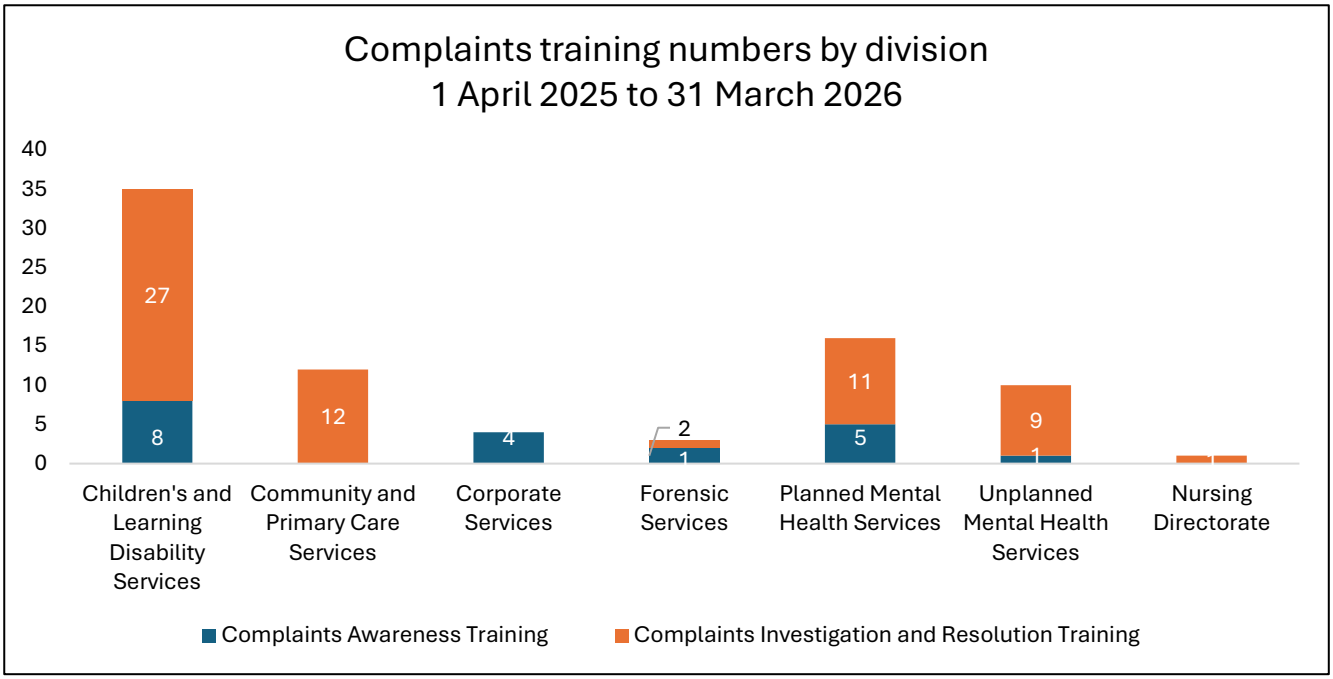
To strengthen the Complaints Awareness Training session, in accordance with the Zero Complaints actions (see 3.4.1) around ensuring patients and carers know how to make a complaint or raise a concern, the session now also includes a section on Zero Complaints and appropriate dissemination of complaints information to patients and colleagues.

Also, to strengthen the recording of compliments in our reporting, there is a section around what constitutes a compliment and a video on how to record a compliment.

The **Complaints Investigation and Resolution Training** course is a more in-depth session aimed at those staff who may lead on or support with formal complaint investigations. Sessions are booked via the Complaints and Feedback Team and can be held either virtually or face to face. The objectives of the course are to ensure that anyone involved with a formal complaint understands:

- The investigation process from beginning to end.
- What a good investigation looks like.
- The rules and process for gaining consent.
- Duty of candour and admitting when we get it wrong.
- The importance of a sincere apology.
- Alignment with Trust policies and procedures including Information Governance (IG), patient safety and safeguarding.

Our complaints training courses were accessed by a total of **81** staff during the year. Graph 12 informs on the number of staff per division who accessed the training.


Complaints training numbers by division
1 April 2025 to 31 March 2026
40
35
30
25
20
15
10
5
0
27
8
12
4
2
1
11
5
9
1
Children's and Learning Disability Services
Community and Primary Care Services
Corporate Services
Forensic Services
Planned Mental Health Services
Unplanned Mental Health Services
Nursing Directorate
Complaints Awareness Training
Complaints Investigation and Resolution Training

(Graph 12)

4.0 Priorities for 2026/27

The table below includes a broad overview of some of the patient and carer experience, engagement and involvement priorities that will be delivered over the next twelve months and focuses on key Trust wide priorities together with a snapshot of the divisional priorities, most of which are included in the Patient and Carer Experience (PACE) Five Year Forward plan.

Goals	Enhancing prevention wellbeing and recovery	Innovating for quality and patient safety	Fostering integration, partnerships and alliances	Promoting people, communities and social values	Developing an effective and empowered workforce	Optimising an efficient and sustainable organisation
PACE Themes	**Our Care**		**Our Partnerships**		**Our Workforce and Organisation**	
Trustwide	We will review and redesign our Patient and Carer Experience (PACE) forums approach.		We will continue to support the wider Integrated Care System (ICS) and attend the Humber and North Yorkshire ICB (Integrated Care Board) Experience of Care Group to network and share Place and provider-based intelligence and insight across the system to inform quality improvement and share learning.		We will continue to strengthen our PACE training modules on the Recovery and Wellbeing College platform to reflect the evolving landscape.	
	We will continue to grow our Expert by Experience database.		We will continue to work in partnership with York and Scarborough Teaching Hospitals NHS Foundation Trust to deliver the joint Scarborough and Ryedale PACE Forum.		We will put robust measures in place to ensure staff identify carers and offering support where required.	
	We will increase the number of Quality Improvement Charters as a result of Friends and Family Test thematic analysis.		We will increase membership from our wider communities to our Trust Forums/Networks.		We will strengthen our approach to ensure every corporate and clinical team have an identified Staff Champion of Patient Experience	
	We will continue to support divisions with national survey action planning.		We will work towards renewing our Veterans Covenant Healthcare Alliance re-accreditation.			
	We will strengthen the process for evaluating qualitative feedback when people have been involved in Trust activities.		We will implement and embed the Trust's new interpretation and translation provision contract.			
	We will gather feedback to inform the next PACE Five Year Forward Plan 2028-2033					

	We will strengthen the approach for the You Said, We Did process across the Trust.		
Children's and Young People's Services	We will create a visual graphic of our Children's Services to provide a tool for understanding how our services work together and their care values.	We will continue to involve young people with Health Stars fundraising for our Children's Services.	We will increase young people's volunteering opportunities within the division.
	We will co-produce a PINS (Partnerships for Inclusion of Neurodiversity in Schools) video on the reasonable adjustments schools can make to support young people with Special Educational Needs and Disabilities	We will continue to work in partnership with Community Vision to support our Humber Youth Action Group members.	We will implement reasonable adjustments to children's therapy spaces to ensure they are welcoming, friendly and inclusive.
	We will launch a series of co-produced videos regarding postural care which will be released across services and with partner organisations and schools.		
	We will launch the Inspire Family Day Service to provide children and young people an alternative to inpatient admission and crisis services.		
Primary Care, Community Services and Addictions Services	We will work to increase the number of Patient and Carer Experience (PACE) Champions who attend all Trust PACE Forums.	We will develop new working relationships with Primary Care GP Practices and their relevant PPGs across the North Yorkshire region in order to enhance membership for the PACE forums for Scarborough and Ryedale and Whitby.	We will increase the number of Volunteers working in community hospitals and in community services.
	We will increase the number of Quality Improvement Charters completed.	We will develop quality improvement initiatives with Addictions Services and involve patients/service users in co-produced projects.	We will ensure that Staff Champions of Patient Experience are embedded in all teams and actively involved in the PACE agenda.
	We will increase the membership of the "Voice" forum in addictions services.		We will develop and increase the number of peer mentors and volunteers across Addictions services.

			Working with staff and patients/service users to develop involvement opportunities.
			We will ensure that panel volunteers are involved in shortlisting during staff recruitment processes as well as being involved and briefed in the interview process.
Forensic Services	We will establish a working group to explore improving The Dining Experience to ensure better use of the space for socialising during and outside of mealtimes.	We will partner with our Research team to conduct semi structured interviews across the service to understand where we are in relation to EDI across the service and what more can we do to improve.	We will complement our inpatient workforce though embedding Volunteering Roles for inpatient service users to improve experiences of care
	We will refresh and enhance our booklet for family, carers and service users to ensure the booklet is more accessible, up to date and incorporating safe and caring cultures ethos.	We will enhance our provision to include an onsite Barbers, co-producing the design alongside service users	We will embed a charter which has been co-produced which holds a shared vision and ethos of the service with involvement and co-production at the centre.
		We will implement an Involvement Mailing list to improve the communication of involvement opportunities and service user involvement updates.	
		Further exploration will have taken place to improve partnerships with friends, family and carers.	
Learning Disability Services	We will embed the Community Learning Disability Co-production Group and Townend Court patient voice group as standard practice by integrating it into governance, service development, and quality improvement processes ensuring a robust feedback loop with the management team	We will work in partnership with patients, carers, clinical teams and system partners to co-design and implement a Trust-wide approach to reasonable adjustments, ensuring that the needs of people requiring additional support are recognised, recorded and acted upon consistently across services.	We will strengthen the learning disability workforce by embedding expert-by-experience input into training packages such as speech and language training and Occupational Therapy Sensory Processing Animation, ensuring learning is informed by lived experience.

Mental Health Services	We will launch a campaign highlighting and celebrating ways that service users and carers can get involved in Adult Mental Health services	We will embed co-production within the Reducing Restrictive Interventions agenda.	We will scope the staff support needed across the division to develop a new co-production toolkit.
	We will develop divisional co-production branding and re-launch the adult mental health co-production group.	We will continue to support increased engagement with community partners around health inequalities and the impact these have on Mental Health.	We will continue to support the recruitment, retention and wellbeing of our Lived Experience workforce including Peer Support Workers
	We will embed co-production in the Community Mental Health Service User Survey action planning.		

This annual report is available in alternative languages and other formats including Braille, audio disc and large print by contacting us in the following ways:

Humber Teaching NHS Foundation Trust
Willerby Hill
Beverley Road
Willerby
East Riding of Yorkshire
HU10 6ED
Tel: 01482 301700
Email: hnf-tr.contactus@nhs.net

If you would like any further information on how to get involved with the Trust, please contact the Patient and Carer Experience Team as follows:

Humber Teaching NHS Foundation Trust
Willerby Hill
Beverley Road
Willerby
East Riding of Yorkshire
HU10 6ED
Tel: 01482 389167
Email: hnf-tr.patientandcarerexperience@nhs.net

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Infection Prevention and Control (IPC) Annual Report 01 April 2025 – 31 March 2026
Author/s:	Executive Lead: Sarah Smyth, Executive Director of Nursing, Quality and Professions Author: Stephanie Hope, Advanced Infection Prevention and Control Nurse
Recommendation:	

To approve	√	To discuss	
To note		To ratify	
For assurance			

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	To provide a summary of the performance and key work undertaken with regards to infection prevention and control for the reporting period 01 April 2025 – 31 March 2026.

Key issues:

Positive Assurances to Provide:

- The number of outbreaks experienced during 2025-2026 has been low despite a high number of respiratory illnesses in general circulation throughout the year and earlier than usual onset of influenza.
- 85% compliance baseline exceeded for Level 1 and 2 IPC mandatory training Trust wide.
- The 85% compliance baseline exceeded for the Hand Hygiene and Personal Protective Equipment (PPE) competency Trust wide.
- Ventilation improvement works completed within Avondale seclusion suite.
- The opportunity to 'Co produce' is now considered and applied as part of all IPC work.
- All IPC related incidents have been subject to an After-Action Review.
- The IPC audit programme maintained.
- Aseptic Non Touch Technique (ANTT) Clinical Competency developed and national eLearning package available and assigned to staff by managers.

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Inpatient ventilation improvement review commenced in Q4 with IPC team, estates and matrons.
- Recruitment process underway in Q4 for the IPC Lead Nurse post. Person appointed to start 28.09.26.

• A new Transmission Based Precautions interactive learning resource using Artificial Intelligence (AI) has been developed.	
Key Risks/Areas of Focus: • Water Safety issues remain at Maister Lodge despite remedial action programme. Mitigation continues. • Water Safety issue at Westlands identified in Q3, remedial programme and mitigations in place. • IPC Lead Nurse post vacant from 05 January 2026, covered through interim arrangements. •	**Decisions Made:** • Capital investment secured for 22 new Powered Air Purifying Respirator (PAPR) Hoods. Procured and delivered to clinical areas in Q3. • Microbiology services contract variation agreed for 01.04.26-31.03.27.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	The IPC team has maintained environmental audit programmes across community and primary care settings, supported the management of infection risks in community hospitals, and worked collaboratively with system partners to reduce healthcare-associated infections across care pathways. This helps ensure patients can receive safe care closer to home while minimising the risk of infection and avoidable hospital admission.
Analogue to Digital	Through the development and adoption of innovative digital learning approaches. During 2025-2026, the Trust developed a new Artificial Intelligence (AI)-enabled Transmission Based Precautions learning resource, supporting staff understanding of infection prevention practices through interactive digital education. In addition, compliance monitoring, surveillance reporting, audit programmes and competency assessment processes continue to utilise electronic reporting and monitoring systems to strengthen assurance, oversight and learning.
Sickness to Prevention	Through surveillance, outbreak management, hand hygiene improvement, mandatory training, antimicrobial stewardship, environmental standards, water safety management and patient safety learning, the Trust continues to prevent avoidable infections and reduce the risk of harm to patients, staff and visitors. The report highlights zero Trust-attributable MRSA, MSSA and E. coli bloodstream infections, high levels of training and competency compliance, and effective management of outbreaks, all of which demonstrate a proactive focus on prevention rather than treatment of infection. The report also evidences work to increase awareness, promote healthy behaviours and enhance population health through infection prevention campaigns and antimicrobial resistance initiatives.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee	-	Remuneration & Nominations Committee	-
Quality Committee	20.08.26	People & Organisational Development Committee	-
Finance Committee	-	Executive Management Team	15/07/26
Mental Health Legislation Committee	-	Operational Delivery Group	-
Collaborative Committee	-	Other (please detail)	13/05/26

			Healthcare Associated Infection Group (HAIG) Physical Health and Medical Devices (PHMD) Group Quality and Patient Safety (QPaS) Group	 03/06/26 16/07/26

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*	
√ *Tick those that apply*	
Innovating Quality and Patient Safety	√
Enhancing prevention, wellbeing and recovery	√
Fostering integration, partnership and alliances	√
Developing an effective and empowered workforce	√
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	√

Areas to include within the report:	
Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	√
Public Exemption:	
Is the report exempt from public disclosure	No

Infection Prevention and Control

Annual Report

01 April 2025 – 31 March 2026



Executive Summary

This report provides assurance that the Trust continues to maintain effective Infection Prevention and Control (IPC) arrangements and remains compliant with the requirements of the Health and Social Care Act 2008 Code of Practice. Significant progress has been achieved against the IPC Five-Year Plan (2023-2028), supporting the delivery of safe, high-quality care across all services.

Key achievements during 2025-2026 include:

- No Trust-attributable MRSA, MSSA or E. coli bloodstream infections were reported during the year.
- Outbreak activity remained low, with eight outbreaks managed effectively despite high levels of circulating respiratory illness and early seasonal influenza activity.
- Hand hygiene audit compliance met or exceeded the Trust target of 95% throughout the year, while Hand Hygiene and PPE competency compliance remained above the 85% target.
- IPC mandatory training compliance consistently exceeded the Trust target of 85% for both Level 1 and Level 2 training.
- PSIRF methodology is now embedded for all IPC-related incidents, with learning identified and shared through After Action Reviews.
- The IPC audit programme has been maintained, and environmental cleanliness standards continue to demonstrate high levels of compliance across Trust services.
- Capital investment has secured replacement Powered Air Purifying Respirator (PAPR) equipment, and ventilation improvements have been completed within the Avondale seclusion suite.
- Innovative learning resources have been developed, including a new AI-enabled Transmission Based Precautions training package and an Aseptic Non-Touch Technique (ANTT) competency framework.
- Key areas of ongoing focus include the management of water safety risks at Maister Lodge and Westlands, continued improvement of ventilation across inpatient settings, and maintaining workforce resilience following the temporary vacancy of the IPC Lead Nurse post. Appropriate mitigations and action plans remain in place for these risks.

Overall, the report provides assurance that robust IPC governance, surveillance, education, audit and environmental management arrangements are in place, with continued progress being made against strategic priorities to reduce infection risks and improve patient safety.

The Trust Board is therefore asked to approve the Infection Prevention and Control Annual Report 2025-2026.

Foreword

It is my pleasure to present the Infection Prevention and Control Annual Report for 2025-2026, which provides assurance regarding the Trust's ongoing commitment to delivering safe, effective and high-quality care for our patients, carers, staff and communities. This report demonstrates the significant progress made against our Infection Prevention and Control Five-Year Plan and confirms continued compliance with the requirements of the Health and Social Care Act 2008 Code of Practice.

The prevention and control of infection remains fundamental to patient safety, quality of care and organisational resilience. Across what has continued to be a challenging healthcare environment, our teams have maintained a strong focus on reducing the risk of healthcare-associated infections, embedding best practice and ensuring that infection prevention and control principles remain central to everyday care delivery. This has been achieved through the dedication, professionalism and commitment of colleagues across all services.

This report evidences how infection prevention and control continues to contribute directly to the delivery of our Trust strategic objectives. Through robust governance, surveillance, education, environmental management and quality improvement, we are supporting our ambition of Innovating Quality and Patient Safety, with no Trust-attributable MRSA, MSSA or E. coli bloodstream infections reported during the year and effective management of outbreaks despite significant seasonal respiratory pressures.

Our work also supports the objective of enhancing prevention, wellbeing and recovery. By focusing on prevention, strengthening antimicrobial stewardship, improving staff capability and involving patients and carers through co-production, we are helping to create safer environments and reducing the risk of avoidable harm.

The continued collaboration with Integrated Care Board colleagues, microbiology services, regional infection prevention networks and partner organisations demonstrates our commitment to fostering integration, partnership and alliances, ensuring that learning, expertise and innovations are shared for the benefit of our communities.

Investment in training, competency development, leadership, innovation and workforce development reflects our commitment to developing an effective and empowered workforce. I am particularly pleased to see the introduction of new AI-enabled training resources and competency frameworks that support staff to deliver safe, evidence-based care.

The report also highlights how we are maximising an efficient and sustainable organisation through ongoing improvements to our estate, ventilation programmes, water safety management, environmental standards and investment in respiratory protective equipment. These initiatives help ensure our environments remain safe, compliant and fit for the future.

Finally, through awareness campaigns, patient engagement, co-production and community-facing infection prevention initiatives, we continue to support our objective of promoting

people, communities and social values, recognising that preventing infection is everyone's responsibility and extends beyond the boundaries of healthcare settings.

The achievements detailed within this report also demonstrate our Trust values of Caring, Growing and Learning. We care by protecting patients, carers and colleagues from avoidable harm. We grow through collaboration, innovation and continuous improvement. We learn by embracing feedback, undertaking robust reviews of incidents and outbreaks, and using insight to strengthen our practice and improve outcomes. These values are evident throughout the work of the Infection Prevention and Control Team and the wider organisation.

While challenges remain, particularly in relation to water safety management and ongoing environmental improvements, I am assured that robust mitigations and improvement plans are in place. The progress described throughout this report provides confidence that the Trust continues to maintain effective infection prevention and control arrangements and remains committed to delivering safe, high-quality care for those who use our services.

Finally, I would like to express my sincere thanks to the Infection Prevention and Control Team, our IPC Link Practitioners, colleagues across the Trust, patients, carers and partner organisations for their continued commitment and contribution throughout the year. Their collective efforts are fundamental to maintaining safe services and helping us achieve our strategic ambitions for the people and communities we serve.

I would like to offer particular recognition to Stephanie Hope, who has provided exceptional leadership and commitment during a period of change by undertaking the responsibilities of the Lead Nurse role on an acting basis. Stephanie's professionalism, expertise and dedication have ensured continuity, maintained momentum against our strategic priorities, and supported the continued delivery of high-quality infection prevention and control services across the Trust.

I would also like to extend my heartfelt thanks and best wishes to Debbie Davies, who retired during the year after many years of dedicated service to infection prevention and control. Debbie has made a significant contribution to the safety of our patients, staff and services through her expertise, commitment and passion for improving standards. Her knowledge, experience and unwavering dedication have left a lasting legacy, and we are immensely grateful for the contribution she has made throughout her career.

Sarah Smyth
Executive Director of Nursing, Quality and Professions
Director of Infection Prevention and Control
Humber Teaching NHS Foundation Trust

1.0 Introduction

In accordance with the requirements of the Health and Social Care Act 2008: code of practice on the prevention and control of infections (Department of Health and Social Care, updated 2022) each NHS organisation is required to produce an annual report providing assurance that effective Infection Prevention and Control (IPC) systems and processes are in place.

This report, covering the period 01 April 2025 to 31 March 2026 aims to provides assurance to the Trust Board of Directors of the achievements and progress made against the Trust IPC 5 Year Plan 2023 - 2028 and the key criteria within the Health and Social Care Act 2008: code of practice on the prevention and control of infections (2022).

1.1 Key achievements

✓ 95% hand hygiene observational audit compliance target achieved each quarter across the inpatient areas.

✓ 90% of clinical staff have achieved the Hand Hygiene and Personal Protective Equipment (PPE) Clinical Competency across the organisation.

✓ Level 1 and 2 IPC Mandatory training compliance exceeded 85% baseline throughout the year.

✓ Patient Safety Incident Reporting Framework (PSIRF) methodology embedded for the review of all IPC related incidents.

✓ The development of a new Trust Transmission Based Precautions interactive learning resource using Artificial Intelligence (AI).

✓ Capital investment for new Powered Air Purifying Respirator (PAPR) Hoods and associated training roll out completed, maintaining Trust Respiratory Protective Equipment (RPE) programme.

2.0 Goal 01 – Innovating Quality and Patient Safety



2.1 Governance Arrangements

The Trust Infection Prevention and Control Arrangements Policy N-014 outlines the specific role responsibilities, management structure and the systems that are in place ensuring that IPC practice and management is effective and efficient within the Trust. This policy will be reviewed in quarter 1 2026-27 to ensure it reflects current arrangements.

The Chief Executive holds ultimate responsibility for ensuring effective IPC arrangements are in place.

The Executive Director of Nursing, Quality and Professions holds the role of Director of Infection Prevention and Control (DIPC) within their portfolio and reports directly to the Chief Executive and the Trust Board.

Following a restructure in the Nursing Directorate, the Head of Nursing Physical Health and Assurance provides managerial support and clinical supervision to senior members of the IPC team as part of their portfolio from quarter 4.

The IPC Lead Nurse continued to provide strategic leadership and expert advice in relation to all matters pertaining to IPC, working collaboratively with all teams within the organisation and partner agencies to ensure effective working relationships and evidence based infection control is practiced minimising the risks to patients, staff and the public until the beginning of January 2026. The post is currently vacant however interviews are planned to take place in quarter 1 2026.

In quarter 4 following the notification of an unexpected termination of contract by the Infection Control Doctor (ICD) and colleagues who fulfilled the provision via a Service Level Agreement (SLA) with Optima Clinics Limited for 1 session weekly. A new arrangement was secured with a Consultant in Infection to fulfil the unchanged agreed specifications to the end of quarter 4. The ICD provides support, expertise, and guidance to the IPC team on IPC and antimicrobial stewardship queries. The Microbiology Services contract variation has been agreed for 2026-2027.

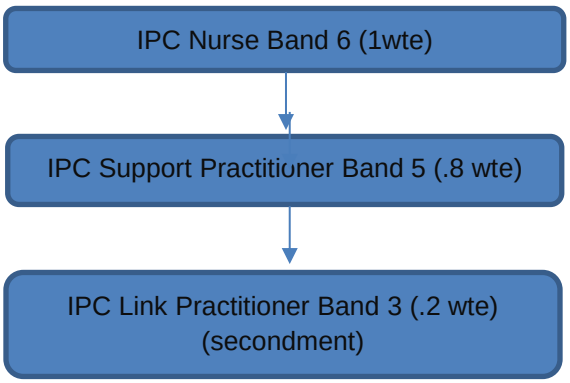
The provision of the IPC 5 Year Plan and annual progress report is seen as an essential element in continuing the Trust focus on reducing Healthcare Associated Infections (HCAIs) and in ensuring compliance to the Care Quality Commission (CQC), Regulation 12(2)(h) assessing the risk of, and preventing, detecting, and controlling the spread of infections, including those that are healthcare associated.

The Healthcare Associated Infection Group (HAIG) have continued to meet quarterly, meeting minutes and items requiring approval in accordance with Trust governance structure are scrutinised at the Quality and Patient Safety (QPaS) Group.

2.2 The Structure of the Infection Prevention and Control Team

Chart 1. The Structure of the IPC Team as of 31 March 2026





2.3 The IPC Link Practitioner Network

The IPC Link Practitioner Network has approximately 153 members represented from across all the Care Divisions. Membership of the group remains diverse with various disciplines and roles represented across Trust clinical services.

The enhanced level of knowledge and skills the Link Practitioners gain supports individual development, wider engagement and compliance with the IPC audit programme. Many members fulfil the Competency Assessor role for the Hand Hygiene and Personal Protective Equipment (PPE) Clinical Competency.

A new induction programme to the role for newly appointed Link Practitioners commenced in quarter 2. A total of 8 sessions facilitated by the IPC Support Practitioner, attended by 23 new Link Practitioners. Based on the positive feedback received, the peer engagement opportunity and improved efficiency of the IPCT time spent meeting and inducting new Link Practitioners the programme will continue in 2026-2027.



The quarterly network meetings have continued throughout 2025-2026 delivered using a hybrid approach of both face to face and virtual meetings following feedback from a survey completed by the network. Despite this engagement and feedback, attendance levels remain low for the network membership.

A survey was repeated in 2025-2026 finding 69% would prefer to meet solely on MS Teams and 62% would prefer the meeting duration to be 1.5 hours. For 2026-2027 the meetings will all be delivered virtually, attendance and feedback will be monitored.

Attendance rate monitoring was introduced into the Matron quarterly IPC report this year to ascertain and understand the reasons and challenges for non-attendance. Issues have included sickness absence, ward acuity and shift patterns. Work will continue to review ways to improve engagement and attendance.

Collective feedback received throughout 2025-2026 for the meetings is summarised below:

- 100% said the meetings provided relevant information to feedback to the clinical team.
- 89% said the meeting duration was right.
- 100% enjoyed the meetings, noting informative, engaging, variety of subjects and good to meet other colleagues and different disciplines.
- Feedback to clinical teams noted to be done via Protected Time for Learning (PTL), clinical meetings, discussions with Managers, showing and supporting colleagues with all that is learnt, emails and discussion at team meetings and group supervision meetings.

2.3.1 Link Practitioner secondment

A Healthcare Assistant based on Avondale was successfully recruited to an experiential opportunity within the IPC team and commenced on a one day a week secondment at the beginning of quarter 2. It is pleasing to report the opportunity has been supported by the Nursing Directorate and Avondale Clinical Lead resulting in the extension of the secondment to the end of quarter 1 2026-2027. During the time with the team, the staff member has received accredited training and is facilitating Face Fit Testing autonomously, contributing to the review of staff resources, developing a new audit and supporting awareness raising events. The individual is an asset to the team and their motivation and enthusiasm for all learning opportunities is evident and having their input from a clinical practice view has been invaluable.

2.4 Performance against Key Indicators

2.4.1 Mandatory Surveillance of Healthcare Associated Infections

Healthcare Associated Infections (HCAIs) can develop either as a direct result of healthcare interventions or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections, including those caused by methicillin-resistant Staphylococcus aureus (MRSA) and Clostridioides difficile (C.difficile). HCAIs pose a serious risk to patients, staff and visitors (NHS England).

The NHS Standard Contract 2025/26 outlines the quality requirements for acute NHS Trusts and Integrated Care Boards (ICBs) to minimise Clostridioides difficile (C.difficile) and Gram-negative Bloodstream Infection (GNBSI) rates to threshold levels set by NHS England.

No regionally contractually agreed thresholds are in place for the number of HCAIs reported in 2025-2026 for the Trust, however individual HCAI cases continued to be monitored and reviewed as part of our focus to support the actions to reduce the risk of the infections and patient outcomes across the ICB.

Table 1. Trust performance against HCAI Key Indicators

Trust wide confirmed bloodstream infection cases	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0
E.coli	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0

It is pleasing to note that zero cases of Trust MRSA, MSSA or *E.coli* bloodstream infections have been reported during 01 April 2025 – 31 March 2026.

2.4.2 Surveillance of Clostridioides difficile Infections

The IPC team works in collaboration with the Humber and North Yorkshire (HNY) ICB IPC Leads and partners in reducing avoidable infections, sharing information and learning, having met regularly throughout 2025-2026.

A review has been held of 3 reported cases of C.difficile toxin positive infections identified on day 3 or after following admission into our care during 2025-2026, 2 were transferred from secondary care to Malton Hospital ward and 1 to Whitby Memorial ward. The Patient Safety Incident Response Framework (PSIRF) methodology has been utilised to determine any learning, an After Action Review (AAR) was facilitated by the IPC team. The AAR once completed is presented to HAIG, the respective Clinical Governance Network and the Clinical Risk Management Group (CRMG) identifying any learning or improvement areas.

Learning identified

Patient 1

- No antimicrobial prescribing during the admission.
- Patient management was in accordance with policy and guidance.
- The need to improve information sharing when Trust Community Services are involved with a patient prior to admission.

Patient 2

- The patient had received several courses of antibiotics in York and Scarborough Teaching Hospitals NHS Foundation Trust prior to admission to Fitzwilliam Ward.
- Patient management on Fitzwilliam Ward was in accordance with policy and guidance.
- Antimicrobial prescribing during admission on Fitzwilliam for the C.diff infection only.
- There was a lack of accurate clinical information provided prior to the patient being transferred to the ward (stool consistency and antibiotics) despite referral processes.
- The patient did relapse following initial treatment completion and recovery. Patient was managed appropriately and recommenced on treatment for C.diff infection.

Patient 3

- The patients extended length of stay in the York and Scarborough Teaching Hospitals NHS Foundation Trust and the requirement for a protracted course of antibiotics, and the prescribing of PPIs are all noted to be significant contributory factors in the acquisition of C. difficile.
- No further antibiotics were prescribed whilst patient residing on Whitby Ward prior to loose stools commencing.
- Advice from the Consultant Microbiologist was sought in a prompt manner and a clear plan was initiated.
- A delay was noted in the patient being moved into a side room due to reported bed capacity.
- Duty of candour discussions not recorded within the patient records.
- A lack of clinical equipment was noted within the unit. Although the equipment utilised for the monitoring of the patients vital signs were reported as being cleaned appropriately between each patient use dedicated equipment should only be used when managing a patient with an infectious disease to reduce the risk of potential cross contamination. This has been escalated and additional equipment requested.
- Education provision for staff as a refresher for the management of symptomatic patients and C.difficile to be explored further with IPC Team and Ward Manager / Matron.
- More embedding of Duty of Candour and documentation.

An action plan is in place for all three patients to address the issues highlighted. All patients recovered without incident.

2.4.3 Hand Hygiene Compliance

Hand hygiene remains a fundamental component in the prevention of HCAIs and the IPC team continue to promote hand hygiene compliance in accordance with the 'WHO five moments for hand hygiene'. Hand hygiene compliance, including bare below the elbow principles is a requirement for all Health Care Workers who provide clinical care as part of their duties.

Opportunistic hand hygiene observations are undertaken by the IPC Link Practitioners on a quarterly basis utilising the Hand Hygiene Observational Audit. Compliance is noted to be achieved at 95% and above. The Trust overall average compliance threshold of 95% has been achieved each quarter during 2025-2026.

Table 2. Trust Hand Hygiene Compliance percentage according to Quarter 2025-2026

Inpatient area	Hand Hygiene Observations			
	Q1	Q2	Q3	Q4
Avondale	100%	97%	100%	100%
Mill View Court	97%	93%	97%	97%
Newbridges	100%	100%	100%	100%
PICU	100%	90%	97%	97%
Westlands	100%	100%	100%	100%
STaRS	100%	100%	Closed	Closed
Maister Lodge	100%	100%	100%	*
Mill View Lodge	83%	100%	97%	100%
Maister Court	100%	100%	100%	100%
Derwent	100%	100%	100%	100%
Ouse	100%	100%	100%	100%
Swale	97%	97%	100%	97%

Ullswater	**97%**	**93%**	**100%**	**97%**
Pine View	**100%**	**100%**	**100%**	**100%**
Lilac	**100%**	**100%**	**100%**	**100%**
Willow	**100%**	**100%**	**100%**	**100%**
Granville	**100%**	**100%**	**100%**	**100%**
Whitby Memorial	**100%**	**100%**	**100%**	**100%**
Fitzwilliam	**100%**	**100%**	**100%**	**100%**
Orion	**97%**	**100%**	**100%**	**100%**

InPhase Hand Hygiene Observation Audit results 2025–2026 RAG+B rating key:

- 0-69.9% Red (Inadequate)
- 69.9%- 94.9% Amber (Requires Improvement)
- 95%-99.9% Green (Good)
- 100% Blue (Outstanding)

* No submission

The themes impacting the inpatient compliance target of 95% are predominantly in relation to non adherence with bare below the elbow principles including staff wearing watches, Fitbits and long sleeve clothing. Audits have captured staff demonstrating the correct hand hygiene technique and washing hands between clinical tasks and adherence to the 5 Moments for hand hygiene.

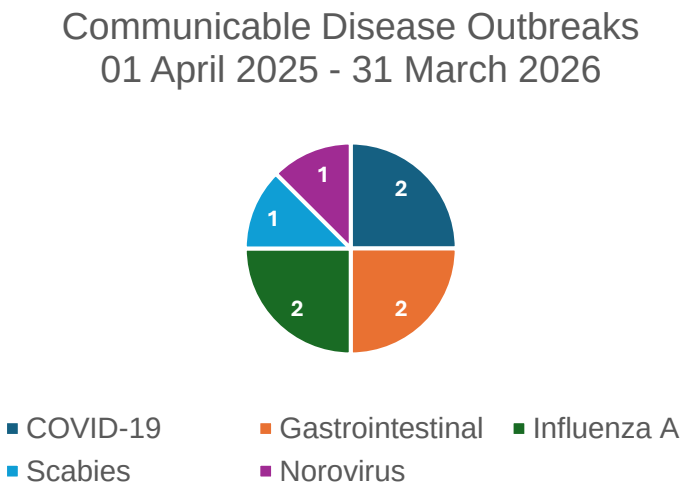
The action taken in practice to address poor adherence with the principles is addressed directly with staff members individually and raised with managers and within clinical supervision as required.

The IPC team continue to provide support to all Link Practitioners, staff and management colleagues when improvement is not sustained. Positive role modelling by senior clinical management is key to supporting the Link Practitioners undertaking the observational audits and striving to sustain improvement with policy and bare below the elbow principles adherence.

2.4.4 Outbreaks of Communicable Infection

A total of 8 outbreaks were declared in the reporting period for inpatient areas in Trust. The Unplanned Care - Mental Health Services Division experienced 7 outbreaks and the Forensic Services Division experienced 1. An existing Bed Escalation Process within the Mental Health Division for COVID outbreaks was reviewed to capture Acute Respiratory Infections and a new process for gastrointestinal outbreaks devised in quarter 4 with initial approval at HAIG and further governance at QPaS scheduled in quarter 1 2026-2027. The process aims to strengthen the outbreak response and patient flow management when faced with bed capacity challenges whilst minimising potential risks ensuring patient safety mitigations are in place. Chart 2 below provides the detail for the known outbreak causative pathogens:

Chart 2. Trust Communicable Disease Outbreaks 2025-2026



Each outbreak is subject to an AAR, learning is summarised below:

- Deteriorating patients were managed in accordance with policy and escalated appropriately, demonstrating adherence to safe care pathways.
- Prompt implementation of enhanced cleaning and IPC measures including universal mask wearing, helping to limit transmission and maintain safe environments.
- Effective communication demonstrated between ward and domestic staff and wider with staff supporting inpatient areas enabling coordinated responses.
- The management of staff displaying symptoms of a respiratory illness not always managed in accordance with Trust guidance. Managers and teams reminded of expectations to ensure consistent application of IPC protocols.
- Availability of swabs for wider respiratory screening not always readily available. Revised monitoring processes put in place to ensure improved stock oversight and timely access to testing materials.
- Food Hygiene elements reviewed including the management of takeaway food and staff training attendance and compliance.
- The challenges of differential diagnosis and access to specialists for advice in the management of scabies have been escalated via the regional ICB IPC Huddle, with partner organisations sharing similar experiences regarding the challenges in practice, highlighting a wider system learning need.
- A patient fed back their thanks to the staff for their support during an Influenza outbreak.
- No suggestions received for future patient management from a patient perspective, patient feedback will continue to be sought to inform ongoing improvement.
- Work commenced in quarter 4 to develop a patient feedback mechanism through coproduction to capture patient experience when required to isolate.
- A new Trust Transmission Based Precautions interactive learning resource for inpatient staff using Artificial Intelligence (AI) was developed by a member of the IPC team and Trust Instructional Designer and approved in quarter 4.

2.6 Antimicrobial Stewardship

The overarching aim of antimicrobial stewardship (AMS) is to optimise safe, appropriate and economic use of antimicrobial agents to improve patient outcomes from infection whilst

minimising negative consequences such as healthcare-associated infections and the development of antimicrobial resistance (AMR). All healthcare professionals are therefore encouraged to facilitate good prescribing practices.

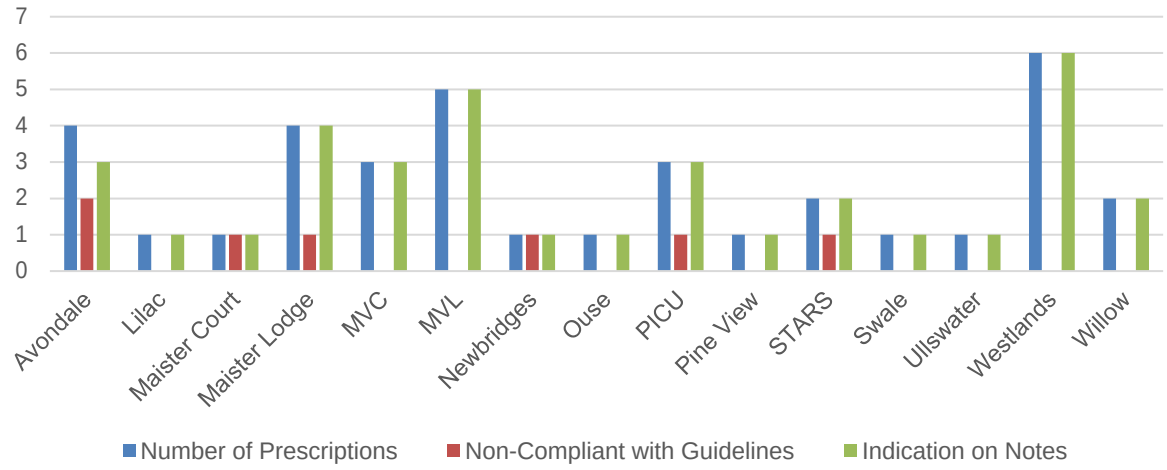
Within the Trust the Drugs and Therapeutic Group has the responsibility for the monitoring and the provision of advice on the optimal and cost effective prescribing of antimicrobial agents. Its aim is to facilitate the development, implementation and audit of policies, guidelines and protocols related to antimicrobial prescribing, with reference to local variations in antimicrobial susceptibility.

In line with the UK Government AMR 5 year national action plan, 'Confronting antimicrobial resistance 2024 to 2029' a Trust Antimicrobial Stewardship Plan is in place outlining the Trust's plan for making a sustained and ongoing progress towards achieving the government vision and ambitions for optimising the use of antimicrobials. This was ratified by the Trust Board on the 26.3.25 and progress against the agreed action plan is monitored by both the Drugs and Therapeutic Groups and the Healthcare Associated Infection Groups (HAIG) Significant progress has been made across all domains within the plan.

All antibiotic prescriptions are validated within the Trust inpatient areas by the allocated pharmacists for appropriateness in accordance with both local and national guidelines. Prompt interventions are made when there are discrepancies with these, particularly in relation to indication, dose, and duration. Individual feedback is provided to prescribers to support learning and where required clinical meeting discussions are held to reinforce adherence to antibiotic guidelines**.**

In accordance with the Trust Antimicrobial Stewardship Plan an audit of the electronic prescribing records of all patients within the mental health inpatients units was undertaken between 01 June 2025 and 15 July 2025. A total of 36 prescriptions for antibiotics were identified during this period within the units. The chart below shows the distribution of the prescriptions according to the inpatient unit.

Chart 3. Antimicrobial Prescribing Audit – Mental Health Inpatient Units



Areas of good practice

- Clinical face to face reviews occurred before any antibiotics prescribed in 36 (97.7%) of the prescriptions.
- Good evidence available that first line antimicrobial therapy was considered in the majority of interventions.

- Documentation of the rationale for the antimicrobial prescription had improved significantly since the 2024 audit review. 35/36 (97%) of all antibiotic prescriptions had an indication either on the prescription chart or recorded within the patients notes.

Areas for improvement

- Work continues to remind all prescribers of the minimum recommended duration of commonly used antibiotics. The length of the prescribed courses particularly in the management of uncomplicated urinary tract infection in females and respiratory illness was noted to be a key theme for when non-compliance occurred. Shortening durations of antibiotic therapy for individual patients is increasingly recommended as a better practice choice. Clinicians should continue to be made aware of any new data, current guidelines and recommendations to ensure they adjust their practices accordingly to provide the best patient care while preserving antibiotics for future use.

An audit of antibiotic practice within the inpatient community settings is planned for completion within quarter 1 2026-2027.

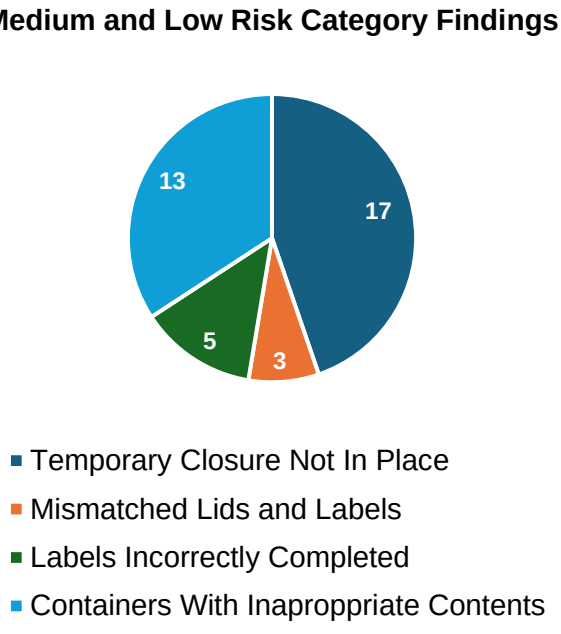
2.7 Sharps Management

The annual external audit took place in July 2025 conducted by Daniels Healthcare Limited. A total of 129 sharps containers were inspected across 39 departments. It was reassuring to note there were no high risk category findings.

It was disappointing to note a decline in compliance in comparison to 2024-2025 audit findings:

- 137 containers across 51 departments
- 0 high risk category findings
- 0 medium risk category findings
- 12 low risk category findings

Chart 4. Sharp External Audit Findings 2025-2026



The 17 medium risk category findings were containers found to not have the temporary closure mechanism deployed when the container was not in use.

The 21 low risk category findings included mismatched lids and label i.e. colour of the label did not match the colour of the container, containers were incorrectly labelled and inappropriate content i.e. none sharps items disposed of.

All teams audited received the findings and educational resources to support improving compliance and practice in the safe management of sharps.

Future sharps auditing

The report produced by Daniels Healthcare this year had changed format due to the data inputting system. The report was in multiple documents and deemed less user-friendly and less suitable for circulation to Health and Safety Group, HAIG and clinical services. Feedback was provided to the company and unfortunately no alternations could be facilitated as the report is system generated.

It was agreed at HAIG and the Health and Safety Group to undertake a review of the sharps management auditing with the new Trust Waste Manager for improved integration and training. This review has commenced including the quarterly IPC audit components relating to sharps management that are well established. This collaborative work will continue into 2026-2027.

3.0 Goal 02 – Enhancing Prevention, Wellbeing and Recovery



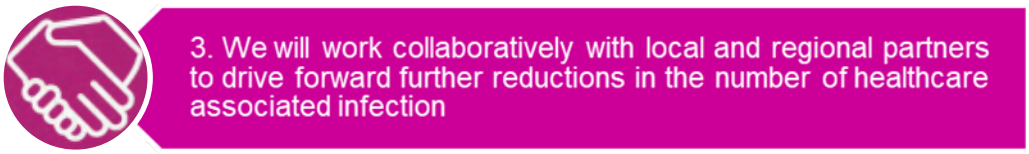
Two members of the IPC team remain active Staff Champions of Patient Experience (SCoPE). Work has continued to ensure IPC initiatives, policies, information resources are shared with all PACE forum members to raise awareness and gain valuable input, maximising opportunities for coproduction. An annual IPCT PACE Development Plan is in place and progress is monitored in accordance with the agreed time scales during the ensuing year.

Summary of IPC PACE achievements for 2025-2026:

- IPC SCoPE attendance at the various PACE related forums has been fulfilled throughout the year.
- In quarter 1 the review of all the IPC patient, carer and visitor leaflets completed and the co production stamp was achieved.
- In quarter 1 the work commenced in quarter 4 2024-2025 by the PACE Staff Champion Working Group to review the SCoPE role profile concluded.
- In quarter 2 the SCoPE collaboratively worked with Health and Safety colleague and produced a Risk Assessment for Dogs in Healthcare as an appendix to a new Trust SOP being developed by the Patient and Carer Experience and Equality, Diversity and Inclusion Lead.
- In quarter 2 as part of the scheduled review the Clostridioides Difficile Infection Policy was shared with the PACE forums for feedback, unfortunately no feedback was received.
- In quarter 4 a Quality Improvement project commenced to coproduce a new feedback method to capture individual experience when required to isolate during an inpatient admission.
- Work continues to maximise the opportunity for patients to access the IPC patient survey developed in 2024-2025 due to the limited displaying of the standardised IPC

inpatient poster. Challenges have included a lack of space available for the display board the Truist standardised posters are displayed within. Competing teams/subject matter to be displayed. Management staff churn and awareness of the IPC poster and how to request.

4.0 Goal 03 – Fostering Integration, Partnership and Alliances



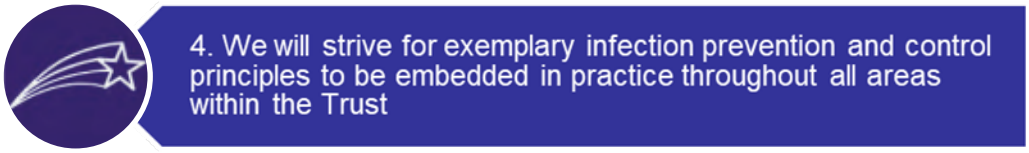
Working collaboratively is essential in the reduction of HCAIs and the IPC team have continued to meet and work with colleagues both locally and nationally to share learning and best practice.

Examples of the opportunities to share learning, supporting colleagues during 2025-2026 have included:

- Collaboration with colleagues in CHCP IPC team to develop Tier 3 IPC training materials, however this training tier was stepped down as part of a wider national review of training.
- Supporting the Humber IPC and AMR Collaborative Forum with World Antimicrobial Awareness Week (WAAW) regional messaging which involved the IPCT members providing a short video clip to raise awareness and promote affective Antimicrobial Stewardship.
- Regular attendance maintained at the HNY ICB IPC Huddle.
- The senior IPCT members and Trust colleagues in the Emergency Planning Team and Community and Primary Care Service Division supported a tuberculosis (TB) incident led by the Humber and Noth Yorkshire Health Care Parentship and HNY ICB.
- The IPCT supported the Emergency Planning (EP) Team led Trust group for the Langdale End Fire in relation to ventilation related queries for the Whitby Hospital site.
- Where required the senior IPCN supported the EP Team Lead with Exercise Pegasus.
- The IPCT engaged with a HNY ICB IPC led system wide Scabies Meeting to discuss regional partners prevalence and challenges. The IPC team will maintain engagement with future collaborative work.

Both the senior members of the IPC team remain members of the national Infection Prevention Society (IPS), which provides opportunities for networking at a regional and national level and access to appropriate educational resources, study days and conferences and membership of IPS Special Interest Groups (SIGs) such as Sustainability and Mental Health.

5.0 Goal 04 – Developing an effective and empowered workforce



The prevention of any avoidable infection remains a priority within the Trust, effective IPC measures and practices are the responsibility of everyone who works within the Trust. Care should be exemplary and delivered by staff who understand and effectively discharge their role and individual responsibilities for the prevention and treatment of HCAIs. Work undertaken

to support all staff in the delivery of their responsibilities during 2025-2026 is captured in this section of the report.

5.1 Review of Infection Prevention and Control Policies and Guidance

In accordance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections (2022) the Trust infection prevention and control policies and guidance are reviewed to ensure they up to date with current evidence base and in line with the national requirements. The IPC policies, standard operating procedures (SOPs) and protocol reviewed in 2025-2026 are captured below in table 3.

Table 3. Reviewed Trust IPC policies, SOPs and protocol April 2025 – March 2026

Policy	Date approved	Changes
The Management of an Outbreak of Communicable Infection Policy (N-009)	14 July 2025 12 March 2026 h 2026	• Updated to reflect the feedback from NHSE, Emergency Preparedness Resilience and Response (EPRR) Core Standard 12 submission in relation to further detail required for High Consequence Infectious Disease (HCID) new section 5.6 added. • Updated to reflect the new on call Infection Control Doctor contact details. Appendix 6 was removed due to the Trust AAR report template been updated. The AAR report template to be accessed via the After Action Review SOP24-022.
Selection of Respiratory Protective Equipment (RPE) and Face Fit Testing Requirements within a Clinical Environment (SOP21-004)	10 December 2025	• Minor amendments made following the change of Trust approved Powered Air Purifying Respirator (PAPR) product from Easiair 2020 to Drager X-Plore 8000. Appendix 3 EIA updated with new Equality and Health Inequalities Impact Assessment (EHIIA) Toolkit.
Clostridioides Difficile Infection (Prevention and Management) (N-010)	11 December 2025	• Removal of all reference to previous investigation methodology, RCAs. Policy updated to reflect the national PSIRF methodology now utilised. • Previous EIA replaced with new Equality and Health Inequalities Impact Assessment (EHIIA) Toolkit

The IPC team enhanced the series of IPC ‘Guidance at a Glance’ staff quick reference documents, developing new guidance for the Management and decontamination of toys.

In quarter 1 all IPC information leaflets were reviewed and approved, these included:

- C. diff patient information leaflet
- Community patient and carers leaflet
- External Contractors leaflet
- Hand hygiene patient and visitor leaflet
- Inpatient and visitor IPC leaflet
- MRSA Inpatient leaflet
- Norovirus patient information leaflet
- Patient and visitor leaflet (easy read)
- IPC Volunteer information leaflet

5.2 Infection Prevention and Control Training Programme

IPC is an integral part of the Trust mandatory training programme for all staff and the commitment to education continues to be a priority throughout the year. The IPC Nurses (IPCNs) continue to participate in the Trust Corporate Induction programme for all newly appointed staff up to the transition to the email based induction model from quarter 1 2026-2027. The virtual session included an introduction to the team, providing guidance on how to access IPC information via the Trust Intranet. A brief overview of Sepsis is included to support raising awareness and signposting to further information and guidance. The IPC team are part of the emails new starters will receive going forward.

The IPC team have continued to utilise the national evidence-based infection prevention and control national education programme for both clinical and non-clinical staff utilising the virtual platform and eLearning packages. As shown in table 4 below the Trust training compliance target of 85% has been exceeded each month during April 2025 – March 2026.

Table 4. Infection Prevention and Control Mandatory Training Compliance 2025-2026

Compliance percentage	April 25	May 25	June 25	July 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Level 1	**98.69**	**98.52**	**98.53**	**98.80**	**98.12**	**98.21**	**98.55**	**98.45**	**98.37**	**98.04**	**89.79**	**94.36**
Level 2	**96.05**	**95.83**	**95.79**	**96.07**	**95.24**	**94.28**	**94.72**	**94.95**	**95.85**	**95.22**	**88.10**	**91.41**

Following a national review of IPC training, NHS England updated the structure and duration of the learning to better reflect the Core Skills Training Framework and the latest national guidance. These changes are designed to make better use of staff time and to avoid unnecessary repetition. The changes to Level 1 requirements for clinical staff were implemented in February 2026 across the Trust.

The Hand Hygiene and Personal Protective Equipment (PPE) competency compliance target of 85% has been achieved and exceeded throughout the reporting period. The Trust overall compliance percentages can be seen below in table 5.

Table 5. Trust Hand Hygiene and PPE Competency Compliance April 2025 – March 2026

Month	Compliance
April 2025	91.72%
May 2025	91.90%
June 2025	92.12%
July 2025	91.81%
August 2025	91.61%
September 2025	90.99%
October 2025	90.51%
November 2025	90.31%
December 2025	90.18%
January 2026	90.64%
February 2026	90.72%
March 2026	92.05%

5.3 Aseptic Non Touch Technique (ANTT) Competency

To enhance the existing ANTT related clinical training provision and to provide evidence for practitioner competency in undertaking and demonstrating the principles the IPC team developed a new ANTT Competency Self-Assessment and Assessor Guidance. A national ANTT eLearning package is available to all staff undertaking an invasive procedure along with ANTT principles incorporated into medical device / catheterisation competency packages.

Wound management training is included in the Preceptorship training programme and competency packages are in place for all levels of wound management. All District Nurses are assigned ANTT and wound clinical competency and this is monitored by the Community Services Matrons in practice on the clinical skills matrix.

Work continues to address the reporting and competency monitoring for ANTT and wound management within all inpatient areas (including Granville Court) to ensure fully embedded across all services. The ANTT Clinical Competency developed supports this work and the development of an action plan is underway to launch and roll out.

5.4 Transmission Based Precautions Learning Resource

A new Transmission Based Precautions (TBPs) interactive learning resource using Artificial Intelligence (AI) to follow the scenario of Doris, an inpatient, and her journey as she becomes unwell with acute respiratory symptoms was developed and approved in quarter 4.

This Trust developed learning resource is a first of its kind to utilise AI, combining subject matter and technical expertise and creativity, overcoming new challenges, and reflecting an amazing example of collaborative work. The training roll out will be aimed at inpatient staff to enhance the understanding of TBPs. The IPCN and the Instructional Designer plan to develop a community service focused learning resource to support clinical training is relatable and relevant to multiple services practice.

5.5 The Continuing Professional Development of the IPC Team

The IPC team has continued to develop and maintain their professional development through a variety of sources, summarised below:

- Attendance at the first dedicated national event focusing on IPC within mental health environments, resulting in invitation for the Trust Hotel Services Manager to present at the 2026 conference regarding the Challenges of Dispensers in Mental Health Environments.
- Trust PROUD Leadership programme successfully completed by the IPCN. Consolidation in practice demonstrated through developing and delivery a bespoke training package to staff on Fitzwilliam Ward regarding the management of patients with gastrointestinal symptoms including C.diff.
- Senior member of the team invited to join the interview panel for the Trust Waste Manager recruitment.
- All team members have completed the AAR training provided by the Health Services Safety Investigation Body (HSSIB) for development in relation to the adoption of PSIRF methodology in the team.
- Lumina Spark completed by all team members.
- Attendance at the HNY ICB Gram Negative Bloodstream Infection Summit.
- Trust Culture of Care Showcase event attendance.
- Practice Assessor role maintained by all team members.
- Quantitative Fit Testing Training refresher (accredited)
- Variety of Antimicrobial Stewardship related national webinars.
- The IPC team attended a Simulation Training session which introduced the team to new delivery method for any future IPC training.

5.6 Respiratory Protective Equipment Programme

With the emergence of global infectious diseases, it is essential that all measures are taken to protect staff against the risk of exposure to airborne pathogens which have been shown to

have potentially devastating consequences for both staff and patients. Respiratory Protective Equipment (RPE) provides staff protection and minimises the risk of onwards airborne transmission.

The Face Fit Tester and Powered Air Purifying Respirator (PAPR) Hood Assessor programme has been maintained for Face Fit Testers and PAPR Hood assessors in all inpatient areas, Whitby UTC, Mental Health Crisis and Community Teams have received refresher training provided by the IPCT. New Face Fit Testers are required to attend an accredited training session and subsequent refresher training to ensure continued face fit testing is maintained. Training compliance is monitored and reported in the Matron quarterly IPC report submitted to HAIG.

Summary of progress and achievements for 2025-2026:

- Funding secured from the Corporate Nursing Division to provide accredited Face Fit Tester training which was facilitated in quarter 3 by an external provider. Members of staff attended from inpatient and community teams.
- Capital funding secured for 22 new Powered Air Purifying Respirator (PAPR) Hoods, this replaced all existing hoods that had become expired and no longer being manufactured.
- IPC team members provided training to the Hood Assessors across all Care Divisions issued with the new Drager X-Plore® 8000 PAPR Hood to allow the assessors to train staff within their team who require the use of a PAPR Hood.
- There has been a significant increase in staff compliance with face fit testing and PAPR Hood assessments although work will continue into 2026-2027 with the areas not achieving their compliance target.

The IPC team will continue to be proactive, providing support to all face fit testers and PAPR Hood assessors to maintain compliance.

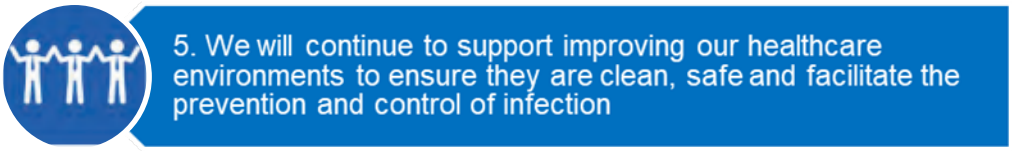
5.7 Spoke Experiential Placement

The IPCT continues to be a Spoke Placement area for all student leaners. Two Learning Disability and one Adult Nursing students accessed this valuable experiential opportunity in 2025-2026. Activities included attending a new Link Practitioner induction session, a network meeting, IPC Environmental audit, contributing towards staff resource development

Feedback included:

- 100% said they found the Student Information Pack useful
- 100% said they would recommend a spoke placement with IPC to other students
- Key learning highlighted knowledge and understanding gained regarding what the IPC team do, the process of audits and the role of the Link Practitioners.
- 1 student putting their name forward to their manager to be an IPC link practitioner

6.0 Goal 5 - Maximising an efficient and sustainable organisation



6.1 Inpatient IPC Environmental Audit Programme

The Trust has an extensive IPC audit programme established which is both environmentally and clinically focused. It is targeted at monitoring and improving IPC practices for all disciplines

across the Trust. Any environmental concerns determined to be of immediate risk are escalated via the Care Division structure and the Clinical Environmental Risk Group (CERG).

The audit programme is completed either by the IPC Link Practitioners, IPC team or the matrons. The audit results are included as part of the quarterly matron report and are scrutinised at the HAIG meeting where each matron is invited to present their reports and improvement plans where required. The results of the IPC environmental audits completed in the inpatient areas during April 2025 – March 2026 can be seen below in table 6.

Table 6. Inpatient Environmental Audit results April 2025 – March 2026

Inpatient area	Environment			
	Q1	Q2	Q3	Q4
Avondale	92%	92%	98%	98%
Mill View Court	95%	92%	87%	95%
Newbridges	84%	93%	87%	95%
PICU	90%	100%	98%	100%
Westlands	95%	100%	*	92%
STaRS	95%	95%	Closed	Closed
Maister Lodge	97%	92%	97%	*
Mill View Lodge	97%	98%	97%	98%
Maister Court	98%	100%	97%	95%
Derwent	95%	100%	100%	100%
Ouse	100%	100%	98%	100%
Swale	95%	95%	98%	98%
Ullswater	92%	89%	95%	97%
Pine View	98%	100%	100%	100%
Lilac	96%	97%	98%	97%
Willow	94%	97%	98%	100%
Granville Court	98%	95%	95%	97%
Whitby Memorial	95%	100%	100%	98%
Malton Fitzwilliam	100%	100%	98%	100%
Orion	92%	98%	100%	100%

*No submission

InPhase IPC Inpatient Environment audit results 2025-2026 RAG+B rating key:

- 0 - <70% Red (Inadequate) 70%
- <90% Amber (Requires Improvement)
- 90% -99% Green (Good)
- 100% Blue (Outstanding)

An additional enhanced level of support is provided as required from the IPC team, Hotel Services and the Estates team to facilitate a collaborative approach to address cleanliness and environmental remedial concerns when identified from audit and or Matron walk rounds across the inpatient areas. It is pleasing to report all areas achieved satisfactory audit results for the IPC environmental audit across all the inpatient services.

6.2 Primary Care IPC Environmental Audit Programme

Despite challenges across the Primary Care estate due to buildings that are not owned by the Trust and the need for effective communication and negotiation skills with our landlords it is pleasingly to report an improved and sustained IPC environmental audit position across Primary Care services as shown in table 7 below. At the end of quarter 4 King Street Medical Centre service transitioned to a new provider. Humber Primary Care services are planned to transition to a new provider in quarter 1 2026-2027.

Table 7. Primary Care Environmental Audit results April 2025 – March 2026

Practice	Environment			
	Q1	Q2	Q3	Q4
King Street Medical Centre	94%	92%	96%	96%
Humber Primary Care - Providence Place	98%	96%	92%	96%
Humber Primary Care - Station Avenue	92%	88%	96%	92%
Market Weighton Practice	98%	100%	100%	100%

6.3 National Cleanliness Standards

It is pleasing to report that the level of cleanliness has met the national standards and local specified requirements within all the Trust inpatient settings during 2025-2026.

The Trust demonstrates full compliance with all the requirements outlined within the National Standards of Healthcare Cleanliness 2025. The annual Efficacy Audit Programme is designed to provide the assurance that standards of cleaning are being met in all areas where patients and visitors present. The IPC team attended the Efficacy audits across all the services, the multi disciplinary team approach was found to be extremely beneficial. The overall findings from the 2025-2026 Efficacy Audits were positive with all areas audited achieving a ‘pass’.

6.4 Patient Led Assessments of the Care Environment (PLACE) 2025

PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent / private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors), in the Trust registered volunteers and individuals from the Lived Experience Team fulfil the patient assessor role.

PLACE assesses aspects of the healthcare setting against common guidelines and standards. The domains include:

- Cleanliness
- Food
- Privacy, dignity and wellbeing
- Condition, appearance and maintenance
- Dementia: how well the needs of patients with dementia are met
- Disability: how well the needs of patients with a disability are met

PLACE assessments are led and coordinated by the Trust Hotel Services with all findings reported to the Trust Health and Safety Group, Estates and Capital Programme Group, Operational Delivery Group and Executive Management Team. The national results were published in quarter 4. Acknowledging the detailed Trust Board report provided by the Director of Finance and Operations Manager, Soft Facilities Management, a summary of the Trust and national results pertaining to IPC interlinked domains i.e. cleanliness and condition appearance and maintenance are provided below in table 8.

Table 8. PLACE results 2025-2026

Domain	Trust score	National Score
Cleanliness	99.93%	98.92%
Condition, appearance and maintenance	97.03%	97.19%

The Trust is marginally below the national average for the condition, appearance and maintenance domain despite 9 sites achieving an improved score and 2 maintaining 100%, one area (Maister Court and Lodge) saw a reduction of 0.73% in the score compared to 2024. The assessment identified areas requiring redecoration and more cupboards in the clinic.

6.5 Environmental Facilities Development / Refurbishment

The IPC team continue to work closely with the Trust Facilities Management Team to support and provide expertise for issues pertaining to IPC to ensure clinical facilities are designed and finished in a way to minimise the transmission of infection and support care delivery in accordance with good IPC practice and standards.

Planning work continued into 2025 to facilitate a major refurbishment of Granville Court, a specialist nursing home for adults who have profound and multiple learning disabilities alongside complex physical health needs that require nursing care to be constantly available. However, it is currently paused due to regulatory and operational constraints. Work is ongoing to identify a preferred option that balances clinical requirements, regulatory compliance, and affordability.

The following provides updates for work planned in 2025-2026:

- Staff shower and toilet facilities and patient bathroom refurbishment work completed on Westlands.
- Darley Seclusion Suite upgrade commenced in quarter 4.
- Improvement to both staff and patient areas at Alfred Bean Hospital (Driffield) as part of a multi year programme of works. Year 1 works completed in quarter 4.
- Improvements to patient facing areas at Rivendell (Driffield) commenced in quarter 4.
- The Dementia room at Malton Hospital, the Trust have commissioned the work and are delivering the project in conjunction with Health Stars.
- The Pine View Reception scheme has experienced significant cost escalation reflecting an expanded scope driven by operational and security requirements. A detailed justification paper is being developed to articulate these changes and ensure the scheme remains aligned to value for money and capital priorities, this will follow the Trusts established governance process.
- The replacement of all sanitaryware on Swale and Ullswater wards within Forensic Services commenced in quarter 4.

A 4 year capital programme has been drafted for approval at Executive Management Team (EMT) in quarter 1 2026-2027.

6.6 The Improvement of Ventilation within the Trust Estate

A paper presented to the EMT redirected the decisions making to the Operational Delivery Group (ODG). The ODG requested a risk based approach to be taken to assess and produce proposed improvement works across the existing inpatient sites and future development, this work has commenced and continues into 2026-2027.

The Ventilation Group has continued to meet quarterly throughout 2025-2026. Enhancing the ventilation within the seclusion suite at Avondale was completed in 2025-2026.

6.7 Water Safety Management

The Trust has an established Water Safety Management Group (WSMG) and has continued to meet quarterly throughout 2025-2026. A subgroup consisting of key members of the WSMG continues to meet monthly to review sites across the Trust estate and fortnightly to review affected inpatient sites.

An external audit programme has been maintained by the Trust appointed Authorising Engineer (Water) throughout 2025-2026 and consists of an annual Governance audit and a 6 monthly Water Quality audit to review and assess the management and operational processes within the Trust.

It is pleasing to report the annual Governance Audit reported 'Reasonable Assurance' which is an improved position from 'Limited Assurance' in the previous annual audit. The Trust maintained 'Reasonable Assurance' following the latest 6 monthly Water Quality audit on 23 December 2025.

6.7.1 Water Safety Training

The annual offering for General Awareness and Usage Evaluation and Flushing Training sessions facilitated by external experts organised by the Estates Compliance Manager is scheduled for quarter 1 2026-2027. The training audience includes inpatient ward managers and matrons to enhance their water safety management knowledge and professional responsibilities understanding in relation to water safety in their areas.

The Legionella/Water Quality Risk Management Responsible Persons training for the Executive Director and Deputy Director of Nursing, Quality and Professions and Head of Nursing Physical Health and Assurance is scheduled for quarter 1 2026-2027.

6.7.2 Continued Water Safety Management - Maister Lodge

Despite an extensive programme of remedial actions and ongoing routes of investigation throughout 2025-2026 the site continues to experience legionella colonisation in the water system. Improvement in areas of the system have been gained however the system design and accessibility pose challenges. All necessary mitigations remain in place and key members of the WSMG have continued to meet fortnightly to review plans and progress.

A new ozone-based water treatment system has been explored and a survey completed deemed the site suitable. Evidence review undertaken by the Trust contracted Infection Control Consultant concluded the ozone system offers a credible and safe enhancement to water safety controls in an older, hydraulically challenging building such as Maister Lodge. It aligns with national guidance, carries minimal occupational risk, and has demonstrated real-world efficacy in reducing microbiological contamination. When implemented alongside established thermal and flushing regimes, ozone can significantly improve overall resilience against Legionella and other waterborne pathogens.

The installation of the ozone treatment was approved by the WSMG in quarter 4, plans to install in quarter 1 2026-2027.

6.7.3 Water Safety Management – Westlands

In quarter 3 water samples were taken as part of pre planned development work to improve staff facilities and a patient bathroom. Legionella species were detected in some outlet samples. Remedial work was carried out encompassed in the development work and resampling post development work completion yielded clear results for all but one outlet. Wider

sampling was undertaken including sentinel points and higher risk outlets (aerosol generating) such as all showers and shower / spray head outlets. Clear results were yielded from several showers and filtered heads were fitted to shower outlets with detection. The seclusion suite ensuite has been impacted and can only be used in an emergency due to the shower and wash hand basin taken out of use due to the inability to protect with filters. A programme of remedial work and investigation continues with mitigations in place to minimise risk. The site is included in the fortnightly meeting with key members of the WSMG.

7.0 Goal 06 – Promoting People, Communities and Social Values



The IPC team work programme has continued to actively support all global IPC awareness raising events. An example of some of the work undertaken by the IPC team or the Link Practitioners is detailed below.

7.1 World Hand Hygiene Day 5 May 2025

In celebration of World Hand Hygiene Day, the IPC team launched a competition with the IPC Link Practitioners and their teams with a theme to get hands on creating a display to raise awareness.

The IPCT receive fabulous entries from MVC, Swale, PICU, Lilac and Willow wards, Ullswater, Ouse, Orion, Westlands and MVL.

The Executive Director of Nursing, Quality and Professions and Director of Infection Prevention and Control had the difficult task in judging the entries and choosing a winner stating ‘they were all amazing in different ways, it was so difficult to judge. I loved the focus on carbon footprint reduction as well as the key principles of hand hygiene. The co production was outstanding!!!!’.

Congratulations went to the staff and patients on Avondale Clinical Decisions Unit for their winning creative Soaper Heroes display. The activity coordinator drew some of the ward staff as Soaper Heroes, using hand hygiene techniques to fight the germs, making for a colourful display. Patients were involved in designing and making the wall display, creating the story behind the display and choosing outfit colours for staff to wear for the design.





7.2 World Sepsis Awareness Day 13 September 2025

The IPC team organised two Sepsis Awareness sessions as All Staff invites facilitated by two guest speakers from The UK Sepsis Trust. This was an invaluable opportunity to build upon knowledge of sepsis and listen to a firsthand account of someone's experience with sepsis.

The IPCT provided an IPC and Sepsis Awareness session as part of the Preceptorship Week including information and sweets to add to their Preceptorship bags, positive feedback was received and many learnt new information regarding sepsis.



The IPCT provided Sepsis information resources discussing with many colleagues, hearing personal accounts of Sepsis. All colleagues across hotel services, estates, recruitment, HR and IT were all aware of Sepsis and enjoyed the pink themed picnic.







Derwent ward staff and patients marked the day by holding a pink theme BBQ.



Orion ward staff and young people created a display on Jenga, their monthly themed wall decoration. They held baking and decorating sessions with the young people to create a pink picnic spread of scones, pink cupcakes, and pink Eton Mess with homemade meringues.





Townend Court staff and patients created a display, raising awareness whilst enjoying sweets.



Westlands created a pink picnic day to spread the awareness around World Sepsis Day with the support from staff, caterers and patients. The patients were involved in the crafts and baking groups to provide props and buns for the picnic.



7.3 International Infection Prevention Week 13-19 October 2025

Information and signposting to resources to raise awareness were provided Trust wide via The Global. The IPCT visited inpatient areas to raise awareness and provide updated IPC posters and information as part of winter preparedness.

Maister Court and Lodge ensured posters were displayed and staff aware.





7.4 World Antimicrobial Awareness Week 18-24 November 2025

To celebrate World Antimicrobial Awareness Week the IPC team visited some of our mental health inpatient units (Avondale, PICU and Westlands). The team produced a display board with key facts and posters, along with an interactive quiz, providing AMR themed crosswords and wordsearches. Staff and patients engaged with the quiz and resources. Feedback supported the activities were fun and engaging whilst providing new information and consolidating knowledge.









Swale Ward raised awareness of WAAW by hosting a ‘blue picnic’ in celebration of the ‘Go Blue for AMR Week’ theme. They invited staff and patients to learn more about AMR whilst enjoying blue themed treats and snacks.



8.0 IPC 5 Year Plan Key Priorities 2025-2026 progress update

1. Innovating quality and patient safety We will embed a culture of continuous quality improvement in all infection control related activities undertaken on behalf of the Trust			
How we will achieve this	**How we will know we have achieved this**	**2025-2026 Progress update**	**Further work required for 2026-2027**
• Utilise the National Infection Prevention and Control (IPC) Board Assurance Framework (BAF) to monitor and evaluate Trust IPC compliance against the Health and Social Care Act 2008 code of practice on the prevention and control of infections and related guidance (updated 13 December 2022) in each inpatient and residential setting.	• Full compliance demonstrated against all the key criteria outlined within the Health and Social Care Act 2008. • The use of the National IPC Board Assurance Framework document is fully embedded as a self-assessment tool in each Trust inpatient/residential setting.	• A localised action plan produced for each inpatient area. • Draft IPC BAF report in place (national version 5 completed).	• Audit to be developed on InPhase for Ward Managers to complete.
• Enhance the mechanisms in place for monitoring compliance to Infection Prevention and Control (IPC) standards and policies to improve IPC practices and outcomes.	• A Trust wide IPC audit programme approved and in place. • Annual review of the content of the IPC audit programme evidenced. • Compliance monitored and rated as 'excellent' in all clinical areas.	• The IPC audit programme maintained, compliance and actions monitored via the quarterly IPC Matron reports and within in the IPC annual report. • Annual External Sharps Audit completed in quarter 2.	• IPC audit programme to be reviewed with stakeholders i.e. waste management.
• Maintain the production of IPC guidelines, Standard Operating Procedures (SOPs) to address clinical and operational needs.	• All new and existing Trust IPC policies developed and reviewed in accordance with the relevant national guidance, and available for our staff on the Trust Intranet.	• All IPC policies, SOPs, guidance documents have been maintained, reviewed when scheduled or required to ensure all documents are up to date and in line with the National Infection Prevention and Control Manual (NIPCM) for England and relevant national guidance. • The production of Trust IPC Guidance at glance has been maintained and	

		additional topics have been developed for staff. • All documents available on the trust intranet.	
• Complete timely and accurate reporting of mandatory surveillance of all alert organisms.	• All mandatory alert organisms are reported promptly and in accordance with national and contractually agreed requirements. • National and locally agreed infection prevention and control targets are met or exceeded.	• All reportable Healthcare Associated Infections (HCAIs) and outbreaks are reported via DATIX. • IPC monthly performance data submitted. • A review of each case completed.	• To review NHS Standard Contract 2026/27: Minimising Clostridioides difficile and Gram-negative bloodstream infections to determine any changes to Trust reporting arrangements.
• Review and strengthen the infection control enquiry and investigation processes across the Trust when dealing with an incident and an outbreak of communicable disease.	• Evidence is available that a multidisciplinary approach is adopted in the management and review of all infection control incidents and outbreaks. • All serious infection incidents are investigated utilising the Patient Safety Incident Response Framework (PSIRF). • We can evidence that any learning is used to promote change across pathways.	• PISRF Methodology for agreed HCAIs and IPC related incidences is embedded. • 11 IPC After Action Reviews (AAR) completed. • All IPCT members completed HSIB AAR training. • AAR reports are discussed at Care Division Clinical Governance Groups, CRMG and HAIG. • Actions taken from issues identified from AAR / management of cases.	• Learning from AARs to be captured in quarterly Matron IPC reports. • Thematic review to be undertaken for all IPC related AARs.

2. Enhancing prevention, patient wellbeing and recovery We will enhance patient and carer involvement in all matters relating to infection prevention			
How we will achieve this	**How we will know we have achieved this**	**2025-2026 Progress update**	**Further work required for 2026-2027**
• Maximise every available opportunity to actively engage with all our patients and patient groups.	• Able to demonstrate that adjustments have been made when required based on patient or carers feedback. • All relevant policies, procedures, and guidelines will reflect feedback received and shared in line with the Trust processes and guidance.	• The IPCT continues to have Staff Champions of Patient Experience (SCoPE) within the IPC team. • Revised IPC policy and protocol in quarter 3 was circulated to all the Patient and Carers Engagement (PACE) forums for feedback, unfortunately none was received. • Following each inpatient area having experienced an outbreak, patient	• To fully embed in all IPC future work / projects. • QR code to feedback form to be added to all patient, carers, visitors IPC leaflets to increase the opportunity to provide feedback. • Collaboration with hotel services to explore feedback for cleanliness and IPC via the Trust public facing web site.

		feedback is sought albeit limited, positive feedback has been received.	• Post IPC isolation experience feedback form / mechanism to be developed as coproduction.
• We will work collaboratively with the Patient and Carer Experience (PACE) Team and the Trust Communication Team to promote, receive, and share information about IPC work with patients, carers, volunteers, and the local communities.	• Evidence the IPC team Staff Champion attendance at the PACE Forum and events, linking in with external relevant work streams. • Ongoing progress is made in respect of the Trust approved IPC PACE Development Plan. • Co-produced patient information / leaflets that reflect patient needs and current evidence base are readily accessible to all patients. • The Trusts co-production stamp is displayed on all co-produced work.	• Continued IPC team maintenance of an annual PACE Development Plan, progress is reviewed by the SCoPE and captured in the annual report. • Co production stamp achieved for the review of all existing IPC patient, carers and visitor leaflets.	• Review visitor information available on the Trust internet site. • Review IPC information provided for new admissions.

3. Fostering integration, partnership and alliances **We will work collaboratively with local and regional partners to drive forward further reductions in the number of healthcare associated infection**			
How we will achieve this	**How we will know we have achieved this**	**2025-2026 Progress update**	**Further work required for 2026-2027**
• The continued commitment of the IPC team to avail themselves of every opportunity to share and learn with colleagues across the local health economy.	• Shared learning with regional partners is demonstrated by the continued regular attendance at regular local and regional meetings. • Representation and contribution to regional working parties and groups can be evidenced. • Contribute to the consultation process for national and regional IPC guidelines and policy, ensuring learning outcomes shared.	• Regular attendance achieved by the IPC Lead Nurse and Deputy at the Humber and North Yorkshire (HNY) ICB IPC Huddle. • Lead Nurse and Deputy are members of the Infection Prevention Society (IPS) and several IPS Special Interest Groups having attended regular meetings which are beneficial to shared learning. • IPC team contribution in to the consultation for the national IPC Mandatory Training package. • Participate in AMS collab forum videos	• Collaborative working with NHS Humber Health Partnership regarding Urinary catheter improvement programme.
• We will work with partners locally to developand	• A Trust Antimicrobial Strategy developed and approved.	• Trust Antimicrobial Stewardship Policy and Plan (2024-2027) produced and approved.	• Trust AMS Plan progress report. • Review the Microbiology Service contract KPIs for 2026/27.

implement a Trust Antimicrobial Strategy.	• Evidence that the Board receives a formal report on antimicrobial stewardship activities annually which includes the Trust progress against the UK action plan for antimicrobial resistance (AMR). • The formalised Trust audit programme of adherence with antimicrobial prescribing demonstrates a high level of compliance and an effective response when areas for improvement are identified.	• A Trust antimicrobial prescribing audit programme is in place for all Trust inpatient and Primary Care settings. Reports provided to HAIG and the Drug and Therapeutics Group. • IPC team supported in the celebration of annual World Antimicrobial Resistance (AMR) Awareness Week. Awareness raised across the Trust sites through information cascade, visits and engagement with staff and patients.	
• Working in partnership with members of the North East and Yorkshire Regional Hydration Improvement Network we will support the delivery of a plan to improve hydration in the clinical inpatient settings as means of reducing infection.	• A Trust Hydration Quality Improvement programme will be developed and in place. .	• Future of the regional network under review, no meetings held for 2025-26. • No regional plan produced.	• IPCT to support the network should this be required.

4. Developing an effective and empowered workforce **We will strive for exemplary infection prevention and control principles to be embedded in practice throughout all areas within the Trust**			
How we will achieve this	**How we will know we have achieved this**	**2025-2026 Progress update**	**Further work required for 2026-2027**
• Review the current IPC Trust Mandatory Training Programme to ensure it fulfils all the recommendations highlighted within the recently produced NHS England Infection Prevention and Control Education Framework (2025).	• All Trust staff are trained in accordance with the 2025 National IPC Education Framework recommendations. • A full suite of learning resources will be readily available for all staff which support the application of clinical best practice. • An 'excellent' Trust wide mandatory training compliance rate achieved for all staff groups.	• Level 1 & Level 2 national changes to the mandatory IPC learning package adopted in the Trust in quarter 4. • The requirement for Tier 3 training has been stepped down due to full review of the national IPC programme. • New Trust Transmission Based Precautions learning resource developed and approved in quarter 4.	• Roll out and embedding of the new Transmission Based Precautions learning resource for inpatient staff. • Explore the development of a Community Service focused Transmission Based Precautions resource with Trust Instructional Designer.

		• Level 2 trust wide compliance maintained / exceed for the year.	
• Fully embed the Hand Hygiene and Personal Protective Equipment (PPE) Clinical Competency assessment tool.	• Evidence is available via the Electronic Staff Record 'ESR' that the Hand Hygiene and PPE Clinical Competency has been successfully attained by each member of staff who are required to deliver direct clinical care. • Hand hygiene practice and the appropriate use of PPE audit compliance results are consistently exceeding the Trust agreed threshold.	• The Hand Hygiene and PPE Clinical Competency embedded. Trust wide compliance has exceeded the 85% baseline for 2025-26. • Quarterly IPC observational audits completed as part of the IPC audit programme.	• Maintaining the current compliance position. • Enhancing the local management processes when non compliance is noted on the hand hygiene observational audit and linking to the staff competency tool.
• Enhance the IPC Link Practitioner Network membership and skills across all clinical services, ensuring that they are equipped with the knowledge and experience of IPC related matters commensurate to their role.	• All clinical staff will have access to an infection control link practitioner and a record of these links will be held and updated by the IPC team. • Evidence of regular IPC Link Practitioner meetings available to access and attendance monitored. • Evidence provided of the IPC Link Practitioner cascading and sharing information available in each clinical area.	• A review of the network meetings content and attendance remains under regular review. Consistently low attendance figures still noted further work ongoing to improve this position. • New Link Practitioner induction session developed and delivered in 2025-2026 with positive feedback received.	• Review the network survey results and action plan accordingly. • The Link Practitioner Competency and Resource Package implemented in 2025-2026 to be evaluated. • Explore methods to improve engagement and network meeting attendance and opportunities. • To maintain the delivery of the New Link Practitioner induction session.
• We will support and enhance the professional expertise of all members of the IPC team by ensuing they are armed with the necessary training and skills to undertake the roles successfully.	• Each IPC team member has a recognised formal IPC qualification or are working towards. • A recognised leadership training programme has been successfully attended by senior members of the team. • Each member of the IPC team is familiar with and utilises the Trust Quality, Service Improvement and Redesign (QSIR) Practitioner Programme methodology in the undertaking of all quality improvement work.	• IPC team member successfully completed the PROUD programme.	• Exploration of the opportunity for a team member to gain an accredited IPC qualification. • To improve the application of QI methodology for all IPC projects.
• We will adopt the National IPC Competency Framework to support and enhance the professional expertise of all members of the IPC team.	• Each member of the IPC team can demonstrate their level of competency as outlined within the National IPC Competency Framework.	• IPS competency framework for each team member informally discussed as part of individual supervision.	

• Provide a learning opportunity to all healthcare learners as a bespoke placement with the infection control team	• Evidence available for Student evaluations completed on the Practice Assessment Record and Evaluation Website.	• Review of spoke placement areas completed which resulted in evaluation no longer captured on the national PARE site. IPCT developed a MS form to capture student feedback. • 3 student learners have accessed the IPCT experiential opportunity and positive feedback received. • Review of Trust spoke placement information completed collaboratively with the Trust PLF team. • IPCT student welcome pack and workbook reviewed and updated.	

5. Maximising an efficient and sustainable organisation **We will continue to support the improvement of our healthcare environments to ensure they are clean, safe and facilitate the prevention and control of infection**			
How we will achieve this	**How we will know we have achieved this**	**2025-2026 progress update**	**Further work required for 2026-2027**
• Work in collaboration with our Facilities colleagues to ensure that IPC is considered specific goals relevant to each construction project are achieved to ensure the provision of a safe and appropriate environment.	• Evidence is available that all capital schemes and preventative maintenance schemes have involved the IPC team from the initial stage of the project. • IPC sign off can be evidenced at all stages of the project. • Evidence is available that improvements to the ventilation system are considered and made in all new builds.	IPC involvement noted in all major developmental work. This has included; • Ventilation enhancement works (Newbridges and Westlands units) • Seclusion suite upgrades plus the instillation of adequate ventilation • Proposed redesign of Granville Court • Involvement in the early stage of the development of a new unit on the Humber site.	• Continue to support all improvement work programmes.

• Ensure that the built environment meets all infection control and national specifications (e.g. HTM /HBN – Technical standards and guidance (health building notes/health technical memoranda documents).	• The fabric of the environment is suitable to meet the needs of the patients, staff and visitors whilst meeting all infection control and HTM/HBN requirements.	• Involved in ensuring all fixtures and fittings approved in new builds or significant refurbishment projects are in line with HBN specifications.	
• Work in collaboration to ensure that the National Standards of Healthcare Cleanliness (2021) are fully embedded in all areas.	• Cleanliness audits independently undertaken by Facilities Services, the Matrons and the IPC team demonstrate a high level of cleanliness in all areas within the Trust Estate. • Positive patient feedback can be evidenced.	• IPC team supported the implementation of the efficacy audit programme to comply with the national cleanliness guidance. • Developed a standardised IPC inpatient feedback form.	

6. Promoting people, communities and social values **We will avail ourselves of every opportunity to promote the importance of infection prevention and control community wide**			
How we will achieve this	**How we will know we have achieved this**	**2025-2026 progress update**	**Further work required for 2026-2027**
• The IPC team will support the Trust participation in local, national and global IPC promotional campaigns raising IPC safety awareness.	• All IPC activities and promotional events undertaken will be shared organisationally and with our collaborative partners.	• The IPC team supported several awareness events throughout the year e.g. World Hand Hygiene Day, World Sepsis Day, International IPC week and World AMR Awareness Week. • Communications produced and cascaded via the Global, intranet and the Link Practitioner Network meetings. • The IPC team attended primary care sites providing information for patients and staff raising AMR awareness. • Trust induction presentation continued to include Sepsis awareness.	

• We will enhance the quality and availability of all Trust IPC promotional resources.	• The usage of a variety of key media styles, including the internet, intranet, and social media platforms has been adopted to promote effective IPC practice and IPC team involvement in all.	• All IPC leaflets reviewed. • IPC produced inpatient posters as part of the standardisation Communication Team led project for information.	• Review the effectiveness of the standardised IPC patient information and feedback form developed.

Humber Teaching NHS Foundation Trust

Agenda Item 12

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Safeguarding Annual Report 2025/26
Author/s:	Rosie O'Connell – Head of Safeguarding
Recommendation:	

To approve	√	To discuss	√
To note		To ratify	
For assurance	√		

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	This Annual Safeguarding Report provides assurance that Humber Teaching NHS Foundation Trust has continued to fulfil its statutory safeguarding responsibilities during 2025/26. The report outlines safeguarding activity, performance, governance arrangements, training compliance, partnership working, learning from reviews and incidents, progress against the Trust Safeguarding Plan, and key priorities for 2026/27. It demonstrates the Trust's ongoing commitment to protecting children, young people and adults at risk, promoting a safeguarding culture, and continuously improving safeguarding practice across all services.

Key issues:

Positive Assurances to Provide:

- Statutory safeguarding duties continue to be met.
- Strong partnership working across safeguarding boards and agencies.
- Safeguarding, Prevent and MCA training compliance exceeded target.
- Safeguarding governance strengthened through the Safeguarding Assurance Group.
- New SystmOne safeguarding, MCA and Gillick templates implemented.
- Increased oversight, reporting and learning from reviews and incidents

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Implement and embed the Trust-wide safeguarding template across all SystmOne services.
- Audit the use of new safeguarding, Mental Capacity Act and Gillick Competency templates.
- Deliver Year 3 of the White Ribbon Action Plan and seek reaccreditation.
- Establish a Trust-wide Domestic Abuse and Sexual Safety Group.
- Relaunch Safeguarding Link Worker forums and increase safeguarding visibility across services.
- Strengthen Think Family practice through audit and improved information sharing.

	• Continue learning from safeguarding reviews and patient safety investigations, ensuring actions are embedded across the Trust. • Develop the next Safeguarding Plan for implementation from 2027 onwards
Key Risks/Areas of Focus: • Statutory safeguarding duties continue to be met. • Strong partnership working across safeguarding boards and agencies. • Safeguarding, Prevent and MCA training compliance exceeded target. • Safeguarding governance strengthened through the Safeguarding Assurance Group. • New SystmOne safeguarding, MCA and Gillick templates implemented. • Increased oversight, reporting and learning from reviews and incidents	**Decisions Made:**

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	Through strong partnership working with local authorities, safeguarding partnerships, community services and multi-agency forums. The Think Family approach, safeguarding referrals, domestic abuse support and community safeguarding arrangements help identify and manage risks earlier within people's homes and communities, reducing the need for crisis intervention and supporting care closer to home.
Analogue to Digital	Through early identification and intervention for domestic abuse, neglect, self-neglect, exploitation and radicalisation concerns. Workforce training, safeguarding audits, learning from reviews and proactive risk management enable staff to identify vulnerability earlier, preventing harm and improving outcomes for children, young people and adults.
Sickness to Prevention	Through the implementation of Trust-wide safeguarding templates within SystmOne, enhanced Mental Capacity Act and Gillick Competency documentation, improved Datix reporting and digital performance dashboards. These developments strengthen information sharing, improve data quality, enhance safeguarding oversight and support better decision-making across services.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee	Sept 26	People & Organisational Development Committee	
Finance Committee		Executive Management Team	8 Sept 26
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	QPaS august 26

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	√
Enhancing prevention, wellbeing and recovery	
Fostering integration, partnership and alliances	√
Developing an effective and empowered workforce	√
Maximising an efficient and sustainable organisation	
Promoting people, communities and social values	√

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	√

Public Exemption:

Is the report exempt from public disclosure	No

Humber Teaching
NHS Foundation Trust

Safeguarding Annual Report 2025/26



Contents

1. Executive Summary
1.1 Foreword by the Executive Director of Nursing, Quality & Professions
1.2 Our Safeguarding Mission, Vision and Values
1.3 A Summary of Key Achievements
1.4 The Humber Safeguarding Team
1.5 Safeguarding Governance Arrangements
1.6 Safeguarding Spotlight – Safeguarding Assurance Group

2. Performance
2.1 Safeguarding Adults
2.2 Safeguarding Children
2.3 Training
2.4 Safeguarding Spotlight - PIPOTS

3. Partnership and Collaborative Working
3.1 Domestic Abuse
3.2 Safeguarding Spotlight – Sexual Violence: Support and Healing Conference
3.3 Modern Slavery and Exploitation
3.4 Safeguarding Spotlight – ER Children Looked After Health Team
3.5 Prevent Board and Channel Panel
3.6 Safeguarding Spotlight – Southport Inquiry
3.7 Collaborative Working Across the Trust
3.8 Learning from Incidents

4. Safeguarding Systems
4.1 Safeguarding Template
4.2 MCA 2005 and Gillick Competency
4.3 Think Family
4.4 Datix Recording and Safeguarding Performance Reports

5. Safeguarding Priorities
5.1 How did we do? 2025/26
5.2 Looking ahead to 2026/27

Dedication

We would like to dedicate this to Helen Young who worked for the Trust for nearly 30 years. Helen was a social worker and after leaving front line practice spent her career supporting the learning and development of other professionals, not only at the Trust but working in partnership with local universities training future social workers and nurses. Helen was passionate about safeguarding and approached her work with compassion and care, demonstrating the Humber values in every part of her work. She was an integral part of establishing the safeguarding service within the Trust, and remained so until she passed away on January 3rd this year. We would like to express our thanks to Helen for everything she has helped us achieve.

1. Executive Summary

The Safeguarding Annual Report provides assurance that Humber Teaching NHS Foundation Trust continues to meet its statutory safeguarding responsibilities for children, young people and adults, whilst maintaining strong partnership working, robust governance arrangements and high levels of workforce compliance with mandatory safeguarding training. The report highlights significant progress made during 2025/26 despite a period of business continuity within the Safeguarding Team and reduced staffing capacity. Core statutory functions and safeguarding duties were maintained throughout the year. Safeguarding remains firmly embedded across the Trust, supported through established governance structures, active participation in local safeguarding boards and partnerships, comprehensive policy frameworks, and the introduction of the Safeguarding Assurance Group, which now provides enhanced oversight of safeguarding activity, quality improvement, learning from incidents and delivery of the Safeguarding Plan.

The Trust remains in a strong position regarding workforce capability and compliance. Mandatory safeguarding, Prevent and Mental Capacity Act training compliance exceeded the Trust target of 85% across all programmes. In addition to statutory training, the Safeguarding Team delivered a broad range of bespoke learning opportunities covering domestic abuse, exploitation, deprivation of liberty safeguards, child neglect, Prevent and other emerging safeguarding themes. A key achievement during the year was the implementation of significant improvements to safeguarding systems and digital infrastructure. The introduction of a Trust-wide safeguarding template within SystmOne has created a more consistent approach to recording safeguarding information, improving visibility, information sharing and future reporting capabilities. Further developments included the implementation of Mental Capacity Act and Gillick Competency templates and enhanced use of Datix to capture safeguarding activity, reviews and People in Positions of Trust (PIPOT) processes.

The Trust has continued to strengthen its partnership work across domestic abuse, exploitation, modern slavery, Prevent and safeguarding review activity. The Trust remains an active contributor to MARAC, MATAC, MACE, MAYVE, Prevent Channel Panels and local safeguarding review processes. During the year, the Safeguarding Team supported or contributed to 60 safeguarding and patient safety reviews, an increase from 36 the previous year, demonstrating a strong commitment to learning and continuous improvement.

Overall, the report demonstrates that the Trust continues to provide effective safeguarding leadership, maintains compliance with statutory requirements, actively contributes to multi-agency safeguarding arrangements, and remains committed to protecting vulnerable children, young people and adults while continuously improving safeguarding practice across the organisation.

1.1 Foreword by Sarah Smyth, Executive Director of Nursing, Quality and Professions



Sarah Smyth,
Executive Director of Nursing, Quality & Professions, Calicott Guardian

I am pleased to introduce the Safeguarding Annual Report for 2025/26, which provides assurance that Humber Teaching NHS Foundation Trust continues to fulfil its statutory safeguarding responsibilities for children, young people and adults, whilst remaining committed to delivering safe, compassionate and high-quality care.

Safeguarding is fundamental to everything we do. It reflects our collective responsibility to protect people from abuse, neglect, exploitation and harm, whilst promoting their rights, wellbeing and independence. Across our diverse range of mental health, learning disability, community and children's services, safeguarding remains firmly embedded within clinical practice, leadership, governance and organisational culture.

This report demonstrates the Trust's continued commitment to our values of Caring, Learning and Growing. We show Caring through our determination to place the safety, wellbeing and lived experience of patients, families and carers at the centre of our work. We demonstrate Learning through our proactive approach to learning from incidents, safeguarding reviews, audits and patient safety investigations, ensuring that improvements are embedded into practice. We continue Growing by investing in our people, strengthening our safeguarding systems and developing partnerships that improve outcomes for the communities we serve.

During 2025/26, the Trust has maintained strong safeguarding performance despite periods of reduced staffing capacity within the safeguarding team. Significant achievements include the introduction of the Safeguarding Assurance Group, the implementation of a Trust-wide safeguarding template within SystmOne, continued high compliance with safeguarding, Prevent and Mental Capacity Act training, and active participation in safeguarding partnerships and review processes across our local systems. The Trust has also strengthened its approach to domestic abuse, exploitation, Prevent, information sharing and learning from safeguarding and patient safety reviews.

This work directly supports the Trust's strategic objectives. Through strengthening governance, quality assurance and learning from incidents, we are Innovating for Quality and Patient Safety. By promoting early intervention, protecting vulnerable individuals and supporting people affected by abuse, trauma and exploitation, we are enhancing prevention, wellbeing and recovery. Our active contribution to safeguarding boards, partnerships and multi-agency forums demonstrates our commitment to fostering integration, partnerships and alliances. Our focus on reducing inequalities, improving access to support and advocating for those most vulnerable reflects our ambition of promoting people, communities and social value. Finally, investment in training, supervision and workforce development supports our objective of developing an effective and empowered workforce.

I would like to thank the safeguarding team, clinical and corporate colleagues, and our partner organisations for their professionalism, expertise and unwavering commitment to safeguarding. I would also like to acknowledge the dedication of Helen Young, whose contribution to safeguarding and professional development across the Trust has left a lasting legacy.

The achievements outlined within this report provide assurance that safeguarding remains a priority across the organisation. As we move forward into 2026/27, we will continue to strengthen our safeguarding arrangements, embrace opportunities for improvement and ensure that protecting those most at risk remains at the heart of everything we do.

1.2 Our Safeguarding Mission, Vison and Values

Our Safeguarding Mission

Humber Teaching NHS Foundation Trust is committed to safeguarding all children, young people and adults who access our services from harm, abuse or neglect.

Our Safeguarding Vision

Safe and effective safeguarding services for children, young people and adults will be delivered by staff.

An organisational wide approach will be taken. Safeguarding responsibilities will be embedded at all levels and across all staff groups in accordance with our statutory responsibilities.

Senior leaders and the Trust Safeguarding Team will be visible to both our patient and staff groups, promoting a positive culture where open conversations about safeguarding are encouraged, and patients, carers and families are listened to.

Our Values

Our safeguarding mission and vision is alligned to the Trust strategic goals, and to its values of Caring, Learning and Growing.



1.3 A Summary of Key Achievements



1.4 The Humber Safeguarding Team

The Humber Safeguarding Team is an integrated service that provides advice and support to Trust staff on both adult and child safeguarding issues. The team consists of the Named Professional for Adult Safeguarding, Mental Capacity Act and Prevent Lead (who has overall management responsibility for the team), the Named Nurse for Safeguarding Children (who acts as deputy manager for the team), 4 Specialist Safeguarding Practitioners, 3 Safeguarding Practitioners and 3 Safeguarding Administration Assistants. Our team has a mix of different professional backgrounds including social work (adult and child), health visiting/school nursing, midwifery, and learning disability, mental health nursing, general nursing (adult) and childrens nursing. **In 2025/26 the team spent a period in Business Continuity and had a very limited safeguarding resource; statutory and core responsibilities were delivered throughout this period.**

The teams core functions include:

Providing advice and support on safeguarding matters, including attending meetings, on a day-to-day basis via a duty desk	Providing safeguarding supervision for complex safeguarding cases, and supporting escalations to partners where there are concerns that cannot be resolved
Providing clinical leadership as an expert in matters relating to safeguarding practice to support the provision of high-quality safeguarding practice for both children and adults	To design and deliver safeguarding, prevent and mental capacity training to support safeguarding practice development and compliance with statutory and mandatory training requirements
To share learning from both internal and external reviews of cases and best practice and raise awareness of key safeguarding issues and national awareness campaigns across the Trust	To carry out or support PSIRF reviews where safeguarding issues are identified, this includes the facilitation of Swarm Huddles as part of the wider patient safety work within the Trust
To participate in Trust governance processes to provide safeguarding expertise and oversight when reviewing incidents, investigations and the development of Trust policies and procedures	Develop and lead the Trusts Safeguarding Plan which includes the delivery of the safeguarding development plan, and safeguarding quality improvement and audit plan
To provide support to staff, and coordinate the training offer, on Mental Capacity Act 2005 and Court of Protection	Participating in external statutory review processes such as child death reviews, domestic abuse related death reviews and safeguarding adult reviews
Carrying out independent reviews on individuals in seclusion, long term segregation and care away from other arrangements	Responsibility for the management of allegations/concerns raised against people in position of trust (PIPOT) working for our Trust

1.5 Safeguarding Governance Arrangements

Safeguarding is firmly embedded within the core duties of Humber Teaching NHS Foundation Trust.

Responsibilities for safeguarding are enshrined in legislation and guidance which the Trust must adhere to, including the Children Act 2004, Working Together to Safeguard Children 2026, the Mental Capacity (Amendment) Act 2019, the Prevent Strategy 2011 and Prevent Duty Guidance: England (2023), the Mental Health Act 2007, the Care Act 2014, Care and Support Statutory Guidance 2016 and the Safeguarding Accountability and Assurance Framework 2026. Under the requirements of Section 11 of the Children Act 2004 the Trust completes annual Section 11 audits and submits them to the local safeguarding children's partnerships to provide assurances on how we are meeting the duties.

The statutory function for the Trust is held by the Executive Director of Nursing, Quality and Professions, who is the executive member for the Trust at the Hull and East Riding Safeguarding Boards and Partnerships. The Trust actively participates in the Board, Partnership and Subgroup activity to ensure safeguards are in place across all our services.

Safeguarding activity is delivered through:

- Safeguarding review of all patient safety incidents reported via the Corporate Safety Huddle and Clinical Risk Management Group (CRMG)
- Duty provision which provides advice and guidance to staff who need safeguarding advice, ensures attendance at relevant safeguarding meeting and a timely response to external professionals seeking the Trusts input on safeguarding cases
- Safeguarding SOPS approved via Safeguarding Assurance Group (SAG), and Policies approved via Quality and Patient Safety Group (QPAS)
- Annual Report presented to QPAS, EMT, Quality Committee and Public Board

- SAG in place which reports to EMT and is attended by Clinical Divisions and other key areas. This includes an Open meeting each year extended to external partners and agencies, where quarterly updates are given on performance data, safeguarding reviews, quality improvement projects, audits, progress against the safeguarding plan and other key workstreams
- Weekly reporting presented to Director and Deputy Director of Nursing, Quality and Professions on PIPOT cases / staff allegations and steps taken
- Learning from incidents and reviews presented to SAG on a Quarterly basis and an annual confidential paper presented to EMT which summarises incidents and key findings

Statutory/Contractual requirement	**How it is met**
Executive Lead for Safeguarding	In place – Sarah Smyth.
S11 Children Act 2004 and Working Together	Annual audit evidencing compliance with Children Act – submitted to Local Authorities and Local Safeguarding Childrens Partnerships.
Safeguarding Lead/Named Professional for Safeguarding Children Child Sexual Abuse and Sexual Exploitation Lead	In place – Kerry Boughen.
Safeguarding Lead/Named Professional for Safeguarding Adults Prevent Lead Mental Capacity Act Lead	In Place – Rosie O'Connell.
Named Doctor for Safeguarding Children	In Place – Priyanjan Undugoda.
Safeguarding Lead for Children Looked After	In Place – Melissa Blencoe.
Safeguarding Policies and MCA 2005 Policies	Full policy schedule in place. SOPs monitored and reviewed via SAG, Policies via QPAS.
Compliance with safeguarding, MCA and Prevent legislation Annual audit/reporting of compliance with safeguarding requirements Annual report of safeguarding activity to Board	Assurance provided on compliance with legislation via the Safeguarding Annual Report to the Board, and through mandatory reporting to NHSE and local Boards and Partnerships.
Provision of safeguarding and MCA 2005 training packages with regard to RCN Intercollegiate Documents	Training programs in place for all and compliance monitored through Safeguarding Assurance Group.
Compliance with child protection information share guidance and Data Protection guidance	The Trust shares information via CPIS and Phase 2 is being implemented; Trust is part of working groups with regards to this. Information sharing processes and agreements covered in safeguarding policies.
Participation with statutory and non-statutory safeguarding reviews led by Local Safeguarding Adult Boards or Partnerships, Child Death Reviews and Learning Disability mortality reviews	Participation in 60 reviews this year alongside child death and learning disability reviews. Reviews monitored and reported via Business Meeting and SAG.
Safe recruitment practices and policies	In place with Recruitment Team and DBS team. Safeguarding monitor risk assessments for staff with offence or caution declared working in patient facing role.

1.6 Safeguarding Spotlight – Safeguarding Assurance Group

This year the safeguarding governance arrangements were reviewed resulting in the Safeguarding Learning and Development Group being replaced with the Safeguarding Assurance Group from September 2025 onwards, reporting directly into EMT. The Deputy Director of Nursing, Quality and Professions chairs the group, and the Head of Safeguarding serves as Deputy chair. The group oversees and coordinates aspects of safeguarding duties the Trust has and ensures appropriate action as necessary in order to safeguard patients. The group has a particular focus on learning from incidents and reviews; all statutory and non-statutory reviews the Trust is involved in are presented at this group, and where learning is identified position statements are presented which details actions required, when, who by and the Trusts current position on those. This approach really emphasises the importance of not only identifying learning from incidents and reviews but embedding that learning and improving the outcomes for our service users and patients.

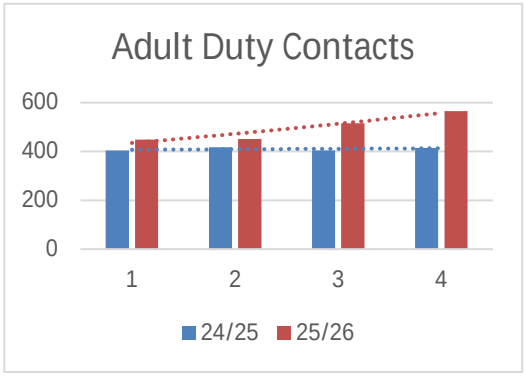
Across 3 meetings the following was achieved:



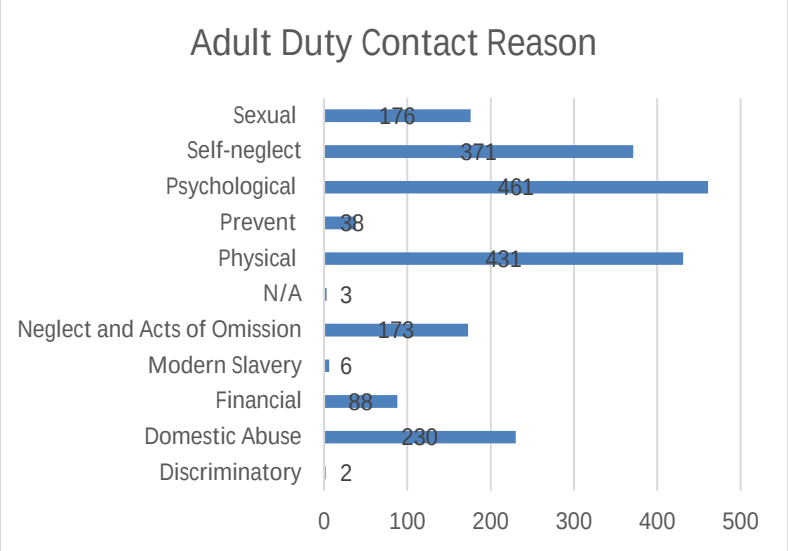
2. Performance

We are making referrals to local authorities, compliant with our Prevent Duty and above set target for our statutory and mandatory training programs, in line with our statutory duties and requirements.

2.1 Safeguarding Adults

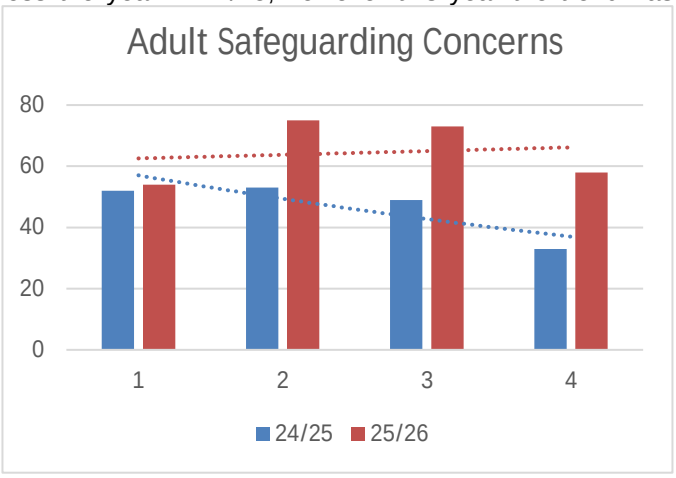


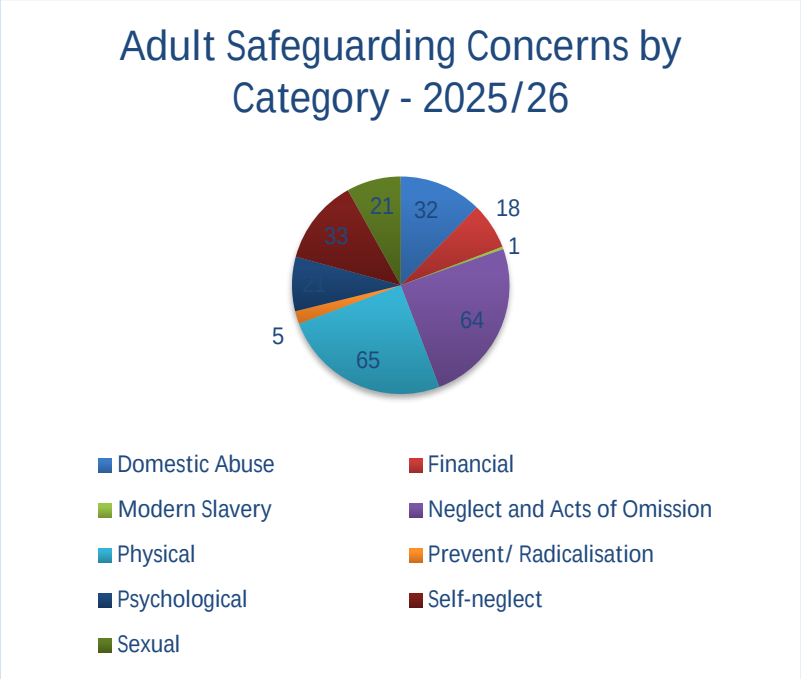
The safeguarding team offer a duty function which means that practitioners are available to provide advice and guidance to staff across the Trust between Monday—Friday 09:00-17:00. The practitioner assigned to duty on a specific day will attend the Corporate Safety Huddle to provide safeguarding oversight of reported incidents, give advice and guidance via email/phone/MS Teams and attended meetings where appropriate and able to do so. This year there was a total of 1979 duty contacts relating to adult safeguarding concerns, **an 8.3% increase from the previous year,** evidencing increasing engagement from staff and teams regarding safeguarding issues. Whereas the 2024/25 year showed a steady number over the year, there has been an upward trend this year, particularly in Q3 and Q4 and that increase in duty contacts each quarter has continued into the 2026-27 year. The Safeguarding Plan 2023-2026 identifies increasing the visibility of the team as a priority, and the increase in duty contact supports the achievement of this goal.



The most reported category of abuse or neglect that staff contacted the duty desk to discuss was psychological (461), followed closely by physical (431) and self-neglect (371).
This is a similar trend to 24/25, but the numbers of contacts are greater and there are more contacts for psychological than physical. This could be reflected by the increase in domestic abuse concerns discussed with the duty desk, which increased from 182 to 230 this year, however when the psychological abuse contacts are broken down further 74% occurred in inpatient settings and relate to reported verbal abuse between patients. This suggests that the increase in psychological abuse contacts is also down to the recognition, responding to and recording of verbal incidents between patients.

A total of 260 safeguarding adult concerns were submitted to the local authority, an increase of 39% from the previous year. Adult concern numbers showed a downward trend across the year in 24/25, however this year the trend has remained overall steady. 121 concerns were submitted within Hull, 78 in the East Riding and 57 in North Yorkshire. The higher numbers in Hull is consistent with previous years and due to the number of services working within this area. Hull is also the 6th most deprived local authority area in the country with 20.8%of working age adults in employment deprived houses; evidence shows that those living in the most deprived areas face the worst healthcare inequalities and are more likely to be socially excluded. Of note is the increase in referrals logged within North Yorkshire which has increased from 34 in 24/25 to 57 this year. This is due to increased scrutiny of datix incident reports from Divisional leadership, ensuring referrals are being correctly recorded.

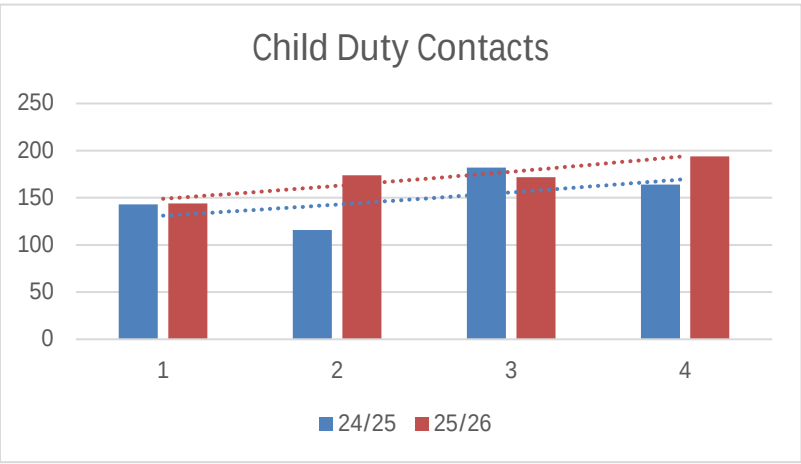




A total of 65 adult concerns were submitted for physical abuse, 64 for neglect and acts of omission, followed by 33 for self-neglect and 32 for domestic abuse. These were the top categories reported as in 24/25. National data for category of risk is only available in relation to concluded S42 enquiries and not referrals made, but this still gives us an idea of the national and regional picture in comparison to the risks the Trust are reporting on. This shows us that our reporting is similar with neglect and acts of omission, and physical abuse, being two of the most reported concerns referred to the local authority. However, the Trust reports higher proportions of concerns around self-neglect and domestic abuse than financial or material, and this has been a consistent pattern over the years, reflecting the nature of our services and the complexities and vulnerabilities faced by our patient population. The Team receives duty calls regarding individuals who are experiencing domestic abuse but who do not meet the Care Act criteria meaning a concern isnt submitted; in the next year using the safeguarding template will help us to better evidence response to domestic abuse as we may still make referrals to domestic abuse services or do a DASH risk assessment.

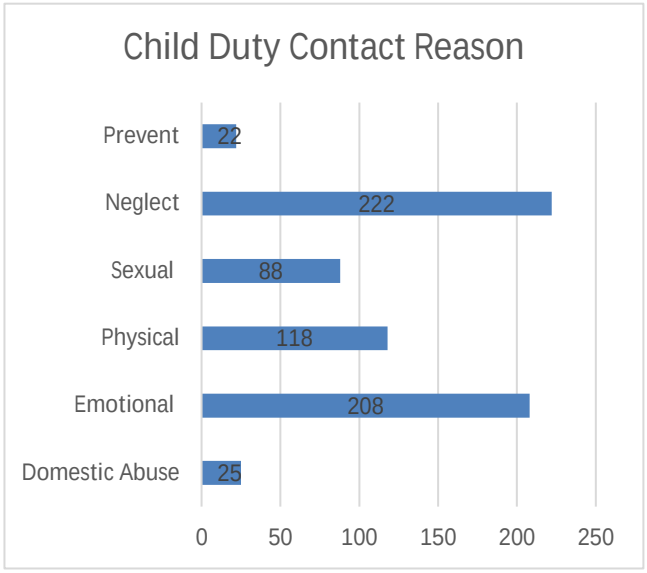
Most common category of risk	1st	2nd	3rd
National (England)	Neglect and acts of omission	Physical	Financial or material
Regional (Yorkshire and Humber)	Neglect and acts of omission	Physical	Psychological
Humber Trust Referrals	Physical	Neglect and acts of omission	Self-neglect

2.2 Safeguarding Children

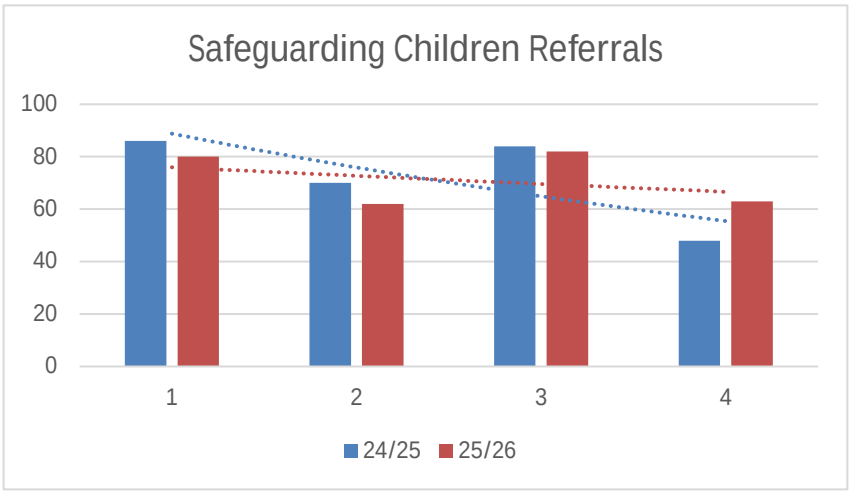


This year there was a total of 684 duty contacts relating to children, a reduction of 23%. It is important to note that although recorded contacts to the duty desk have reduced, referral numbers remain steady and audits completed this year have found we are making referrals to local authorities in line with our statutory duties. As with 24/25, there was a slightly increasing trend as the year progressed. It is thought that the reduction in duty contacts could be related to there being an established reporting mechanism on datix now for 'Early Help' referrals. Previously all Early Help referrals would be badged under safeguarding and be subject to review, however this year reporting has changed. In 2026/27 data from the new safeguarding template will be able to tell us how many Early Help referrals are made and across which services.

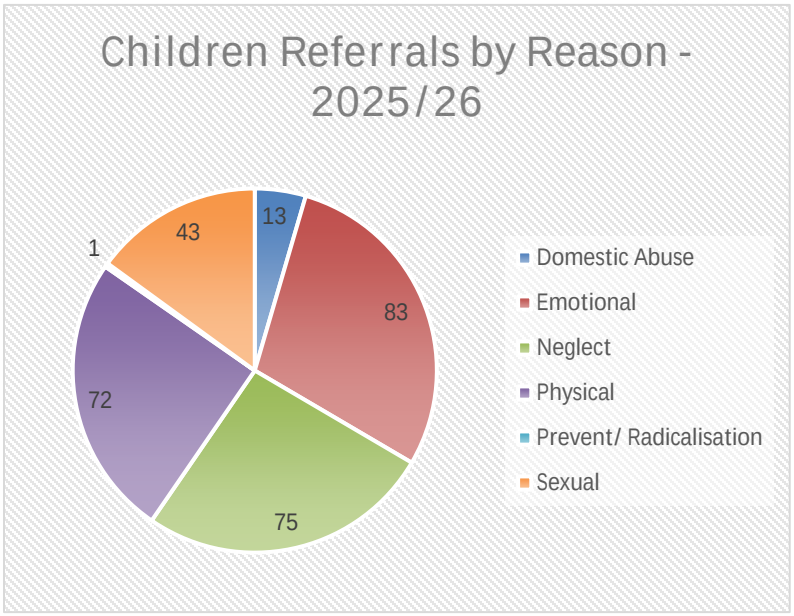
There were 222 contacts in relation to child neglect, 208 for emotional abuse and 118 for physical abuse; this reflects a similar picture to duty contacts in 24/25. It is thought the high numbers of emotional abuse contacts correlate to childrens experience of domestic abuse; a finding of an audit completed and presented to the Safeguarding Assurance Group this year. There were also 22 contacts relating to Prevent. This is logged where a member of staff has a Prevent query, or if the Safeguarding Team are contacted to provide information to the Counter Terrorism Police in line with its Prevent Duties. Queries increased following the release of the Southport Inquiry Phase 1 in April 2025, however this has started to settle towards the end of the year.



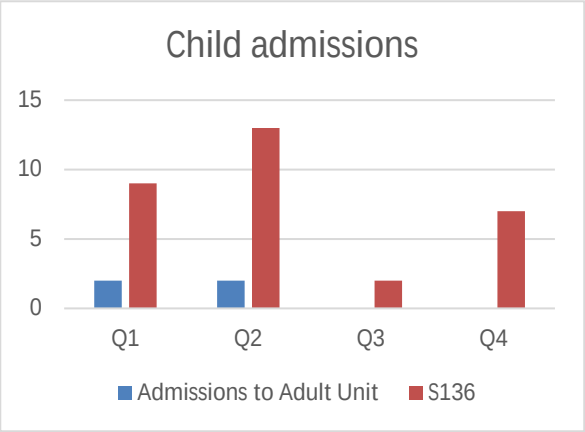
A total of 287 safeguarding children referrals were submitted to the local authority this year, similar to the number the previous year – 288. 92 were from adult services, showing our adult services are 'Thinking Family' and responding to safeguarding concerns for the patients family. The trend of referrals somewhat levelled out across the year, due to referral numbers in Q4 not dropping as significantly as they did the previous. 183 were submitted within Hull, 91 in the East Riding, 9 in North Yorkshire and 4 in local authority areas outside of the geographical area the Trust works in. This is in line with previous trends as the Trust operates the majority of its childrens services in Hull and East Riding and has no childrens services in the North Yorkshire area other than the Keyworker Service that works across the Yorkshire and Humber ICB area.



The most reported category of abuse when making a referral to the local authority was emotional abuse, followed by neglect and physical. The increase in emotional, from 62 to 83, reflects the changes in recording to use emotional where clear emotional harm has been caused by a young child witnessing domestic abuse, this is common within Hull where the largest proportion of safeguarding referrals are made. Statistically across England the most common reason for a child being on a protection plan is neglect, followed by emotional abuse and then physical (significant reduction in physical compared to neglect and emotional), therefore our top reported categories are in line with National themes but with a slight variation due to the increasing numbers of emotional abuse and domestic abuse contacts we are seeing. There is a strong correlation of neglect and domestic abuse. In regards to referrals for neglect, we have started to develop child neglect guidance which explores how professional curiosity and earlier recognition can support families.



The Trust operates a policy which requires a datix incident report to be completed when a child is admitted to an adult unit; the safeguarding team are immediately notified via datix and contact the service to check if the child remains there and what safeguards are in place. This includes ensuring CAMHS are supporting the child and the inpatient team, and offering a visit / call with the child to discuss any concerns they have. The CQC are also notified when the placement lasts longer than 48 hours as per reporting requirements. The same process is followed when a child is admitted to a place of safety within Humber Teaching NHS Foundation Trust on a S136.



During 2025/26, only two children under the age of 18 were admitted to adult mental health inpatient beds. Both admissions occurred during Quarter 1 (April 2025). One young person was transferred to the Inspire Unit on the following day and the second was transferred to a specialist CAMHS inpatient unit within two days of admission. The low number of admissions demonstrates the Trust's commitment to ensuring children and young people receive care in age-appropriate environments wherever possible. Where admission to an adult ward is unavoidable, safeguarding processes are implemented immediately, including notification to the Safeguarding Team, oversight of the placement, liaison with CAMHS services and regulatory notification where required.

2.3 Training

The Safeguarding Team oversees training for Safeguarding Adults, Safeguarding Children, Prevent and Mental Capacity Act 2025. At the end of this financial year, all course compliances are above the Trust target of 85%; the Trust are in a strong position.



Safeguarding Adults and Safeguarding Children courses are delivered using a blended approach. Levels 1 and 2 are e-learning courses, and Level 3 requires staff to complete e-learning prior to attending an interactive taught session by a Safeguarding Practitioner. The Prevent courses are split into two levels; Prevent awareness and Prevent WRAP which is designed for front line staff working with patients. The Mental Capacity Act courses are also split into two levels; MCA L1 for awareness and MCA L2 which comprises of 6 e-learning modules on specific areas of the subject including assessing capacity, making best interest decisions, restraint, MCA for young people aged 16-17, DOLS and LPA/Deputyships and advanced decisions. All courses are on a 3 year cycle.

The Royal College of Nursing Intercollegiate documents for safeguarding training adults and children have both been updated this year. A Specialist Safeguarding Practitioner is currently undertaking a detailed review of these documents and changes will be made to competency requirements and course content to ensure continued compliance.

Outside of the Statutory/Mandatory training program the Safeguarding Team have also delivered training/guidance on:

B5 to B6 Nursing Development Program

Trust Induction

Bespoke training to Psychologists and Medics in training at the University of Hull

Use of HollieGuard app for stalking, harassment and domestic abuse victims

PIPOT awarness for HR Advisors

Multi agency risk management (MARM) tool

Several sessions on new Safeguarding template on SystmOne

Deprivation of Liberty Safeguards

Toxic and positive masculinity

Safeguarding children referrals: Thresholds

Polysubstance misuse

Female Genital Mutilation

Child Exploitation

Prevent

Trustwide Domestic Abuse Conference

White Ribbon Days of Action

Making Safeguarding Personal

The above have been presented as a Safeguarding Spotlight session or a Safeguarding Spotlight learning document; these are shared via Global newsletters and through Safeguarding Link / Domestic Abuse Champion networks. There are plans for the 2026/27 year to build a safeguarding learning library on the Trust intranet page that will house all training presentations, recordings, guidance and newsletters.



2.4 Safeguarding Spotlight – PIPOTS

All individuals working in or on behalf of the Trust have a commitment to protect children and adults at risk. In addition, the Local Safeguarding Children and Safeguarding Adults Partnerships and Boards have their own policies in place and provide guidance in relation to safeguarding children and safeguarding adults where allegations are made against individuals considered to be a person in a position of trust (working with children, young people or adults with care and support needs).

Where an allegation is made about a member of staff in a position of trust the PIPOT process is followed to ensure appropriate action is taken to safeguard those involved from further risk of harm, and reduce the risk of harm to others who the person may work with or go on to work with. In 2025/26 there were:

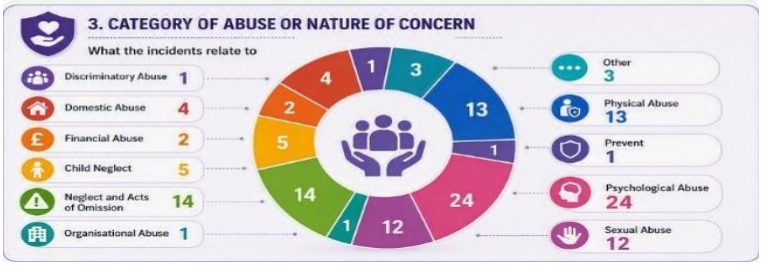
364 datix incident reports where staff had highlighted that an allegation or concern had been raised about staff. Each report is reviewed in the Corporate Safety Huddle and sent on to the Safeguarding Team if it is felt further review is needed.

161 were sent on to be reviewed by the Safeguarding Team. The incidents reviewed at Huddle but not progressed were either incorrectly recorded, related to Information Governance and Medication Errors resulting in no harm, were issues of conduct/practice but not relating to, or presenting, a risk to a vulnerable client, or for other stipulated reasons meaning a review by safeguarding was not required.

83 recorded to have progressed to a formal PIPOT process within the Trust. This means that the Managing Concerns Against People in Position of Trust Policy was followed, formal meetings were held between Safeguarding, HR, Senior Management and other appropriate persons, and the allegation or concern reviewed.







For the purposes of the annual report PIPOTs are broken down to local authority area, location and category of abuse or concern. The PIPOT cases align to contact and referral reporting trends we tend to see and the majority of allegations are made by patients within an inpatient unit. Reporting for PIPOTs started in December 2025 and all ongoing processes at the time the reporting process was introduced were logged; therefore 83 is a lower number than the actual figure. Going into 2026/27 as the reporting is developed, we will be able to see full year numbers and outcomes of processes which could be:

- Referral to DBS or Professional Body
- Formal HR process
- Safeguarding/LADO/PIPOT referral to local authority
- No further action

3. Partnership and Collaborative Working

We are established members of local safeguarding boards and partnerships, and contribute to multi agency meetings across all 3 local authority areas. We refer, and contribute to safeguarding reviews and investigations in line with our statutory duties, and are committed to learning from incidents.

The Executive Director of Nursing, Quality and Professions is the named executive member for safeguarding at the Trust at the Hull and East Riding Safeguarding Boards and Partnerships; the Deputy Director of Nursing, Quality and Professions, Named Professional and Named Nurse deputise on their behalf. The Named Professional and Named Nurse also represent the Trust in North Yorkshire Boards and Partnerships.

The Trust is represented at strategic and operational partnership meetings including key multi agency safeguarding meetings across the areas where risk is considered, and agencies work together to mitigate that.

The Named Professional and Named Nurse work closely with local authority and ICB colleagues where safeguarding issues need to be escalated due to a concern about action taken (or not) or risk to the person not being managed, this is supported by the professional relationships the Trust have with other agencies across safeguarding board and partnership areas, and work is undertaken jointly to find a resolution.

3.1 Domestic Abuse

Multi agency risk assessment conference (MARAC)

MARAC is a multi-agency meeting where information is shared on high-risk domestic abuse cases and safety plans are put into place to increase the safety of victims of domestic abuse and those around them. The Trust has representatives at, and regularly attends, both Hull and East Riding MARAC. During MARAC, cases are discussed and the Trust contributes information from its services. The representative supports a multi-agency discussion to consider the risk, immediate actions that need to be taken and ongoing safety planning for the victim and those around them such as children in the house. Due to increasing numbers in previous years, Hull MARAC is now limited to 54 per meeting and both panels operate a pre screening process.

Year	East Riding	Hull
2024/25	839	1296
2025/26	897	1118

This year, the safeguarding template has been launched on SystmOne and is in its initial implementation phase. Going into 2026/27 the template will be used to report data on MARAC referrals, a break down of who is making these, MARAC cases and cases where staff are referring patients for support from Domestic Abuse services or completing DASH risk assessments.

Multi agency tasking and coordination (MATAC)

MATAC has been established for over three years now, but numbers of cases discussed remain lower than MARAC which is expected. The purpose of the group is to focus on repeat perpetrators of domestic abuse and how to work with them to reduce the risk of harm to victims, this is a consent based process which explains why numbers are lower than MARAC, meetings generally have a case discussion number of around 4 to 6. A Specialist Safeguarding Practitioner attends this meeting alongside substance misuse services due to the high number of individuals being known to substance misuse services or having substance misuse issues.

White Ribbon and Sexual Safety

The Trust is in its final year of the White Ribbon Plan having been accredited for a second year running. White Ribbon is a charity working in England and Wales to engage men and boys and prevent men's violence against women and girls. In October 2026 the Trust will submit its completed White Ribbon Action plan showing the work that has been undertaken across services to achieve this goal and begin its third plan going into 2027. Accreditation shows that HTNFT aims to:

- Drive social change to strengthen gender equality and stop violence against women
- Improve organisational culture, safety and morale
- Increase its knowledge and skills of staff to address violence against women

The final year of the White Ribbon Plan focussed on lived experience of domestic abuse and responding to domestic abuse within older adults and learning disabilities. A men's group was also established to improve male engagement with the work, and lead change. This is being led by a male member of staff who is a White Ribbon Ambassador.

The White Ribbon work is part of the wider Domestic Abuse work stream identified in the Trusts Safeguarding Plan, which reports in the Safeguarding Assurance Group and to EMT. It's also closely aligned to the Sexual Safety work across the Trust which has focussed on improving the sexual safety of staff and patients and ensuring compliance with new legislation and sexual safety requirements and frameworks. This year, workforce and staff disciplinary investigations have considered our responsibilities as a White Ribbon Accredited Trust and as a Trust signed up the NHS Sexual Safety Charter, and two formal HR cases heard concluded that staff were not aligned to these values and took appropriate action; showing that as a Trust we are taking our commitments to these values seriously and responding to reported concerns of staff not aligning to these values. Being a White Ribbon accredited Trust, and shining the light on domestic abuse, has led to increasing contacts to the duty desk for domestic abuse, increased support of colleagues experiencing or witnessing domestic abuse, and an increased knowledge and awareness of domestic abuse across our workforce. All staff who complete Level 3 safeguarding training receive training on routine enquiry and DASH risk assessment; however, audits still find inconsistent application and recording of this. It is hoped the new safeguarding template will improve recording and give us a better idea of use of application of training and use of tools across the Trust.

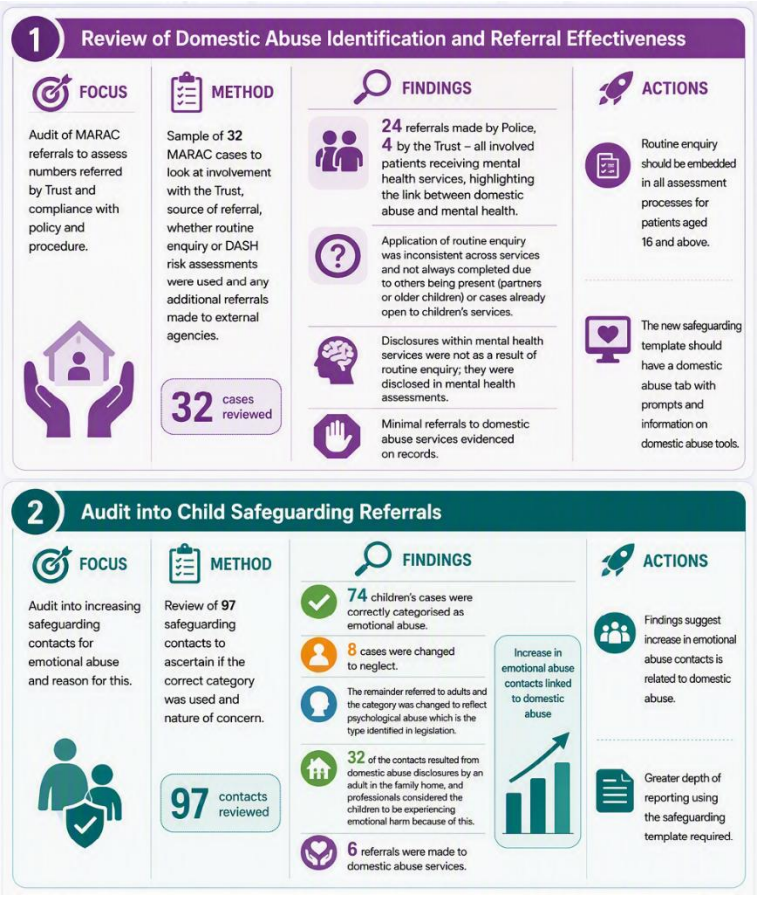
Due to the close links a new group is going to be introduced in 2026/27 'Domestic Abuse and Sexual Safety' Group which will bring together the Domestic Abuse, White Ribbon and Sexual Safety Work in one place. The group will report into the Safeguarding Assurance Group and be responsible for:

- Data capture and analysis of domestic abuse and sexual safety incidents via performance dashboard
- Greater depth of reporting on domestic abuse data such as referrals to DA services, DASH completion and characteristics
- Compliance with legislation and assurance frameworks
- Delivery of White Ribbon and Sexual Safety Plans
- Administration of sexual safety risk assessments for all areas
- Monitoring of domestic abuse and sexual safety training, awareness campaigns

Audit and Quality Improvement

The Safeguarding Audit and Quality Improvement Plan has a number of audits into domestic abuse identified. All audits are presented to the Safeguarding Assurance Group and actions tracked via the Safeguarding Team with a quarterly update on that presented at SAG.

In 2025/26 two audits were completed in relation to domestic abuse. The first audit looked at MARAC referrals and use of routine enquiry and the Domestic Abuse, Stalking and Harassment (DASH) tool; the audit found that all patients known to the Trust were receiving mental health support, highlighting the link between domestic abuse and mental health and the importance of our staff being trained to recognise and respond to domestic abuse concerns. The second was a focus on child emotional abuse contacts which had increased in Q1 of 2025/26 against known local and regional themes; this highlighted the prevalence of domestic abuse and impact and emotional harm caused to children in homes featuring domestic abuse.



3.2 Safeguarding Spotlight – Sexual Violence: Support and Healing Conference

In July 2025 the Safeguarding Team hosted a conference which welcomed nearly 80 guests for a thought provoking and powerful day of learning, reflection and shared experiences. The day included speakers from:

- Independent Domestic Violence Advocates
- Suicide Prevention Programme Lead and Lead for Men's Group – White Ribbon
- Head of Sexual Violence Services
- Blue Door Support Service (Hull)
- Humberside Police Sexual Offences Unit
- Trauma Stress Service (Humber)



Each presentation offered powerful insights into the ongoing work, challenges, and support available across services for those affected by sexual violence.

A particularly moving moment came from **Lisa Squire**, who travelled a long way to share the story of her beloved daughter, Libby. Lisa's heartfelt talk focused on her lived experience, Libby's legacy, and her tireless campaign**, 'It Does Matter',** which advocates for the reporting and recognition of non-contact sexual offences.

We thank Lisa and all speakers for their time.

3.3 Modern Slavery and Exploitation

Modern Slavery

The Trust is a member of the Humberside Modern Slavery Partnership and produces a statement on its public internet page pursuant to section 54(1) of the Modern Slavery Act 2015 which provides assurances on its organisational structure, approach, policies, recruitment and procurement and supply chains. A dedicated safeguarding practitioner attends the Humber wide modern Slavery Partnership meeting and shares appropriate updates from that. This year attendance has increased to include forums in each local authority area, ensuring we are involved in local developments as well as region wide.

This year within the Safeguarding Team all practitioners have re-completed training on the National Referral Mechanism (NRM), which is mandatory in order to attend and contribute to the NRM panel which explores concerns of modern slavery and seeks to coordinate interventions to safeguard vulnerable children, young people and adults from exploitation and modern slavery. This year 41 children and young people were discussed in the NRM panel. There is no data from the previous year to compare this to, due to the panel being newly embedded into the MAYVE process and the Trust previously not directly contributing to NRM.

Cuckooing

The Multi-Agency Cuckooing Advisory Panel (MACAP) seeks to provide front line professionals with a multi-agency framework to facilitate effective working with adults or children who are at risk due to cuckooing. Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation. Core membership of the panel includes Prison and Probation Services, Adult and Children Social Care, Humberside Police, Health providers and commisioners, care providers and voluntary agencies and housng and enviornmental health services. Humber Teaching NHS Foundation Trust joined MACAP as a core member after it was set up and a Specialist Safeguarding Practitioner attends on a monthly basis to share information, share risk across agencies, advise on concerns and support the panel to make recommendations and identify actions.

The panel currently operates in Hull but work is underway in East Riding to host a panel there.

Multi agency child exploitation (MACE) and Multi agency youth violence and exploitation (MAYVE) meetings

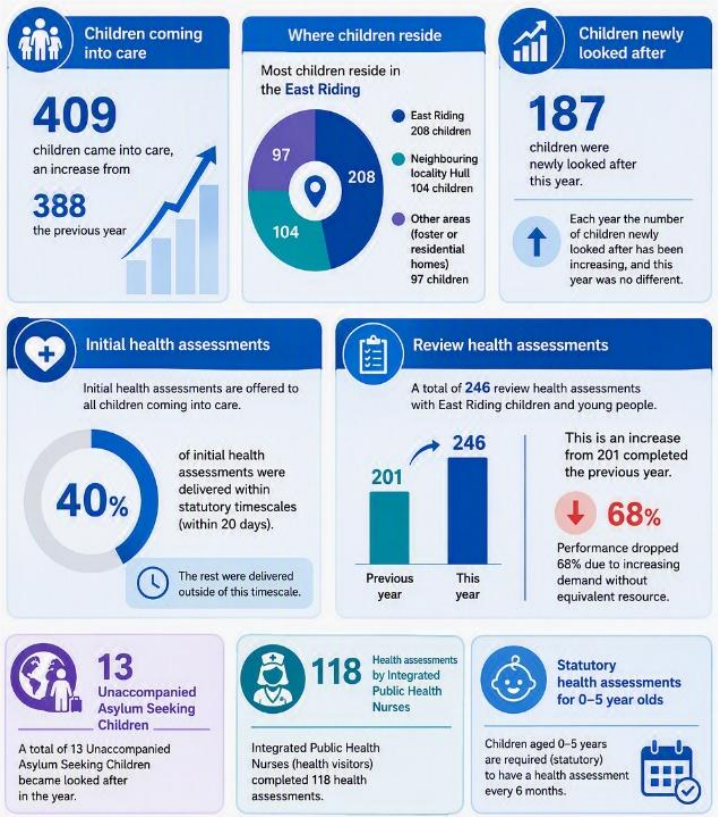
The Trust attends both the Hull and East Riding MACE and MAYVE meeting on a monthly basis. The MAYVE meeting in Hull was expanded to include youth justice and children and young people who may be victims of modern slavery; the NRM panel remains a separate decision making process and not all agencies are required to attend this (Humber do).

Year	Hull	East Riding
2024/25	123	74
2025/26	114	89

Numbers at each panel vary depending on new referrals or return cases following further concerns being raised about a person previously discussed. Numbers in Hull remain higher than East Riding, this is in line with previous years. The introduction of pre-mace / vulnerability and risk panels triages and remove cases that might not meet the threshold for MACE, meaning only the cases appropriate for that level of risk management are discussed.

As with last year, Access to social media platforms and mobile phone applications continue to be a common cause for concern with regards to exploitation; many perpetrators use these applications, and it is a rapidly developing area of technology. There are emerging concerns this year about children, young people and young adults using social media platforms and online networks to encourage, normalise and incentivise behaviours that result in emergency service responses. These communities often encourage self-harm or other risky behaviour to illicit a response. In these instances, there has been a multi-agency response to ensure all safeguards are in place for those involved, and that professionals working with this cohort are aware of the risks online and how to respond.

3.4 Safeguarding Spotlight – ER Children Looked After Health Team





The Trust delivers the Children Looked After Health team. This year the Named Nurse for Looked After Children retired and **we would like to thank her for the work she has done and for being such a dedicated professional and leader.** The Looked After Children Team are commissioned to arrange initial health assessments, carry out review health assessments and complete a leaving care summary as the young person reaches their 18th birthday – this summary provides a history of their health rom birth onwards and the team receive positive feedback on this as it provides the young person with details about their life achievements which can be lost during their time in care. As indicated, only 40% of initial health assessments were offered within statutory timescales; this is mainly around the team not being provided with correct paperwork and consent in time for the assessment to be completed (20 days) but can also be due to limited capacity in the clinic time available. Previous annual reports have highlighted lack of GP cover – this has now been increased and there are 2 specialists GPs providing 5 clinic slots per week now. The Named Nurse is an active member of the ERYC Foster Panel, Supported Lodges Panel and sits on the Emotional and Wellbeing decision making forum, maintaining a strong positive relationship with the Council. The Making a Change nurse works as an integral member of the local authority team working intensely with young people who are being exploited, and their families. Safeguarding supervision is completed regularly and the team attend safeguarding strategy meetings for young people open to them.

3.5 Prevent Board and Channel Panel

The Counterterrorism and Security Act 2015 requires health bodies to consider the need to safeguard individuals from being drawn into terrorism. The Trust has an appointed Prevent Lead who attends all local Prevent Boards, and a Specialist Safeguarding Practitioner who attends the operational Channel Panel which is a multi-agency panel that identifies how best to support people who are susceptible to terrorism. The Trust submits quarterly reports to the ICB on its Prevent figures and training compliance, to assure the ICB of the Trusts commitment to the Prevent agenda.



A member of the Trusts Safeguarding Team attends both Hull and East Riding Channel Panel, providing information on behalf of the Trust to support decision making, and supporting clinical staff who are working with the individuals open to the Prevent process. When a referral is sent to Prevent, the Counter Terrorism Case Officer contacts the Safeguarding Team to request any relevant information the Trust holds on the individual and to ascertain if any additional support is required at the time. This information is shared in a timely manner and supports the Prevent decision making process.

	Hull 24/25	Hull 25/26	East Riding 24/25	East Riding 25/26
Channel Cases	39	42	16	34
Prevent Referrals by Trust	3		8	

This year Channel Panel case discussion number increased as did referrals into Prevent made by the Trust. This reflects national changes following the announcement of the Southport Inquiry Phase 1 in April 2025 which concluded in April 2026. Following the announcement Prevent Boards in Hull and East Riding discussed the national increase in referrals to Prevent and more caution being used when referring onto Channel Panels for discussion and consideration of adoption.



3.6 Safeguarding Spotlight – Southport Inquiry

Following the murder of 3 children in July 2024 a public inquiry was set up to examine the circumstances surrounding the incident and events leading up to it. Phase 1 of the inquiry was announced in April 2025 and carried out over the course of the year. Key findings of the report, which did not include any Humber services, focussed on there being an absence of risk ownership, critical failures in information sharing, misunderstanding of autism, lack of oversight of online activity and parental failure. Though this happened in another part of the country and involved mental health services in that area, professionals within the Forensic Division, along with Head of Safeguarding who is the Trusts Prevent Lead, have reviewed this report for any transferable learning and presented findings to the Safeguarding Assurance Group and Forensic Divisional meetings.



3.7 Collaborative working across the Trust

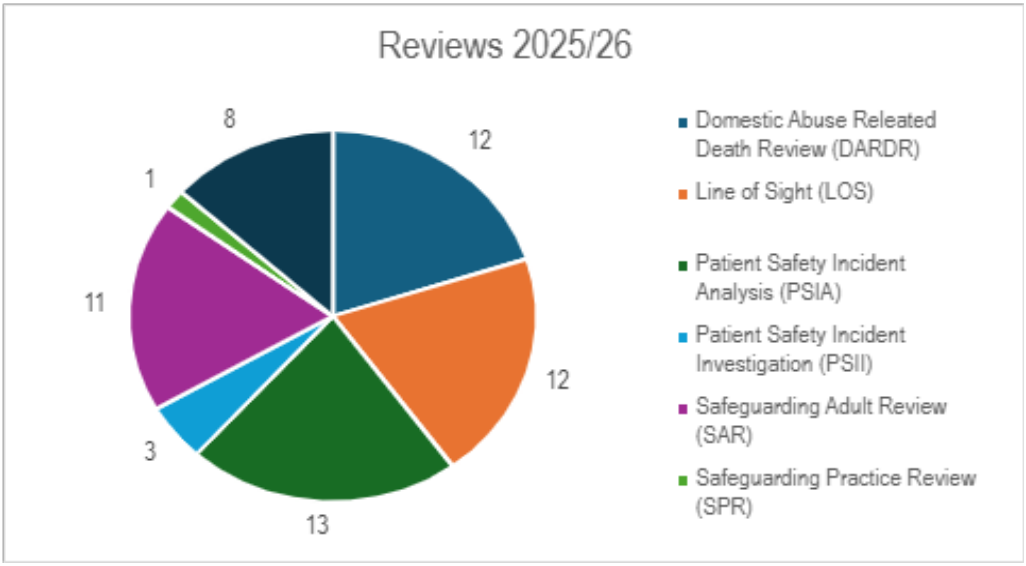
Safeguarding is embedded across all areas of the Trust – from the very beginning of a service being commissioned and across all Divisions.

The Safeguarding Team supports a staff group of approximately 3600 staff working across 79 sites. This includes clinicians working directly with our patients, as well as non-clinical staff providing a vital role to these services. The Safeguarding Team work closely with colleagues in non-clinical work areas, including Workforce and operational HR and Complaints. This supports our Safeguarding Vision which is that we take an organisational approach to safeguarding and promote the welfare of our patients and that safeguarding responsibilities are embedded across all staff groups. Examples of how this happens across non clinical areas include:

- PIPOT processes – working alongside HR and Flexible Workforce, this includes the provision of PIPOT training to HR advisors, so safeguarding issues are recognised within reports made to HR
- Sexual Safety – Head of Safeguarding is co-chair of the Sexual Safety Group along with Head of People Experience, ensuring a joint approach to the agenda
- Training and awareness – Such as domestic abuse/white ribbon awareness with non clinical staff.
- DBS process – working with colleagues in the DBS Team to support the DBS risk assessment process where staff in patient facing roles' DBS lapses or caution or conviction is declared/returned
- Complaints – Supporting, and on occasions completing, complaints where safeguarding issues are raised. This includes advising the team on safeguarding and mental capacity matters and what steps to take
- Advising formal HR investigations as subject matter experts, or sitting on discplinary panels to ensure safeguarding oversight of a particular concern
- Commissioning - Supporting contracting processes, including where bids or tenders are made for new commissioned services, so that safeguarding matters are factored into the process and to ensure there is adequate resource to provide this
- Working with Occupational Health to review the provision of support for staff who experience of witness a sexual safety incident
- Providing advice and support to line managers, HR and Occupational Health when staff are experiencing abuse and in need of support. This includes provision of the Hollie Guard premium app free to all staff who require it
- Acting as subject matter expert on the development and review of training packages
- Working with colleagues and teams across the Provider Collaborative

3.8 Learning from Incidents

The Trust works across 3 local authorities and the safeguarding team supports statutory and non-statutory safeguarding reviews held in these. Where a review is agreed and the Trust has is or was involved with the individual, a member of the Safeguarding Team supports the review process. Staff from the Clinical Divisions who worked with the individual are also involved in the process and attend practitioner events with support and debrief opportunities. The Safeguarding Team also works closely with the Patient Safety Team advising on, supporting or leading Patient Safety reviews. The Named Professional for Adult Safeguarding and Named Nurse for Safeguarding Children review all completed Patient Safety reviews prior to approval.



In 205/26 the Safeguarding Team supported or completed 60 reviews, an increase from 36 the previous year. This not only reflected the close working with our Patient Safety Team, but the increase in safeguarding reviews being considered and agreed by our local authority partners. DARDR and SAR numbers remain high, however this year we also saw an

increase in use of LOS audits – this is because the methodology (also called a ‘desk top review) is being used across adults now as well as children.



There are a number of non-statutory adult and child review processes in place across Hull and East Riding, fewer for North Yorkshire due to the limited child footprint. Although they are non-statutory, they do reflect the principles of statutory guidance (DfE 23) These include and Safeguarding Assurance Group reviews and Joint Targeted Area Inspection practice reviews (JTAIs). Multi agency audits take place for adult cases within the Boards sub groups for audit, quality and assurance, and these take place monthly.

These are all multi agency reviews that form part of the Partnership’s learning and quality assurance frameworks. They occur monthly with nominations for cases taken from all partners. Learning and best practice from the reviews is taken through the Partnership’s governance structures and actions are monitored for assurances from providers. Outcomes are also shared with divisions and relevant teams and where possible, clinical workers from the cases are invited to attend the reviews along with the safeguarding team. All actions are presented to the Safeguarding Assurance Group, recorded on the safeguarding investigations tracker, overseen in the Business Meeting and Safeguarding Assurance Group, they are also reflected in the safeguarding development plan.

Learning themes from reviews have been collated and are shown in the infographic above. A number of the learning themes correlate with findings from patient safety reviews; for example, the Patient Safety Annual report identifies information sharing and professional curiosity as a key theme found in their reviews, this is also seen in safeguarding reviews, showing a close correlation between both processes. Key learning themes and actions taken this year include:

- Familial mental health concerns not known to services – Introduction of Think Family SOP and use of SystmOne across Trust, including safeguarding template, which promotes sharing of information about family
- Impact of addiction on individual and wider family – self-neglect training delivered with focus area on substance use and impact on the individual and wider family/friends
- Use of routine and targeted enquiry into domestic abuse – all mental health, children and learning disability patient records now include safeguarding template which has section to record routine and targeted enquiry
- Utilisation of MARM tool – Promotion of this in training, on the intranet and via safeguarding spotlight. Referrals also made via Duty. Recording of MARMS to take place later this year.

- Information sharing gaps – Think Family SOP, safeguarding template and SystmOne shares that allow information to be shared across services and different agencies

4. Safeguarding Systems

Aligned to the Trusts strategic goal to optimise an efficient and sustainable organisation; we are embracing new, safe and secure technology to improve recording of safeguarding and mental capacity information on electronic patient records and to ensure information is shared across child and adult services. We are generating a better quality of data to feed into performance reports and using systems to record safeguarding activity within the team.

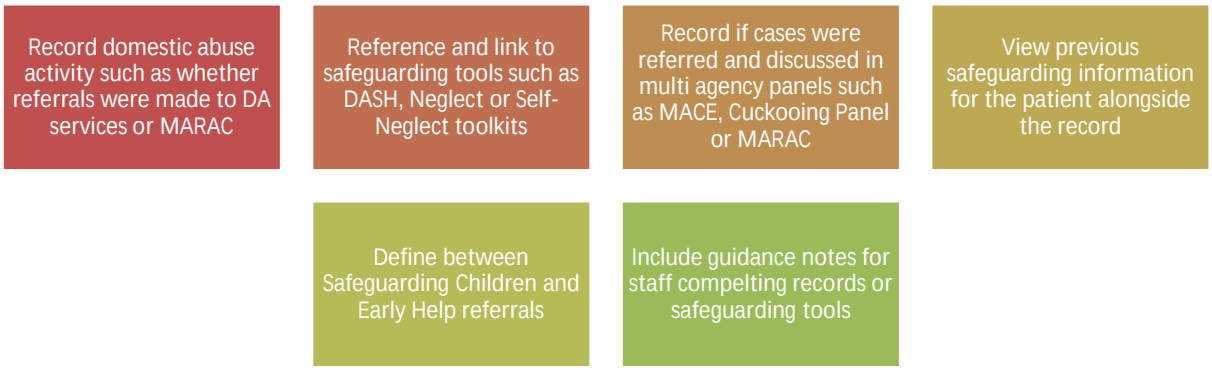
This year is the third and final year of the delivery of the Trusts Safeguarding Plan 2023-2026. A key priority this year has been supporting the initial implementation period following the transition of the electronic patient record for mental health and learning disability services from Lorenzo to SystmOne. Mental health and learning disability services are now using the same systems as our community and childrens services, this means for example that CAMHS can see information entered by health visitors and vice versa. Due to sharing agreements in place it also means that our partners such as CHCP can see relevant information, one example of this being that the safeguarding practitioner who sit in multi-agency safeguarding hubs at the local authority can see if a person has had recent involvement with our services, thus supporting initial local authority enquiries, and our services can see any GP or community information that they wouldn't have normally seen. Sharing information is quite often identified as an issue in safeguarding reviews so this is an extremely positive step towards improving how we share safeguarding information and work together to support families.

We have implemented the Safeguarding Template across all SystmOne units, updated Mental Capacity templates across all SystmOne units and also introduced a template for Gillick Competency towards the latter part of the year. The Safeguarding Team have also improved recording of safeguarding reviews, PIPOT reviews and duty contacts on Datix, meaning there is now a greater depth of safeguarding activity being reported across the Trust and directly into the Safeguarding Assurance Group.

There are still some teams using different platforms and it is a priority in 2026/27 to understand what teams are using this and ensure they have access to appropriate templates to record safeguarding and mental capacity data.

4.1 Safeguarding Template

The Safeguarding Template was introduced February 2026 after months of consultation with colleagues and development with IT and Systems. There is now one template for all SystmOne users to record safeguarding information; previously different services had different templates and some didn't have any at all, which led to inconsistent or lack of recording of safeguarding information. The new template allows us to:



Currently, data is not being collected from the template due to it being in its implementation period. Once feedback has been gathered and any initial issues resolved, we will move to collecting and analysing data from the template to determine if it can be used to support mandatory reporting of safeguarding activity, and to feed into the safeguarding performance report which is presented to the Safeguarding Assurance Group and Quality and Patient Safety Group on a quarterly basis. As part of this, an audit of use is being completed in 2026/27.

4.2 MCA and Gillick Competency

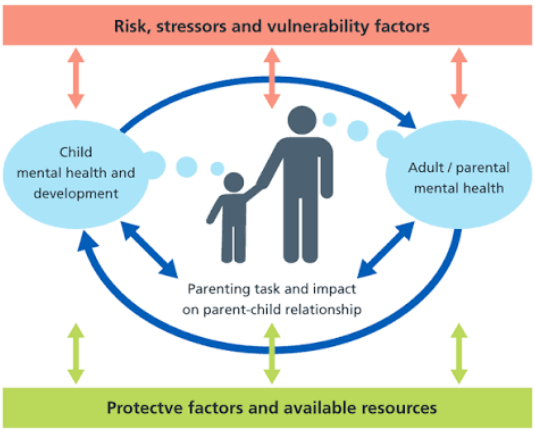
This year the templates on SystmOne for 'Mental Capacity Assessment' and 'Best Interest Decision' have been embedded into current practice. The new templates were created in 2024/25 with a working group and then uploaded onto SystmOne (delay in this due to priority work with the electronic patient record transition). They have been in place for the majority of the year and are embedded into practice; staff are using forms that are reflective of current legislation and case law to evidence their assessments and decisions, and the forms include guidance and links to case law to support robust completion of assessments. A mental capacity audit has been introduced on Inphase this year, and a furthermore in depth audit will be carried out by a safeguarding practitioner in the next year.



This year, following increasing queries and concerns relating to the competence of children and young people in our care, and in response to the MCA audit completed the year prior, a new template has been implemented for staff to evidence whether the child or young person is competent and able to make a decision. This template will support staff evidencing decisions in particularly complex or contentious situations, and guidance has been issued alongside of it. An audit will take place later in the year once the template has been in use for a period of time, this will examine use of it, quality of assessments and whether further training or support is required. Our MCA training packages (e-Learning for healthcare) cover Gillick Competence.

4.3 Think Family

Recent Child Deaths, Safeguarding Adult Reviews (SAR) and Domestic Abuse Related Death Reviews (DARDR) have highlighted missed opportunities to share crucial information due to relationships or family members not being accurately recorded within patient records. We also know that fathers of children are under recorded on records and details of them not known to other professionals. This year the Safeguarding Team have introduced a new SOP for Think Family – Holistic Family Assessment and Information Sharing, which supports a consistent approach to assessing families and recording information so that professionals know details not just of the patient, but those around them, and records reflect that.



Now we are using SystmOne for the majority of our services electronic patient records, this gives us an opportunity to make sure professionals can record and view information about family members and carers, and therefore share key information or safeguarding concerns about those individuals with appropriate services. Over the next year an audit will be completed to look at how well this approach is followed, and identify any further support or changes required.

4.4 Datix Recording and Safeguarding Performance Reports

The Safeguarding Team use Datix to record all safeguarding contacts and referrals. This year recording has been improved, and we are now able to record and report:

- **Safeguarding Reviews/Investigations** – are now recorded on Datix and a record of review which includes meeting minutes and draft report versions is held on that. This gives us quarterly data on the number of reviews open, type and service area and also on the number of reviews closed. In 2026/27 the safeguarding performance report will be updated to include this, this will report into QPAS and Safeguarding Assurance Group and also feature on the Insight Report submitted to EMT by Deputy Director of Nursing, Quality and Professions, thus improving and increasing the reporting of statutory safeguarding activity across the Trust.

- **PIPOTS –** There is a new form to record PIPOT activity which is confidential and not accessible to external teams. This form feeds into a dashboard of all open and ongoing PIPOTS which allows for weekly monitoring and reporting to the Director and Deputy Director of Nursing, Quality and Professions. In 2026/27 the

safeguarding performance report will be updated to Include a high level report (number and Division only) of PIPOT activity.

The Safeguarding Team continue to use technology available to improve reporting across the Trust, whilst reducing resource demand/impact on the team by having prepopulated and automatically generated dashboards in place.

5 Safeguarding Priorities

This section reviews progress against the priorities identified in the 2025/25 annual report, and identified priorities for the next year.

5.1 How did we do?

Domestic Abuse We will recognise and respond appropriately to those who are at risk of or are experiencing or perpetrating domestic violence and abuse.

We have delivered Y2 of the White Ribbon Plan and are progressing through to Y3. Reaccreditation will be secured later this year. Audits have taken place on MARAC referrals, use of routine and targeted enquiry, and QI projects are underway for co-production of domestic abuse resources for individuals with learning disabilities. We have delivered training on domestic abuse across the year, including a conference in July 2025 which was very well attended and involved our partner agencies. We refer for consideration of DARDRs and participate in any reviews declared; the number of DARDRs taking place and being considered has increased this year showing an increased awareness of the process, this includes Humber recognising and making referrals as part of its internal patient safety review. Contacts to the duty desk have increased for domestic abuse concerns, and referrals for emotional harm of children witnessing domestic abuse has also increased. Learning is shared across the Trust via our Safeguarding Assurance Group. We support staff experiencing, witnessing or who may perpetrate domestic abuse, working with line managers and signposting to support services, this includes providing a free mobile phone app ‘Hollie Guard’ to all staff who may be at risk of being stalked or harassed.

Child Neglect We will recognise and respond appropriately to children and young people who are at risk of or are experiencing child neglect and abuse.

We have delivered multi agency training with local authority colleagues on use of child neglect tools. We continue to be part of local safeguarding partnership boards sub groups for child neglect, at strategic and operational level. A new safeguarding template on SystmOne now allows us to capture when child neglect is a concern and whether a child neglect tool has been used, an audit on recognition and response to child neglect is underway.

Liberty Protection Safeguards We will understand our responsibilities when a person is deprived of their liberty and empower and protect service users who may lack the capacity to make decisions for themselves.

Implementation of LPS continues to be delayed. However great progress has been made on Mental Capacity Act work. New templates for mental capacity assessments and best interest decision records are now embedded in practice and an Inphase audit is in place which audits on a monthly basis compliance with the MCA 2005. A further audit is planned next year Gillick Competency is included in MCA training and a new template for staff to use has been created and uploaded onto SystmOne. MCA reporting has improved across the Trust – with a dedicated dashboard now feeding into the safeguarding performance report. The MCA lead also prepares an update report to the Mental Health Legislation Committee. The Team continues to support colleagues in clinical services and our Legal Team with Court of Protection cases.

Self-Neglect We will recognise signs of self-neglect and respond appropriately, whilst adopting a preventative approach to reduce the risk of self-neglect occurring with service users.

Self-neglect policies have been updated to reflect new MARM process which has replaced VARM. This is also referenced on the new safeguarding template and staff can select if a MARM referral has been made or whether they attended a MARM. Over the next year we will be able to report on this. The Trust are part of both Hull and East Riding self-neglect groups and there is a dedicated section within the Level 3 safeguarding training package. We continue to make referrals for concerns about self-neglect, proportionately more than national trends, indicating we are recognising self-neglect and when it may be a safeguarding concern.

Think Family We will think about the whole family when working with a service user. We will understand how trauma can impact families, and work with our partners to safeguard our service users and their families from harm and abuse.

We led a working group looking at how adult and child services work together to consider the whole family, and how they gather and share information across the service. A SOP was subsequently delivered, working alongside Divisions and IT/Systems to improve sharing of safeguarding information across families and services. An audit is planned in the next year to review effectiveness of this. Our SystmOne electronic patient record allows us to share information across services meaning colleagues in front door safeguarding teams can access information to enable statutory decision making. Our own services can see each other's information and this allows for more wholistic decision making and understanding of risk within the family home.

Increased Visibility of Safeguarding Team We will increase our visibility across our patient and staff group and reach out to diverse groups and people who experience health inequalities. We will become a more regular presence for patients and staff to seek support.

The Safeguarding Team maintain a strong presence across inpatient services where patients may be subject to seclusion, long term segregation or care away from other arrangements. Attendance at Divisional network and governance networks has improved and the Safeguarding Assurance Group provides a platform across the Trust to report on safeguarding activity and developments. Contacts to the Duty desk have increased this year and continue to do so in 2026/27, the team work agile and are able to attend more meetings or contact staff more often because of this flexibility. We have worked closely with colleagues in patient safety, complaints and HR to ensure safeguarding is embedded across all areas, and attend Board, Partnership and ICB meetings, maintaining visibility of our safeguarding team and organisation across other areas.

Ensuring a safeguarding empowered workforce, we will empower our workforce to prevent, recognise and respond to safeguarding issues confidently and with our patients at the heart of this process

Training compliance is above 85% set target and training in Level 3 courses has improved. The Safeguarding Team have provided bespoke training and guidance on a number of current safeguarding issues, evidencing cascading of learning from current incidents or reported themes locally and nationally. The Safeguarding Assurance Group is now in place and focusses on sharing learning from reviews, local and national developments and sharing safeguarding activity across the Trust. Reporting into this group has improved. A part 2 confidential report detailing learning will be produced after this annual report, due to finer details not able to be produced in a public report for confidentiality reasons. The Safeguarding Link Worker role has been put on hold due to demands on the safeguarding team over the year, however this has now been picked up and will be relaunched in the coming year. We have assisted with training and development groups across the Trust such as B5/B6 development program, and with university courses meaning compliance for student staff within the corporate division has increased.

Improving efficiency and effectiveness across safeguarding systems We will provide a way for safeguarding information to be recorded and shared in an efficient and effective way across the Trust.

We have made great progress in this area. A Trust wide safeguarding template has been launched and is in its initial implementation phase and subject to review and audit. This has introduced a consistent way of recording safeguarding information which is visible to all looking at the electronic patient record. The MCA and Best Interests templates have been updated and the Gillick Competency template introduced. The Safeguarding Team are using Datix to improve recording and reporting of statutory safeguarding activity and the quality of safeguarding information being reported into the Safeguarding Assurance Group has improved and is more meaningful. The use of technology allows the Safeguarding Team to prioritise resource in other areas.

5.2 Looking ahead to 26/27

Our priorities are identified in the Trusts Safeguarding Plan 2023-2026 and timescales within the Development Plan. The Safeguarding Plan is under review and a new one will be launched early 2027 for a three year period.

Domestic Abuse We will recognise and respond appropriately to those who are at risk of or are experiencing or perpetrating domestic violence and abuse	**We will:** • Deliver Y3 of our second White Ribbon Plan and apply for reaccreditation in October 2026 for our third plan.

	• Refer into and support statutory Domestic Abuse Related Death Reviews when declared, sharing learning from reviews into the Safeguarding Assurance Group. • Continue to deliver QI project into domestic abuse and how those with learning disabilities experience it. • Improve domestic abuse reporting using SystmOne template. • Introduce Trust wide Domestic Abuse & Sexual Safety Group.
Child Neglect We will recognise and respond appropriately to children and young people who are at risk of or are experiencing child neglect and abuse	We will: • Raise the profile of child neglect and child neglect tools across the Trust. • Work with partners to deliver multi agency training on use of child neglect tools. • Audit use of child neglect tools and how it helps staff to identify and respond to concerns of child neglect.
Liberty Protection Safeguards We will understand our responsibilities when a person is deprived of their libertyand empower and protect service users who may lack the capacity to make decisions for themselves	We will: • Introduce bespoke training on completion of mental capacity templates and best interest decisions. • Audit the use of new MCA and Gillick competency templates implemented. • Support training and policy reviews required following changes to DOLS legislation.
Think Family We will think about the whole family when working with a service user. We will understand how trauma can impact families, and work with our partners to safeguard our service users and their families from harm and abuse	We will: • Complete an audit to look at how adult and child services work together to consider the whole family, and how they gather and share information across the service, which will include how information is recorded on systems. •
Increased Visibility of the Safeguarding Team We will increase our visibility across our patient and staff group and reach out to diverse groups who experience health inequalities. We will become a more regular presence for patients and staff to seek support from in person	We will: • Implement Safeguarding Drops Ins across Trust following its pilot • Improve visibility across Division networks and other meetings as resource allows.
Ensuring a safeguarding empowered workforce We will empower our workforce to prevent, recognise and respond to safeguarding issues confidently and with our patients at the heart of this process	We will: • Continue to deliver bespoke training courses and where possible do this in person to improve experience and participation • Reintroduce Safeguarding Link Quarterly Forums. • Share learning from incidents and reviews • Deliver Part 2 report to the Annual Report detailing safeguarding reviews and investigations undertaken or supported during the year, themes, recommendations, actions and how we have learnt from these processes, towards end of 2026.

	• Work with colleagues across both clinical and non clinical divisions to ensure safeguarding is embedded within all areas.
Improving efficiency and effectiveness across safeguarding systems We will provide a way for safeguarding information to be recorded and shared in an efficient and effective way across the Trust	We will: • Audit the use of the new safeguarding template. • Remove all pre-existing safeguarding templates to ensure one single record exists. • Improve how child and adult services record and share information about an individual and their group and family relationships, particularly where there are safeguarding issues.

Glossary of Abbreviations

Abbreviation	Meaning
AAR	After Action Review
CAMHS	Child and Adolescent Mental Health Services
CHCP	City Health Care Partnership
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
CPIS	Child Protection Information Sharing
CPR	Cardiopulmonary Resuscitation
CRMG	Clinical Risk Management Group
CSF	Cerebrospinal Fluid
CT	Computed Tomography
CTLD	Community Team for Learning Disabilities
CQC	Care Quality Commission
DA	Domestic Abuse
DARD	Danger, Assessment, Response, Documentation
DARDR	Domestic Abuse Related Death Review
DASH	Domestic Abuse, Stalking and Harassment Risk Assessment
DBS	Disclosure and Barring Service
DDoN	Deputy Director of Nursing
DfE	Department for Education
DOLS	Deprivation of Liberty Safeguards
EMT	Executive Management Team
ERYC	East Riding of Yorkshire Council
ET	Employment Tribunal
FTSU	Freedom to Speak Up
GP	General Practitioner
HCA	Healthcare Assistant
HR	Human Resources
HTNFT	Humber Teaching NHS Foundation Trust
HUTH	Hull University Teaching Hospitals
ICB	Integrated Care Board
IIR	Initial Incident Review
ISPHNS	Integrated Specialist Public Health Nursing Service
JTAI	Joint Targeted Area Inspection
LAC	Looked After Child
LADO	Local Authority Designated Officer
LPA	Lasting Power of Attorney
LPS	Liberty Protection Safeguards
MACAP	Multi-Agency Cuckooing Advisory Panel
MARAC	Multi-Agency Risk Assessment Conference
MARM	Multi-Agency Risk Management
MATAC	Multi-Agency Tasking and Coordination
MCA	Mental Capacity Act
MACE	Multi-Agency Child Exploitation
MAYVE	Multi-Agency Youth Violence and Exploitation
MDT	Multi-Disciplinary Team
MHAST	Mental Health Assessment Team
MHCIT	Mental Health Crisis Intervention Team
MHLS	Mental Health Liaison Service
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus aureus
MVL	Millview Lodge
NHSE	NHS England
NRM	National Referral Mechanism
PICU	Psychiatric Intensive Care Unit
PIPOT	People in Positions of Trust

PPE	Personal Protective Equipment
PSIA	Patient Safety Incident Analysis
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PSL	Patient Safety Lead
PTSD	Post-Traumatic Stress Disorder
QPAS	Quality and Patient Safety Group
RCN	Royal College of Nursing
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SAG	Safeguarding Assurance Group
SAR	Safeguarding Adult Review
SG Team	Safeguarding Team
SOP	Standard Operating Procedure
TEC	Townend Court
VARM	Vulnerability and Risk Management
WRAP	Workshop to Raise Awareness of Prevent

End.

Humber Teaching NHS Foundation Trust

Agenda Item 13

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting – 30 September 2026</td></tr>
<tr><td>Title of Report:</td><td>Trust Winter Plan 2026/27</td></tr>
<tr><td>Author/s:</td><td>Claire Jenkinson, Interim Chief Operating Officer</td></tr>
<tr><td>Recommendation:</td><td>
<table>
<tr><td>To approve</td><td>√</td><td>To discuss</td><td></td></tr>
<tr><td>To note</td><td></td><td>To ratify</td><td></td></tr>
<tr><td>For assurance</td><td>√</td><td></td><td></td></tr>
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</td></tr>
<tr><td>Purpose of Paper:

Please make any decisions required of Board clear in this section:</td><td>Trust Board are required to approve The Trusts Winter Plan 2026/27.

The Trust Winter Plan for 2026/27 provides an overview of the winter planning process undertaken, the key issues that are likely to impact on our operational response and the plans developed to mitigate the service pressures and risks anticipated for this winter. Our plan has been predicated on Winter requirements set out by NHS England, principles and work undertaken within the Humber and North Yorkshire along with our learning from internal and wider health system lessons from winter 2026/27.

Key requirements expected to be met this winter are:

• improve vaccination rates
• increase the number of patients receiving care in primary, community and mental health settings
• meet the maximum 45-minute ambulance handover time standard
• improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care
• set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings</td></tr>
<tr><td colspan="2">Key issues:</td></tr>
<tr><td>Positive Assurances to Provide:

• The Trust plan has been developed with Place and system partners to identify a range of actions to mitigate the impact of Winter 2026/27
• That the ICB objectives have been considered and addressed in the plan where they are appropriate
• The plan has been predicated on operational capacity and demand modelling that has considered seasonal variation, infection and respiratory virus</td><td>Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

• The plan details the range of work in place and underway to address the impact of winter 2026/27 on the operational delivery of services.</td></tr>
</table>

prevalence, staff availability, impact of adverse weather and associated surge in demand. • The plan has tested internal arrangements to respond to increasing levels of pressure from winter virus outbreaks, with effective measures to maintain patient safety and minimise risk • A Quality and Equality Impact Assessment has been completed and included in the plan	
Key Risks/Areas of Focus: • System pressures have remained high during 2026. • Overall demand on Trust services continues to be high in some areas and all services continue to see high complexity and acuity in most patient groups. • Maximising staff availability is critical to mitigating the adverse impact of winter pressures. Reducing staff sickness absence needs to remain a priority. • Industrial action may impact on our patients and our staff.	**Decisions Made:** • Trust Board are asked to approve the Winter Plan for 2026/27.

Alignment with the Three Shifts in the Long-Term Plan (*If not applicable please state*)	
Hospital to Community	The Winter Plan supports our overall patient flow and the systems in place to support discharge planning and a system wide health care approach.
Analogue to Digital	N/A
Sickness to Prevention	N/A

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	25.08.2026
Mental Health Legislation Committee		Operational Delivery Group	27.07.2026
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	
Enhancing prevention, wellbeing and recovery	
Fostering integration, partnership and alliances	X
Developing an effective and empowered workforce	X
Maximising an efficient and sustainable organisation	
Promoting people, communities and social values	

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	X

Public Exemption:

Is the report exempt from public disclosure	Yes/No

NHS
Humber Teaching
NHS Foundation Trust

Humber Teaching NHS Foundation Trust
Winter Resilience Plan 2026/27



Caring, Learning
& Growing Together

Contents

1. Introduction 6
2. Our Trust 6
3. Our Services 7
4. Objectives 7
5. Planning Principles 7
   5.1 Planning Considerations 8
6. Key Risks 8
7. Managing demand, admission avoidance & optimising patient flow 8
8. Workforce 9
9. Working with partners 9
10. Dealing with Surge 9
11. Dealing with outbreaks 10
12. Emergency Preparedness, Resilience and Response 10
    12.1 Command and Control 10
    12.2 Adverse Weather 10
    12.3 Business Continuity Plans 10
13. Directorate action plans 12
    13.1 Mental Health Services Adults and Older People 12
    13.2 Children and Learning Disabilities 14
    13.3 Community & Addictions 16
    13.4 Forensic Services 20
    13.5 Workforce & Wellbeing 21
    13.6 Estates & Hotel Services 23
    13.8 Emergency Preparedness, Resilience & Response 25
14. Summary 26

Appendix 1 - Equality and Health Inequalities Impact Assessment (EHIIA) Toolkit 27

1. Introduction

Our Winter Resilience Plan sets out the framework for the Trust to continue to deliver services with the increased potential of operational pressure and infection rates throughout the winter period.

This plan sets out a summary of the key elements that have informed our planning and preparedness. The Trust's approach to planning for the coming winter is robust and has taken a system wide approach to support the management of pressures across services both internal and external. Planning for the coming winter is considered early, recognising pressure and planning developments and initiatives that will have a benefit to our service users across the health system. Escalation arrangements through the Opel framework, daily system calls, and the activation of relevant business continuity plans have and will continue to be considered to bolster the Trust's service delivery throughout the winter period, to support our patients, staff and a whole health system approach.

Pressures across the NHS and specifically upon urgent and emergency care are likely to be substantial and it is recognised collaborative working is required across all providers. This is paramount to ensure that the whole system is managing the flow of patients and ensuring service delivery.

This Plan has therefore been produced to support the Trust's services response going into winter 2026, recognising that the period will once again be challenging, with high demand, pressure on community and inpatient capacity, and gaps in local workforce. Whilst this plan should be considered as a standalone plan to support the services provided at Humber Teaching NHS Foundation Trust, it is also a significant element of the wider NHS Humber and North Yorkshire System Winter Resilience Plan. The plan has considered effective practices identified over previous winter periods and ensured these are carried forward into winter 2026 planning and preparedness.

A lack of capacity across the NHS has an impact on all areas of the system and it is essential that access to primary care, community health services and mental health services for urgent patients is sufficient to ensure patients do not always need to present to emergency services. With that in mind, the Trust is clear on its role and responsibilities within the system and as outlined in the 'Working together to deliver a resilient winter,' document this will be the focus and aligns to our organisational values of Caring, Learning and Growing.

2. Our Trust

Humber Teaching NHS Foundation Trust covers a large geographical area, and we are a leading provider of integrated healthcare services across Hull, the East Riding of Yorkshire, Whitby, Scarborough, and Ryedale. Our wide range of health and social care services are delivered to a population of 765,000 people, of all ages, across an area of over 4,700 square kilometres. Services covered within those areas include, community and therapy services, primary care, community and inpatient mental health services, learning disability services, healthy lifestyle support and addictions services.

The Trust provides specialist services for children including physiotherapy, speech and language therapy and support for children and their families who are experiencing emotional or mental health difficulties.

In addition to the above, the Trust has specialist services, such as forensic support and offender health, which supports patients from the wider Yorkshire and Humber area and further afield as well

as our Children and Adolescent Mental Health inpatient unit ‘Inspire’ which aims to serve the young people of Hull, East Yorkshire and North Lincolnshire.

3. Our Services

Our services cover a wide-range geography comprising Hull, the East Riding of Yorkshire, Scarborough and Ryedale, Pocklington and Whitby.

Our Trust is grouped into four Divisions:

- Community and Addictions
- Children’s and Learning Disability
- Forensic Services
- Mental Health

We support our service users in a wide variety of settings including patients own homes, GP practices, health centres, outpatient clinics, hospitals, local authority premises and our inpatient units.

4. Objectives

- To manage anticipated operational pressures and provide safe, high-quality services for patients including effective management of infection, ensuring patients are seen in the right place and right time, whilst maintaining privacy and dignity
- To achieve and maintain key areas of service performance
- To provide assurance that robust plans are in place
- To maintain a healthy workforce by reducing risks of sickness and absence and increasing staff attendance at work
- Identify opportunities/actions to respond to system surge throughout the winter months
- To work with system partners to escalate and respond to service and system pressures
- To support the delivery of our restoration plans and share best practice
- To respond to national guidance

5. Planning Principles

- The Trust will plan for emerging infections in the same way as seasonal influenza and as part of business-as-usual arrangements
- Recognise that system resilience is 365 days of the year
- We use our command-and-control arrangements to support system escalation when required
- Staff Support and Wellbeing arrangements are in place to enable a resilient workforce
- We evaluate system wide learning from the previous winter to inform future planning including the Operational Pressures Escalation Levels Framework (OPEL)
- We escalate early in anticipation of demand surges, not in response to them. (Collaboration with ambulance services and primary care to monitor illness, patterns in the local community and weather changes that may affect specific patient cohorts)
- That we identify winter schemes early through learning from the previous winter
- We consider the impact of wider transformational schemes on system plans
- We engage as a system both clinically and as leaders in the ongoing development of plans and oversight

- Develop communication plans with system partners and the public to influence behaviours
- Ensure that Health Inequalities are integral to all plans

5.1 Planning Considerations

- Smooth transition of admissions from Emergency Departments reducing 12 hr waits and eliminating 24 hr delays
- Tackling discharge delays through Multi Agency Discharge Events (MADE)
- Seeing more children in the emergency department within 4 hours
- Increasing vaccination uptake
- System Infection Prevention & Control (IPC) plans
- Local Partners working together
- Reduce length of stay and readmission
- Robust workforce plans in place
- Robust mental health plans in place for High Intensity Use (HIU) and reduce Out of Area (OOA) placements

6. Key Risks

- Potential for reduced staffing due to sickness and infection related absence
- Potential for an increased demand for inpatient beds for both adults and children
- Increased patient acuity within service areas having an impact on service delivery
- Increase in system pressure that impacts on Mental Health Services and Community Services
- Paediatric services increase in demand
- Planned services seeing an increase in referrals
- Local Authority care package availability directly impacting on patient flow
- Increase in infections within inpatient groups
- Potential for severe weather to impact on service delivery
- Potential for consultant industrial action
- Movement from RaidR to a new system for Opel reporting

7. Managing demand, admission avoidance & optimising patient flow

Our winter planning assumptions again have needed to consider the increased demand for beds. Our winter preparations and commitment to ensuring that the Trust can meet the continuing demand is to focus on ensuring all hospital admissions are appropriate and purposeful, length of stay is as short as possible, accelerating discharge of people clinically ready for discharge and optimising the out of hospital pathways with a “home first” approach. Key actions in the plan to achieve this are:

- Maximising the emergency department mental health streaming facility
- Following clear escalation process between key providers and HTFT
- Delivering the NHS 111 mental health option 2 to support patients in crisis.
- Expanding the peripatetic health care assistant workforce further across children’s and learning disability services.
- Optimising the virtual ward capacity in North Yorkshire (and adhere to NHS England » Virtual wards operational framework).
- Embedding frailty pathways maximising holistic assessment and advance care planning

- Enhanced overnight community nursing service across all community areas to focus on palliative care and hospital avoidance in North Yorkshire
- Maximising Intermediate Care Team capacity across Scarborough and Ryedale
- Continue to support the Mental Health Response vehicle working in collaboration with YAS.
- Identifying additional step up and step-down support/beds for older adult mental health patients
- Increase AMHP (approved mental health professional) capacity.
- Maximise the inpatient vaccination programme in all areas.
- Maximising the children's and young people's community intensive eating disorder service to avoid acute hospital and CAMHS bed admissions.

8. Workforce

Critical to our winter plan is the availability of our staff to achieve safe staffing levels. The Trust is committed to maintaining a healthy workforce and recognises that recent years have been especially challenging and therefore we aim to:

- Continue to recruit both to our bank and substantive posts ahead of winter supported by rolling adverts and bespoke recruitment campaigns.
- Support hybrid working where possible.
- Continue to maximise opportunities for filling nurse and consultant vacancies, regularly reviewed via the Recruitment Task and Finish Group. This includes approaches to maximise newly qualified nurse recruitment, with arrangements in place to facilitate over-recruitment in some areas.
- Enhance advertising of hard to recruit roles in advance of winter, maximising our communications plan that includes recruitment campaigns, jobs fairs and staff benefits package.
- Continue the Staff Health and Wellbeing Programme for all employees and bank staff (MOT, physical and wellbeing checks) in addition to a series of health-related promotional campaigns and continuation and expansion of available staff health and wellbeing activities.
- Work with the flexible workforce team to ensure sufficient capacity to maintain a healthy workforce.
- Target of end of November to hit 71% of the workforce for the flu vaccine, a 5% uplift from 2025/26.

9. Working with partners

The Trust continues to work closely with its system partners across a wide range of forums, and the work focuses on delivery of services and the anticipated winter pressures.

- The Trust has an agreed measure for determining standard OPEL level reporting with our ICS mental health partners.
- The Trust will attend and actively support all Strategic, Tactical and Operational System and Resilience calls when required.
- The Trust will work closely with ICS partners to agree system plans and strategies to address system pressures and surges, including mutual aid actions.
- Clear escalation process will be utilised to highlight and address service pressures.
- Work closely with local authorities to ensure the early identification of care/home packages.
- Work closely with primary care networks to improve access and support prevention.

10. Dealing with Surge

The Trust OPEL triggers will be deployed when surge occurs both internally and externally. Service level OPEL reporting is in use daily across the Trust and is a robust system of reporting internal and external escalating pressures.

These are further reinforced with identified actions specifically being put in place to address additional demand over the winter period. The Trust actively takes part in system calls and is responsive to pressures within the system and proactively supports other organisations with mutual aid as required.

The Trust utilises command structures on a dynamic basis to support perceived risks and pressures to the organisation and its services as set out in our EPRR policies and procedures.

11. Dealing with outbreaks

In the event of an outbreak occurring the Infection Prevention and Control Team will manage the episode in accordance with all relevant national guidance. The recommendations highlighted within NHS England » Transmission based precautions (TBPs) will be adopted ensuring the transmission of any communicable disease are minimised.

The Trust has access to a dedicated area on the Trust intranet which provides up to date guidance on all communicable diseases such as influenza, norovirus, covid and other infections. Information is easy to access by all teams across the services within the Trust.

12. Emergency Preparedness, Resilience and Response

12.1 Command and Control

The Trust has robust command and control arrangements in place which can be stood up both in and out of hours if required to respond to system surge, winter pressures or any incident response. Our on-call teams are undertaking their Health Command Training identified as mandatory by NHS England, the Trust has robust on call arrangements in place.

12.2 Adverse Weather

The Trust has a plan for services and staff to support them in the event of adverse weather conditions. The aim of the plan is to provide a framework which enables the Trust to prepare, respond and recover from adverse weather. It is recognised that during periods of severe weather staff may face difficulties, not only attending their place of work but also in returning home. Several considerations relating to staff are included in the plan:

- Communication alert system in place to cascade early notification of likelihood of adverse weather.
- Supporting with working from different bases
- Flexing starting/leaving times.
- Utilising Trust 4 x 4 vehicles to support clinical services.
- Mountain Rescue services support for our far-reaching rural services
- Providing accommodation for staff who are unable to get home.
- Continue to support staff working from home.

12.3 Business Continuity Plans

A key element of our winter planning is ensuring that all our clinical and corporate services have business continuity plans that are robust and fit for purpose. These plans are in place for all our clinical and corporate areas. Through our EPRR arrangements these plans are reviewed and tested on a rolling programme to ensure that they are updated at least annually and are fit for purpose. These plans are predicated on minimising service disruption associated with winter pressures.

13. Directorate action plans

13.1 Mental Health Services Adults and Older People

Adult Mental Health			
Aim	**Objective**	**Mitigating actions**	
Admission Avoidance	Eradicate 24hr waits and lessen 12 hr waits for Mental Health	➢ Strengthen the escalation process for adults for admission from Emergency Departments in hours and OOH. ➢ Review the performance indicator to improve upon the 80% streaming target patients suitable for streaming. ➢ Work collaboratively to optimise ED streaming, including to ensure and delays due to Mental Health Act Assessment are minimised. ➢ Resolve access to Security to maximise patient access to the Humber Suite ➢ Explore the employment agency AMHP 1 wte to ensure robust rota to cover Mental Health Act Assessments ➢ Strengthen Mental Health Action Cards responding to system/Opel pressures	
	Reduce mental health presentation to Emergency Departments	➢ Consider providing Mental Health Practitioner to support MH Response Vehicle with YAS ➢ Consider increasing capacity within Crisis and IST to meet demand and minimise escalation to ED ➢ Liaise with Primary Care to support uptake of vaccinations of patients on SMI Register ➢ Understanding what messaging tools can be utilised to avoid ED admission and go through other routes ➢ Expansion of older adult intensive treatment team and community ACS	
	Maximise opportunities within UTC for mental health presentations	➢ Work with UTC provider to agree pathways for mental health presentations	
	Reduce demand on Crisis service, MH inpatients and on Primary Care	➢ Consider increasing resource at point of GP referral for triage and assessment to support interventional and treatment (MHTAT and CITOP) ➢ Explore block booking of 4 age-appropriate community functional step-up beds	
	Maintain Crisis Access	➢ Optimise staff levels across Crisis and IST to support NHS 111 and crisis teams during periods of heightened pressure.	

Maintain key areas of service performance	Reduce OOA Placement	➢ Continue with routine Multi Agency Discharge Events (MaDE) with escalation to Super MaDE ➢ Progress proposal to provide 4 step up beds for Older people ➢ Consider increasing Acute Community Service capacity and expand Community Intensive Triage for Older People ➢ Work with system partners to maximise PICU capacity across the ICB ➢ Consider expanding access to MIND step down beds moving from 5 to 7 ➢ Support more timely discharge with Community support post discharge – First Point of Contact by 3wte B6 Nurses across Hull & ER Adult CMHT and Older CMHT ➢ Progress the development of single gender PICU and HDU	
	Maintain Safer staffing across all areas	➢ Review requirements to expand capacity of current unregistered peripatetic team across inpatient and community teams ➢ Band 7's within inpatient units, liaison and crisis team 7 days a week (including bank holidays) ➢ Identify vulnerable staff and patient cohort that may require a Covid vaccine to support their wellbeing. ➢ Review of annual leave allocation across the Christmas Period (2 weeks) to support in bolster staffing across inpatient units. ➢ Explore voluntary pool staff to support during the Christmas period, to bolster staffing levels. ➢ Maximise use of Eroster to ensure safer staffing versus patient acuity if effectively monitored	
	Expand capacity to Memory Assessment Service	➢ Increase psychiatry time to support assessment and formulation of additional referrals received over winter period	

13.2 Children and Learning Disabilities

Children & Learning Disabilities		
Aim	Objective	Mitigating actions
Admission Avoidance	Seeing more children in 4 hours and ensure appropriate placement	➢ Ensure gateway assessment (form 1) can be completed 24/7, with the training of crisis team staff ➢ Review of current escalation procedure for children for admission from Emergency Departments in hours and OOH to include children social care OOH support ➢ Improve waiting timings across Contact Point and CAHMS ➢ Regular complex care meetings with children social care to discuss escalating cases
	Respond to Public Health advice regarding outbreak trends	➢ Health Visitor service has a proposal to support under 5 years children's vaccinations in the community ➢ 0-19 services to support herd immunity targets in MMR vaccination roll out if bid successful ➢ 0-19 presenting at homeless and traveller centres to maximise uptake.
	Minimise CYP admissions for patients presenting with Eating Disorder	➢ Complete evaluation of the current service with the aim to maintain the Eating Disorder Intensive Treatment service
	Provide an alternative space for CYP in Crisis	➢ Maintain Safe Space and widen access criteria. ➢ Day Service in CYP is up and running ahead of winter
	Avoid unnecessary Learning Disability admissions	➢ Ensure continued In-reach to HUTH to avoid admission for patients with LD ➢ Review of dynamic support register to reduce risk of admission with partner agencies ahead of winter period. ➢ High risk patients and frequent attenders shall be shared with the key worker service and DSR register.

Maintain key areas of service performance	Mental Health Support Teams (MHST) to provide full coverage across Hull and East Riding Schools	➢ Where do schools do not have access to the MHST's to provide a service offer
	Maximise use of technology to maintain service provision and provide service user support	➢ Promote maximise use of CHAT Health and understand what other messaging tools can be utilised for children to avoid ED admission and go through other routes ➢ CAHMS website up and running ahead of the winter period ➢ Continued offer of virtual technology to support appointments
	Maintain safer staffing across service areas	➢ Introduction of a peripatetic team to support short term sickness across division ➢ Identify vulnerable staff and patient cohort that may require a Covid vaccine to support their wellbeing. ➢ Review of annual leave allocation across the Christmas Period (2 weeks) to support in bolster staffing across inpatient units. ➢ Explore voluntary pool staff to support during the Christmas period, to bolster staffing levels. ➢ Over-recruit in areas of high demand ➢ Ensure duty management cover providing senior support across wards to mitigate pressures and plan service provision ➢ Ensure monitoring of winter workforce plan through current strategic workforce meeting ➢ Refresh of business continuity plans

13.3 Community & Addictions

Community & Primary Care		
Aim	**Objective**	**Mitigating actions**
Admission Avoidance	(CS) Sustain available Virtual Ward bed capacity and utilisation.	➢ Complete and embed IV guidance, progress the Gentamicin SOP through Drugs and Therapeutics review in July, and finalise the supporting training package. ➢ Maintain bi-monthly engagement with YAS to review pathway performance, share learning with the team, and sustain the refreshed referral SOP agreed with YAS in September 2025. Continue Virtual Ward participation in Scarborough Hospital discharge meetings to support appropriate referrals and patient flow. ➢ Maintain clear inclusion and exclusion criteria focused on clinical safety and patient choice, validated through GPwER input and communicated to referring services. This has been completed through the GIRFT review, with supporting examples and a crib sheet now in use to aid admission decision-making. ➢ Sustain remote assessment and home visiting capacity by increasing use of video consultation, maintaining digital infrastructure investment, and strengthening GPwER support.
	(WUTC) Ensure there is continuous and appropriate access to urgent care, reducing the likelihood of patients defaulting to SGH ED outside of regular hours.	➢ Embed triage protocols to assess and manage patients with urgent, non-life-threatening conditions safely and consistently. ➢ Work with SGH to expand access to on-site diagnostics, supporting more comprehensive assessment and treatment outside current contractual hours. ➢ Embed live verbal advice and guidance pathways between SGH, JCUH and the UTC to reduce inappropriate onward referrals. ➢ Strengthen integrated care pathways with local GPs and primary care services to streamline referrals and follow-up from the UTC, including Pharmacy First, Eye CAS and Extended Access. ➢ Improve flexible staffing arrangements to ensure the UTC remains fully operational throughout opening hours.

	(CS) Ensure the 2UCR team is highly responsive, with the capacity to deploy to patients' homes within 2 hours of referral.	➢ Strengthen referral pathways with YAS, primary care, secondary care and HTFT community services through updated SOPs, refreshed communications and shared patient stories. Maintain bi-monthly YAS engagement to review pathway performance, share learning with the team, and support daily Scarborough Hospital discharge walkrounds attended by the Virtual Ward team. ➢ Align clinical criteria by mapping SystmOne referral reasons to the nine UCR criteria and implementing routine monitoring to ensure accurate categorisation. ➢ Strengthen data and performance oversight through a UCR dashboard, regular referral reviews including declined cases, and triangulation of system data with ED and SDEC trends. ➢ Support workforce planning by reviewing vacancies against service need, actively promoting recruitment and tracking progress. Align future capacity with expected NYC integration mobilisation from October/November 2026. ➢ Drive consistency and innovation by benchmarking with regional providers, attending regional UCR network meetings at Band 7/Band 8a level, developing technology-enabled care pathways with the ICB, and standardising activity definitions across the patch.
	(ERP/HPCAS) Reduce drug and alcohol related admissions through continued timely access to specialist community treatment, harm reduction interventions and integrated care pathways.	➢ Maintain continuity of opioid substitution treatment (OST), including Methadone, Buprenorphine and Buvidal, particularly during weekends and bank holidays. ➢ Work proactively with acute hospitals, primary care, community pharmacies, mental health services and Inclusion Health teams to support admission avoidance and timely discharge. ➢ Prioritise hospital discharge referrals to ensure prescribing, follow-up appointments and ongoing support are in place, reducing the risk of readmission. ➢ Undertake MDT reviews for individuals with frequent hospital attendances, repeated overdoses or complex health and safeguarding needs.
Maintain key areas of performance	(All) Patient Care Prioritisation	➢ Continue RAG rating to prioritise patients by urgency, ensuring those with the greatest clinical need receive timely care. ➢ Use established triage tools across services, including UTC triage and SPOC/UCR triage through community services. ➢ Maintain patient flow through routine MADE events, with IC, UCR and IPU teams consistently attending scheduled meetings and contributing to flow discussions.

	(CS) Nursing staffing levels to be maintained 24/7	➢ Embed Making Every Contact Count within physical health services to maximise prevention and early intervention opportunities. ➢ Use the telephone nursing service to support remote patient monitoring and flex staffing capacity during business continuity pressures. ➢ Maintain robust overnight community nursing across Scarborough, Ryedale and Whitby, with a focus on palliative care and hospital admission avoidance. ➢ Ensure Band 7 cover is available seven days a week, including bank holidays, to support clinical leadership and oversight. ➢ Explore use of voluntary pool staff over the Christmas period to strengthen staffing resilience. ➢ Review annual leave allocation across the two-week Christmas period to support staffing resilience across inpatient units. ➢ Develop a North Yorkshire staff bank for registered and unregistered roles to increase flexible workforce capacity. ➢ Maximise use of eRoster to monitor safer staffing against patient acuity and support timely escalation where required.
	(All) Proactive Pharmacy Collaboration	➢ Strengthen proactive communication and collaboration with community pharmacy colleagues, particularly in Addictions and through the Electronic Prescribing System (EPS), to enhance patient support. ➢ Explore digital tools and telepharmacy services to monitor patient medication use remotely through the Virtual Ward. ➢ Provide patients and caregivers with clear guidance on how to access emergency medications and advice if issues arise outside of normal hours.
	(ERP/HPCAS) Maintain safe, responsive and equitable access to community addiction services throughout periods of increased demand.	➢ Maintain business continuity through flexible deployment of staff across ERP and HPCAS sites where appropriate. ➢ Prioritise high-risk referrals using clinical triage, ensuring individuals at greatest risk are assessed promptly. ➢ Monitor waiting times, caseload pressures and prescribing activity through routine operational oversight, escalating risks where required. ➢ Utilise telephone and virtual consultations where clinically appropriate to maintain patient engagement during adverse weather or staffing pressures. ➢ Maintain multidisciplinary working to coordinate care for individuals with complex physical health, mental health and safeguarding needs.

		➢ Continue delivery of physical health interventions, including BBV testing, Hepatitis C treatment pathways, smoking cessation advice and vaccination signposting.
IPC	(All)	➢ Promote seasonal vaccination for staff and eligible service users where appropriate.

13.4 Forensic Services

Forensic			
Aim	**Objective**	**Mitigating actions**	
Admission Avoidance Maintain key areas of performance	Maintain efficient pathways	➢ Facilitate pathway moves with timely transition, step down and discharge ➢ Increase availability of primary care/ general physical health input ➢ Provide education and advice about vaccination programme and offer vaccines ➢ Maximise use of virtual appointments and telephone contacts for community services	
	Maintain effective levels of workforce	➢ Implementation of recommendations from 24/25 staffing which include the following ➢ Over-recruit to registered staff where available (1 additional per ward) ➢ Over-recruit to HCSW where available to provide additional resource or peripatetic offer for sickness and high acuity cover ➢ Ensure duty management cover providing senior support across wards to mitigate pressures and plan service provision ➢ Ensure monitoring of winter workforce plan through current strategic workforce meeting ➢ Refresh of business continuity plans ➢ Consider more Band 7's in 7 days a week (including bank holidays) ➢ Identify vulnerable staff and patient cohort that may require a Covid vaccine to support their wellbeing. ➢ Explore 'pick and mix' hour contracts and part shifts to support during the Christmas period, to bolster staffing levels ➢ Review of annual leave allocation across the Christmas Period (2 weeks) to support in bolster staffing across inpatient units ➢ Ensure planning of admissions in line with environmental offer and staffing projections ➢ Engage with collaborative services for updates, shared understanding and mutual aid where required.	

13.5 Workforce & Wellbeing

Workforce/Wellbeing		
Aim	**Objective**	**Mitigating actions**
Maintain key areas of performance	Staff availability due to viruses	➢ Vaccination programme for flu to further improve on 2025/26 uptake through a targeted approach and weekly dashboards across the Trust, allowing for data driven decision making. ➢ Ensure infection prevention guidelines adhered to maximise virtual working to minimise exposure ➢ Targeted flu campaign to be created collaboratively between People and OD and Comms – emphasising the importance of the uptake to aid winter pressures. ➢ Vaccination programme to increase availability, and targeted support offered to areas with low uptake in 2025/6 and areas with high flu sickness absence in 2025/6 specifically ensuring North Yorkshire availability of vaccines ➢ Consider Medical Director or Executive Director of Nursing to talk about the benefits of vaccination to all staff ➢ Consider the current booking arrangements to ensure ease of vaccination bookings ➢ Support divisions with their vaccination programmes and increasing uptake through staff and patient cohorts ➢ Target of end of November to hit 71% of the workforce
	Minimise use of agency staff due to absence/vacancy	➢ Maintain robust sickness management inc return to work, monitoring ➢ Increased recruitment to Trust Bank and prime staff ready for the winter period. ➢ Bank recruitment campaign to maintain rolling advertisements for clinical roles, with a view to continue to expand all levels of clinical personnel on the Bank ➢ Proactively go out to Bank Staff that are currently inactive and understand if they will support going into Winter ➢ Maintain safer staffing reviews ➢ Maximise on mutual aid provided across organisation ➢ Continue to use the Patient Acuity Tool to support decision making ➢ Ongoing recruitment to medical vacancies ➢ Weekly review of medical staffing recruitment/progress ➢ Maximise medical and clinical skill mix opportunities ➢ Maintain rolling advertisements for clinical roles ➢ Review advertising and initiatives for hard to recruit to roles in advance of winter ➢ Healthcare Support Worker programme to maintain momentum in the lead up to and throughout winter.

		➢ Support ongoing optimisation of e-roster. ➢ Continued investment in student nurse recruitment ➢ Over-recruitment considerations, including student nursing cohort and within areas that have staff challenges.
Maintain key areas of performance	Ensure workforce resilience	➢ Workforce planning cycle completed ➢ Continued access to occupational health/counselling/physio ➢ Health and Wellbeing offer enhanced and maintained ➢ MOT Physical and Wellbeing checks available to all personnel ➢ Expanded staff health and wellbeing activities provided ➢ Organisation Development team working closely with clinical areas to support areas of pressure/disharmony ➢ Internal mentoring and external coaching available ➢ Appraisal performance remains high

13.6 Estates & Hotel Services

Estates & Hotel Services			
Aim	**Objective**	**Mitigating actions**	
Maintain key areas of performance	Maintain access to all Trust sites	➢ Continue with gritting procedures guided by weather predictions, Ice Watch and requests from site staff ➢ All engineering staff prepared for 'first job of the day' to ensure adhoc gritting or snow clearing is dealt with as a priority ➢ Annual PPM of heating systems to ensure safe and suitable working environment for staff, visitors and patients ➢ Ensure company vehicles are prepared for the winter conditions with de-icer and screen wash to enable effective use ➢ Extreme weather to prompt 'toolbox talks' regarding the appropriateness of travel arrangements ➢ Continue to maintain generators at ERCH and Willerby Hill during times of power outage ➢ Discussions with landlords of our buildings to ensure adequate severe weather arrangements e.g. gritting	
	Manage demand and respond to internal surge	➢ Prioritise the feeding of patients and cleaning of all high-risk areas utilising resources appropriately to achieve this ➢ Ensure bedrooms are cleaned to enable efficient admission in times of high demand ➢ Support the inhouse engineering team with a range of multi-disciplinary external contractors, available upon request ➢ Maintain regular contact with inpatient facilities to identify any 'works' required in conjunction with electronic requesting method	

13.7 Infection, Prevention and Control

Infection Prevention and Control			
Aim	**Objective**	**Mitigating actions**	
Maintain key areas of performance	To minimise patients, staff and visitors from being harmed by the transmission of infection.	➢ The Trust Respiratory Pathway protocol will remain under regular review to ensure it reflects national guidance recommendations. ➢ An increase in the frequency of the IPCT patient surveillance review schedule will be implemented to ensure the effective usage of the side rooms within the community hospital inpatient units during periods of increased infection prevalence. ➢ Process for the management of staff presenting with symptoms suggestive / confirmed as having a respiratory infection in place. ➢ A risk-based review of the ventilation across the inpatient estate will be maintained in support of the ongoing Trust ventilation improvement programme. ➢ Regular IPC updates and key messaging provided utilising a variety of communication methods, including the Managers Operational Briefing, intranet, internet and social media platforms in place to promote effective IPC practice. ➢ Staff respiratory vaccination programme delivered in line with national guidance. ➢ Hand Hygiene and Personal Protective Equipment (PPE) Competency assessments successfully completed for all clinical staff who deliver direct clinical care. ➢ Universal mask wearing will be initiated in all areas / staff groups experiencing a high prevalence of respiratory disease, supported by the national Universal Masking Tool. ➢ The delivery of antimicrobial stewardship refresher sessions for the medics and the non-medical prescribers. ➢ Outbreak of Communicable Infection Policy updated and available for all staff reference. ➢ Face Fit testing programme maintained across inpatient services, Granville Court, ECT, Whitby UTC and Mental Health and CAMHS Crisis Teams. ➢ The number of Face Fit Testers within the organisation will be reviewed regularly and additional external training will be purchased when required. ➢ Face Fit Testing register maintained across the Trust. ➢ All covid vaccinations are now delivered by pharmacies and GP practices.	

		➢ Trust Transmission Based Precautions (TBP) eLearning resource developed for all inpatient-based staff to enhance knowledge and understanding and support effective application of TBP principles in practice.	

13.8 Emergency Preparedness, Resilience & Response

EPRR			
Aim	**Objective**	**Mitigating actions**	
Maintain key areas of performance	Planning for severe weather	➢ Stand up/down command and control arrangements if required ➢ Review the Adverse Weather Plan ahead of Winter and activate if required ➢ Test the Winter Resilience Plan with all leads. ➢ EPRR Team maintain links with system partners ➢ Work with Trust communications team for key messaging ➢ Ensure services implement their business continuity plans where required	
	Support System work and communication	➢ Daily sitrep reporting in place across all areas ➢ Mutual aid arrangements in place across ICB providers ➢ Mental Health and Community service managers attend daily system calls to support patient flow ➢ Agile working in place to minimise travel and maintain business continuity ➢ Oversee plans to mitigate the impact of industrial action	

14. Summary

This Winter Plan outlines Humber Teaching NHS Foundation Trust's comprehensive and proactive approach to managing the challenges of Winter 2026/27. It reflects a system-wide commitment to maintaining safe, high-quality services during a period of increased demand, infection risk, and workforce pressures. The plan builds on learning from previous years, incorporating robust escalation procedures, workforce resilience strategies, and close collaboration with system partners. By focusing on admission avoidance, patient flow, infection control, and staff wellbeing, the Trust is well-prepared to respond to winter pressures while continuing to meet the needs of the population it serves.

Appendix 1 - Equality and Health Inequalities Impact Assessment (EHIIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document of Process or Service Name: Winter Resilience Plan
2. EHIIA Reviewer (name, job title, base and contact details): Alexandra Smith, EPRR Manager
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Plan

Main Aims of the Document, Process or Service
To set out the requirements that must be met for approval, ratification and dissemination of all Humber Teaching NHS FT policies.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the proforma

Equality Target Groups	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
This toolkit asks services to consider the impact on people with protected characteristics under the Equality Act 2010 as well as the impact on additional groups who may be at risk of experiencing inequalities in access, outcomes and experiences of health and care.	Equality Impact Score Positive = evidence of positive impact Neutral = little or no evidence of concern (Green) Moderate negative = some evidence of concern (Amber) High negative = significant evidence of concern (Red)	• who have you consulted with? • what have they said? • what information or data have you used? • where are the gaps in your analysis? • how will your document/process or service promote equality and diversity good practice?

Equality Target Group	**Definitions** (Source: Equality and Human Rights Commission, 2024)	**Equality Impact Score**	**Evidence to support Equality Impact Score**
Age	A person belonging to a particular age (for example 32-year-olds) or range of ages (for example 18- to 30-year-olds).		This process considers a range of age.
Disability	A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.		This process considers disabilities.
Sex	Man/Male, Woman/Female.		This process considers gender.

Marriage / Civil Partnership	Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples.		This process considers marriage and civil partnership.
Pregnancy / Maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a person unfavourably because they are breastfeeding.		This process considers pregnancy and maternity.
Race	A race is a group of people defined by their colour, nationality (including citizenship) ethnicity or national origins. A racial group can be made up of more than one distinct racial group, such as Black British.		This process considers race.
Religion or Belief	Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.		This process considers religion and beliefs.
Sexual Orientation	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.		This process considers sexual orientation.
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex		This process considers gender re-assignment.
Poverty	People on welfare benefits, unemployed/low-income, fuel poverty, migrants with no recourse to public funds		This process considers poverty.
Literacy	Low literacy levels, including includes poor understanding of health and health services (health literacy) as well as poor written language skills		This process considers literacy.
People with English as an additional language	People who may have limited understanding and/or ability to communicate in written or spoken English		This process considers people with English as an additional language.
Digital exclusion	People who can't or don't want to use digital technology due to cost, access to connectivity or devices, digital skills or lack of confidence or trust in digital systems		This process considers digital exclusion.
Inclusion health groups	People who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes:		This process considers a

	• people who experience homelessness		range of health groups.
	• drug and alcohol dependence		
	• vulnerable migrants		
	• Gypsy, Roma and Traveller communities		
	• sex workers		
	• people in contact with the justice system		
	• victims of modern slavery		
Rurality	People who live in remote or rural locations who may have poor access to services.		This process considers rurality.
Coastal communities	People who live in coastal communities which may experience unemployment, low educational attainment, poor social mobility, poor health outcomes and poorer access to services.		This process considers coastal communities.
Carers	Carers and families of patients and service users, including unpaid carers and paid carers		This process considers carers.
Looked after children	A child or young person who is being cared for by their local authority. They might be living in a children's home, or with foster parents, or in some other family arrangement.		This process considers looked after children.
Veterans	Anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations.		This process considers veterans.
Neurodivergence	People with alternative thinking styles such as autism, attention deficit hyperactivity disorder, dyslexia, developmental co-ordination disorder (dyspraxia), dyscalculia.		This process considers neurodivergence.
Other	Any other groups not specified in this toolkit who may be positively or negatively impacted		

Summary

Please describe the main points/actions arising from your assessment that supports your decision above	
EIA Reviewer: Alexandra Smith	
Date Completed: 27th April 2026	Signature: A Smith

Winter Planning 26/27
Board Assurance Statement (BAS)

1. Purpose
The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement
Please include the Trust / Provider name at the top of the tab.
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to
the national UEC team via england.eecpmo@nhs.net by **30 September 2026.**



Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):	OTHER - Please write below
If Other, write Provider/Trust Name:	*Humber Teaching NHS Foundation Trust*
Contact details (email, phone number):	
Date:	01/07/2026

Please complete these sections

		Assurance statement	Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes	The winter plan is within the 30th September Trust Board Papers for approval.	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	A QEIA is within the winter plan, which is within the 30th September Trust Board papers for approval.	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	There was a winter workshop with key stakeholders across the Trust to develop the Trust's winter plan. Good practice and Lessons Learnt have been incorporated into the 2026/27 HTFT Winter Plan from internal review and external system feedback.	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	HTFT representatives attended a Winter Planning Testing exercise on 17th September 2026.	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Claire Jenkinson, Interim Chief Operating Officer & Accountable Emergency Officer	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	Escalation processes in place across all areas and operational leadership.	

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

		Section B: 26/27 Winter Plan checklist	Please complete these sections Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	Our end of year data for 2025/6 for the Trust was 66% frontline staff. A 5% increase would be 71% of patient facing by the end of March 2026. 71% target by the end of November. This is to be achieved by maximising local peer vaccination a range of dedicated Occupational Health led drop-in clinics for personnel, and a strong clinically supported communication plan.	
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	As above	
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	Part of the divisonal elements to the winter resilience plan.	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	Part of the divisonal elements to the winter resilience plan.	
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	The introduction of routine Multi Agency Discharge Events oversees patient flow and discharge. These meetings incorporate local authorities to support the effective discharge of patients. Additional social work provided for Older Adult Services to improve patient flow and discharge.	
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: • coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	The introduction of routine Multi Agency Discharge Events oversees patient flow and discharge. These meetings incorporate local authorities to support the effective discharge of patients. Daily bed report and discharge planning is montiored.	
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	Part of the divisonal elements to the witner resilience plan.	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	N/A	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Embedded frailty pathways maximising holistic assessment and advance care planning.	
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	There has been a safer staffing review for the period of October 2025 to March 2026 and this has gone through QPAS, ODG and EMT.	
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Robust on call arrangements are in place, with Duty Managers in place at key times. Consultant, Director and Manager on call rotas 24/7. Daily attendance at System Calls takes place to understand the broader system and partner pressures.	
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	N/A Whilst this is primarily focussed on delivery by acute partners. HTFT have developed waiting list improvement plans that span the winter period for planned services.	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	The Trust focus is to reduce 52ww as at end of August to below 1% of the overall waiting list (exc Neurodiversity). This has been achieved at 0.7% across all Divisions and trajectories will further improve over the Winter period.	
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	Strengthen referral pathways with YAS, primary care, secondary care and HTFT community services through updated SOPs, refreshed communications and shared patient stories. Maintain bi-monthly YAS engagement to review pathway performance, share learning with the team	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	N/A Plans and escalation processes in place to support our acute colleagues.	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	N/A Plans and escalation processes in place to support our acute colleagues.	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	System Calls take place on a daily basis weekdays, with Director Calls stood up 7 days a week if required for escalation.	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	N/A Plans and escalation processes in place to support our acute colleagues.	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	Part of the divisonal elements to the winter resilience plan.	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	There was a winter workshop with key stakeholders across the Trust to develop the Trust's winter plan and IPC were a key stakeholder	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	Compliance rates have been achieved / exceeded in all areas deemed nationally and organisationally to be of high risk and we are therefore complaint against this ask. The plan over the next quarter is to enhance this position further to maintain staff safety.	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	There is an outbreak policy which is understood by all staff. IPC colleagues work closely with all staff.	
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	The Manager and Director on Call SOP has been reviewed and updated and robust arrangements are in place. A consultation is taking place to make recommended changes that will further enhance the resilience of the Manager on call rota. There is a Consultant on call rota in place for MH and Community	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	HTFT produce a daily sitrep report and this is supported by UEC RaidR reporting 7 days per week.	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	Mutual arrangements are in place across the Trust and wider health system.	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	Annual rolling programme in place for all Business Continuity Plans.	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	All Business Continuity Plans have adverse weather sections and there is a Trust Wide Adverse Weather Plan that has recently been reviewed.	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	Lessons are captured following industrial aciton and are incorprated into future inicidents.	
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	Continued access to occupational health/counselling/physio Health and Wellbeing offer enhanced and maintained	
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	Included in the mental health section mitigating actions within the Trust's winter plan. This includes increasing access to temporary staff l across the MH	
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes	Included in the mental health section mitigating actions within the Trust's winter plan. The Frequent Attender Service has developed mitigation plans for all patients who frequently access the service. Ongoing surveillance and	
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.	Yes	Liasion pathways and section 136 arrangements remain resilient heading into winter.	

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name:	Humber Teaching NHS Foundation Trust
Provider CEO name:	Michele Moran
Date reviewed:	
Provider Chair name:	Caroline Flint
Date reviewed:	

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)
Claire Jenkinson

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.
Confirmation that the SRO has reviewed this document and approved the responses.

Please confirm date reviewed

BAS Self-Assessment Dashboard

Trust		
	Overall Assessment Rating: 5 - Full assurance	
		Rating
Section B	Prevention	**5 - Full assurance**
	Flow, occupancy and discharge	**5 - Full assurance**
	Capacity and community	**5 - Full assurance**
	UEC Flow	**5 - Full assurance**
	Infection Prevention and Control (IPC)	**5 - Full assurance**
	Leadership and operational grip	**5 - Full assurance**
	Specific actions for Mental Health Trusts	**5 - Full assurance**

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 14

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Health Inequalities Trust Board Highlight Report September 2026
Author/s:	Sarah Clinch, Senior Partnerships and Strategy Manager Tess Owen, Partnerships and Strategy Officer
Recommendation:	

To approve		To discuss	
To note	✓	To ratify	
For assurance	✓		

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	This paper and the accompanying highlight report provide the Board with an update on progress made in addressing health inequalities.

Key issues:

Positive Assurances to Provide:

- The programme remains on track against the delivery plan.
- Significant progress has been made across multiple workstreams, including:
  - Finalising annual report HI data and conducting additional analysis of the Newbridges inpatient cohort
  - Delivering a workshop to the workforce teams to support completion of trauma informed self-assessments
  - Work in CAMHS to outreach to minority groups using champions roles
  - Reasonable Adjustment Policy has been reviewed by Trust and Divisional ODGs.
  - Citizens Advice Hull and East Riding have agreed to pilot supporting the Multi Agency Discharge Event
  - The programme is supporting the development of the Neighbourhood Mental Health Hub clinical model and wider neighbourhood working.

Key Actions Commissioned/Work Underway:

- Recognising and addressing health inequalities within our services and communities.
- Driving change at every level of the system.
- Health inequalities at the heart of our biggest programmes of change.
- Ensuring our communication and interactions are inclusive and welcoming to everyone.
- Tackling the broader social determinants of health.
- Collaborating closely with partners to maximise impact.

Key Risks/Areas of Focus:

- During this reporting period, the Health Inequalities Delivery Plan was refreshed following a review of progress during 2025/26.
- The refreshed delivery plan strengthens alignment with Care, Culture and Equity, neighbourhood health, prevention and population health priorities whilst maintaining a focus on reducing inequalities in access, experience and outcomes.
- See risk register

Decisions Made:

- No decisions requiring escalation have been made during this reporting period.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)

Hospital to Community	Community based, neighbourhood health models will be a key delivery mechanism for future work to address health inequalities.

Caring, Learning
& Growing Together

Analogue to Digital	Use of Trust and population health data continues to support and inform the programme.
Sickness to Prevention	A preventative approach to addressing health inequalities underpins the programme, due to our strong focus on the wider social determinants of health

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	26/08/26
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

✓ *Tick those that apply*

Innovating Quality and Patient Safety	✓
Enhancing prevention, wellbeing and recovery	✓
Fostering integration, partnership and alliances	✓
Developing an effective and empowered workforce	✓
Maximising an efficient and sustainable organisation	✓
Promoting people, communities and social values	✓

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	✓

Public Exemption:

Is the report exempt from public disclosure	No

HEALTH INEQUALITIES EMT/TRUST BOARD HIGHLIGHT REPORT		Period Covered:	March-August 2026		Project End Date	n/a
Project Name:	Health Inequalities	Project RAG Status:	Current:	G	Previous	G
Division:	Finance Division	Service Area:	Partnerships & Strategy			
Project Lead:	Sarah Clinch & Tess Owen	Project Ref:	N/A			

Work Area	RAG		Progress in this reporting period
	Current	Previous	
Understanding health inequalities in our services and communities			• Annual report data on health inequalities has been collated, reviewed with services and service level actions identified. These will be embedded within transformation programmes and service planning. • Analysis of the social circumstances of patients admitted to Newbridges has identified high prevalence of socioeconomic disadvantage, housing instability, relationship breakdown, unemployment and limited literacy skills among this cohort. The analysis will inform the development of Neighburhod Metal Health Hubs. • Preparatory work has commenced on the Workforce Health Inequalities Project, including discussions regarding workforce data, staff wellbeing and future priorities for reducing inequalities experienced by staff.
Change happens at all levels			• The first session of the East Riding Population Health Training Programme was delivered in June. HTFT will deliver Inclusion Health content later in the programme. • A Care, Culture and Equity workshop was delivered to the workforce teams to support completion of trauma informed self-assessments. • Initial scoping has been undertaken regarding a Care, Culture and Equity Learning Hub to support sharing of learning and good practice. • Health Stars funding has continued to support projects addressing health inequalities, with work underway to evaluate the impact of funded projects on patient outcomes and experience.
Health inequalities at the heart of our biggest programmes of change			• Discussions regarding transitions and access to support for children and young people have continued. The group has initiated work in minority groups using champions roles and monitoring uptake of support. • Children's Therapies are leading a project on resource allocation informed by DNA/population health data. • The DNA and Health Inequalities project has transitioned into business-as-usual reporting, with dashboards now available to support improvement work and service transformation. • Community service teams continue to explore use of deprivation and activity data to inform service redesign and resource allocation. • An Access Policy Task and Finish Group has been established to review content, identify gaps and support development of a draft policy.
The way we communicate and interact with patients and service users is welcoming to all			• The Trauma Informed Language Guide has been finalised and is preparing for publication. • The Translation and Interpretation procurement process entered the standstill period week commencing 10/08/26 and contract award is imminent • The Reasonable Adjustment Policy has been reviewed by Trust and Divisional ODGs. • Development of the patient information Leaflet Library has progressed from testing to launch planning, with content being prepared and uploaded ahead of go-live.

The way we deliver care supports health equity			• Discussions have taken place regarding use of DIALOG+, personalised care approaches and outcome measures to better recognise wider determinants of health. • Meetings have been held with Learning Disability and Forensic services to understand how social needs e.g. financial difficulties, are reflected within assessments, care planning and discharge planning. • Care, Culture and Equity communications materials and podcasts have been launched across the Trust.
Tackling the wider causes of inequality			• QI pilot on Avondale on access to support from Citizens Advice Hull and East Riding is progressing well, with steady referrals and work underway to develop a data-sharing agreement. • Citizens Advice Hull and East Riding have agreed to pilot supporting the MADE group for one year using their Health Inequalities funding, to help reduce delayed discharges. • The SMI Health Check audit has been completed and findings are being linked into delivery of the Physical Health Strategy. • Community MH Grants Scheme continues to support local projects addressing health inequalities. 53 applications have been received and reviewed, with 42 grants awarded totalling £187,667.
Working with partners			• The health inequalities programme is supporting the development of the Neighbourhood Mental Health Hub clinical model and wider neighbourhood working. • Discussions have taken place with Practice Plus Group (Reconnect) regarding prison release pathways, continuity of care and opportunities to strengthen joint working arrangements.

Key Risks / Issues / Late Tasks	Risk Rating		Actions to Mitigate Risk
	Current	Previous	
Capacity of the BI team to support data analysis for HI work	Moderate	Moderate	BI are actively involved in Care, Culture and Equity meetings and reviewing data requirements. Strong support from BI to incorporate HI metrics in PowerBI dashboards
Items for escalation: None			

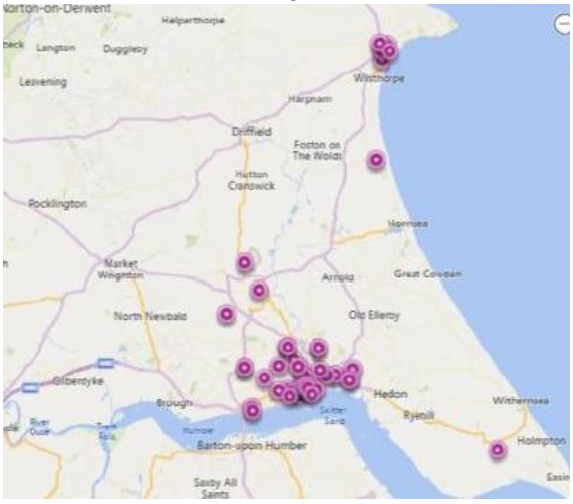
Community Mental Health Grants

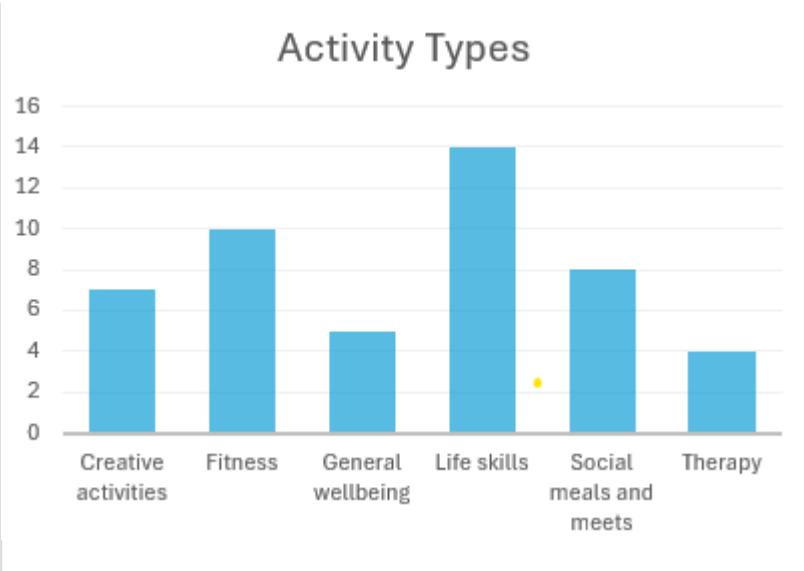
53 applications received and reviewed

42 grants awarded

Total awarded £187,667.

Location of activity





Humber Teaching NHS Foundation Trust

Agenda Item 15

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Care Quality Commission Assurance Report
Author/s:	Sam Faine, Head of Nursing, Physical Health and Assurance Sarah Smyth, Executive Director of Nursing, Quality and Professions
Recommendation:	

To approve		To discuss	√
To note		To ratify	
For assurance	√		

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	To provide the Trust with assurance regarding the Trust's preparedness for CQC inspection, progress against regulatory actions, and the effectiveness of arrangements in place to monitor and drive continuous quality improvement.

Key issues:

Positive Assurances to Provide:

- Well-Led readiness reviews underway.
- Mock Well-Led inspection completed.
- Inspection action plans in place and monitored.
- Regular CQC engagement meetings established.
- Six mock inspections completed, providing assurance regarding leadership, quality, safety and regulatory readiness.
- Learning from inspections is being shared and embedded.
- Forward mock inspection programme in place to support readiness.
- Governance arrangements provide oversight of improvement actions.
- Continued focus on regulatory compliance and quality improvement.
- Robust arrangements are in place to support regulatory compliance, inspection readiness and quality improvement. Adult Community Mental Health Services remains the principal area requiring enhanced oversight.
- Quality Committee oversight of CQC assurance

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Delivery of CQC inspection actions.
- Well-Led readiness review and improvement work.
- Ongoing mock inspection programme.
- Development of the Well-Led briefing pack.
- Monitoring of inspection action plans through governance processes.
- Environmental and estates improvements in inspected services.
- Embedding learning from inspections and mock inspections.
- Preparation for anticipated future CQC inspections.

Key Risks/Areas of Focus:

- Delivery of focus work relating to the Adult Community Mental Health Services

Decisions Made:

- Continued oversight of CQC inspection action plans through existing governance arrangements.

• Completion of outstanding CQC inspection actions. • Timely implementation of environmental and estates improvements. • Embedding learning and improvement from inspections and mock inspections. • Managing system and partnership challenges that impact patient flow and care quality.	• Development of a Well-Led briefing pack to support inspection readiness. • Bi-monthly CQC Engagement Meetings. • Continued focus on organisational readiness for anticipated CQC activity from October 2026. • The report has been strengthened after discussion at EMT to include the approach to prioritisation of the mock inspections and robust assurance statements. The Board can take assurance that the Trust has robust arrangements in place to monitor regulatory compliance, deliver improvement actions and maintain organisational readiness for future CQC assessment. The Trust remains well positioned to respond to anticipated regulatory activity, with Adult Community Mental Health Services continuing to receive enhanced executive oversight due to outstanding risks identified through the national inspection programme.
Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	Robust arrangements are in place to support regulatory compliance, inspection readiness and quality improvement. Adult Community Mental Health Services remains the principal area requiring enhanced oversight.
Analogue to Digital	Uses triangulated intelligence, performance data and governance processes to identify risk, target assurance activity and support inspection readiness.
Sickness to Prevention	Supports early identification of quality, safety and regulatory risks, enabling proactive intervention, quality improvement and prevention of avoidable harm.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	08.09.26
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	√
Enhancing prevention, wellbeing and recovery	√
Fostering integration, partnership and alliances	√
Developing an effective and empowered workforce	√
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	√

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	

Public Exemption:

Is the report exempt from public disclosure	Yes/No

CQC Assurance Report – September 2026

1.0 Executive Summary

This report provides an update on Care Quality Commission (CQC) activity, inspection readiness and improvement work across the Trust.

The Trust has continued to strengthen its assurance arrangements through an Internal Audit review of Well-Led readiness, a Trust-wide mock Well-Led inspection, development of a Well-Led briefing pack and delivery of a structured mock inspection programme aligned to the CQC Single Assessment Framework. These activities provide assurance regarding governance, leadership and regulatory preparedness, whilst identifying opportunities for further improvement.

Inspection action plans are in place for all completed CQC inspections, with progress monitored through established governance arrangements. The Trust also continues to await the final report following the Community Mental Health Team inspection undertaken as part of the national inspection programme.

Following the inspection of Adult Community Mental Health Services in March 2026, feedback identified areas requiring improvement relating to oversight of patients awaiting treatment and physical health monitoring. A comprehensive improvement programme has been implemented, with progress subject to enhanced executive oversight and monitored through established governance arrangements ahead of anticipated further regulatory activity from October/November 2026.

Six mock inspections were completed during the reporting period, identifying significant strengths in leadership, culture, multidisciplinary working and patient-centred care. Common improvement themes included governance consistency, documentation quality, operational oversight, communication and partnership working.

Assurance Statement

The Board can take assurance that the Trust has robust arrangements in place to monitor regulatory compliance, deliver improvement actions and maintain organisational readiness for future CQC assessment. The Trust remains well positioned to respond to anticipated regulatory activity, with Adult Community Mental Health Services continuing to receive enhanced executive oversight due to outstanding risks identified through the national inspection programme.

2.0 Current CQC Position

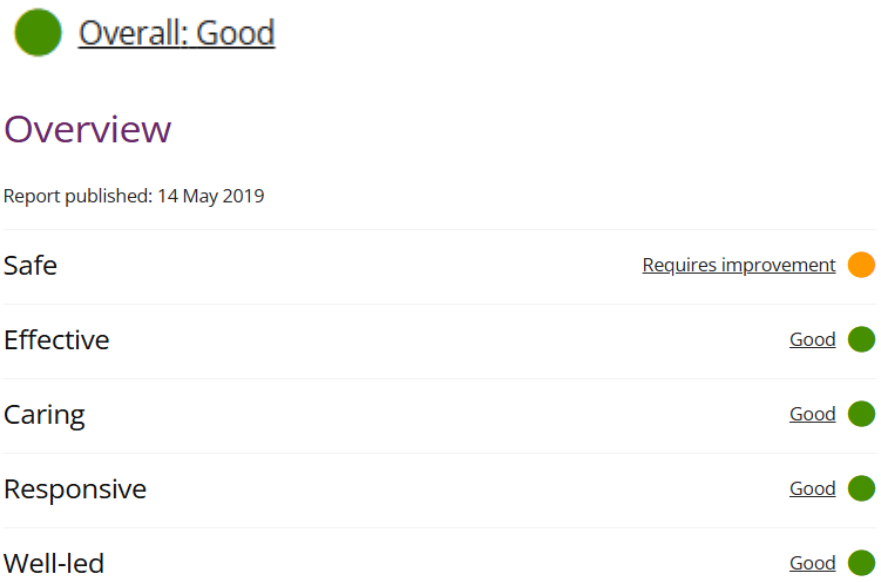
The Trust continues to strengthen organisational preparedness for regulatory assessment through a programme of internal assurance, mock inspection activity and targeted improvement work.

An Internal Audit review of Well-Led readiness is currently underway, providing independent assurance regarding governance, leadership, quality oversight and regulatory compliance arrangements. In addition, a Trust-wide mock Well-Led inspection has been completed to assess performance against the CQC Single Assessment Framework and identify opportunities for further improvement. Findings from both activities are informing organisational development plans and enhancing inspection readiness.

To support consistency of approach, a Well-Led briefing pack is being developed which brings together key evidence, performance information, governance arrangements and examples of impact. This will support services and senior leaders in demonstrating compliance with the characteristics of a well-led organisation and provide a consistent evidence base for future regulatory activity.

Assurance Statement

The Board can take assurance that a range of internal assurance mechanisms are in place to assess organisational readiness, identify areas for improvement and strengthen preparedness for future CQC assessment activity.



3.0 Recent CQC Activity

The following are all the inspections completed using the Single Assessment Framework:

- Adult community mental health team (as part of the national inspection programme) – inspected 17th to 31st March 2026, awaiting report.
- Mental health crisis services and health-based places of safety (as part of the national inspection programme) – inspected 17th to 31st March 2026, report published 13th July 2026 **GOOD**
- Wards for people with learning disabilities or autism – inspected 11th to 12th November 2025, report published 13th March 2026 **GOOD**
- Child and adolescent mental health wards – inspected 4th and 5th February 2025, report published 9th May 2025 **GOOD**

The Trust maintains oversight of all changes to CQC registration and regulatory requirements, ensuring that new services, locations, regulated activities and organisational changes are assessed, approved and implemented in line with statutory obligations and the Fundamental Standards.

During this reporting period the following have been submitted to CQC:

April 2026 - Removal of Kings Street Medical Centre and Humber Primary Care due to transfer to new provider.
August 2026 - Removal of Market Weighton Practice due to transfer to new provider 1 October 2026

3.1. Inspection Action Plans

Updates on inspection action plans are reported through the Quality Standards Group, Executive Management Team, Quality Committee and bi-monthly CQC Engagement Meetings. These arrangements provide assurance that actions are progressing as planned, learning is embedded, risks are escalated appropriately and compliance with regulatory requirements continues to strengthen.

3.1.2. Townend Court – Summary of CQC Regulation Breach Action Plan

Following the CQC inspection, a comprehensive improvement plan has been implemented to address concerns relating to Regulation 9: Person Centred Care. The plan focuses on three key areas:

- Improving the care environment.
- Strengthening consistency of staff practice.
- Enhancing the quality and implementation of care plans and Positive Behaviour Support (PBS) plans.

Progress is monitored through established governance arrangements, with several actions completed and the remaining actions on track for delivery by October 2026. Environmental improvements, workforce development initiatives and care planning enhancements are being implemented to support delivery of person-centred care and improve patient experience.

Whilst good progress has been made, completion of some environmental improvements remains ongoing. This is being actively monitored through the action plan governance arrangements.

A programme of audit, quality assurance and patient feedback has been established to monitor progress and provide assurance that improvements are embedded and sustainable.

Assurance Statement

The Board can take assurance that actions to address the Regulation 9 breach are progressing, with improvements evident across the care environment, staff practice and care planning arrangements. Progress against capital plans are the principal delivery dependency for the completion of outstanding environmental actions.

3.1.3. Health Based Places of Safety

Following the CQC National Inspection Programme of Community Mental Health Services, which included Health Based Places of Safety (HBPoS), a regulation breach was identified in the report for the Crisis Services and HBPoS service group. As these concerns had been identified through a Mental Health Act inspection, undertaken as part of the same inspection on the HBPoS, the CQC agreed that the Provider Action Response Statement, action plan would be used rather than requiring a separate improvement plan.

A six-point action plan was developed following the Mental Health Act inspection. Progress is overseen through established governance arrangements, with four actions completed, two actions in progress. Improvements have focused on enhancing the patient environment, improving patient experience and strengthening operational arrangements within the service.

The principal outstanding actions relate to improving patient access to fresh air and addressing system-wide delays in Mental Health Act assessments. Delivery remains dependent on a new operational model to support patients to have fresh air when appropriate, additional Approved Mental Health Professional (AMHP) capacity and wider system partner support. These risks continue to be monitored through the Section 136 Steering Group and established governance arrangements.

Assurance Statement

The Board can take assurance that the majority of actions have been completed, and improvements have been made to the patient environment and experience. The remaining actions are understood, subject to active oversight and are primarily dependent upon wider systems, partnerships and operational solutions.

3.2. Community Mental Health Teams – CMHT

The Trust is awaiting the draft report for the 'Working Age Adults' service group which covers the Community Mental Health Teams from the Care Quality Commission (CQC) following the inspection undertaken as part of the national Community Mental Health inspection programme. Whilst verbal feedback was received during the inspection process, the formal draft report has not yet been issued. Upon receipt, the report will be reviewed in detail and any recommendations incorporated into existing improvement plans and governance arrangements.

Initial feedback identified areas requiring improvement relating to the oversight of patients awaiting treatment or intervention and the monitoring of physical health for individuals prescribed medication within Adult Community Mental Health Services.

The Trust has undertaken a comprehensive review and implemented an improvement programme to address these findings. This has included strengthening governance and oversight arrangements, enhancing monitoring and assurance processes for patients awaiting treatment, and improving physical health monitoring and follow-up arrangements. Progress is subject to enhanced executive oversight, including weekly reporting to the Executive Management Team (EMT), to support delivery and sustainability of improvements.

Assurance Statement

The Board can take assurance that the concerns identified through the inspection process have been recognised and are being actively addressed through a comprehensive improvement programme. Progress is being closely monitored through established governance arrangements, although Adult Community Mental Health Services remains the principal area requiring enhanced oversight pending receipt of the final CQC report.

3.3. CQC Notifications

The Trust has robust processes in place to ensure statutory notifications are submitted to the Care Quality Commission (CQC) in accordance with regulatory requirements. Notification activity is

monitored through established governance arrangements to ensure submissions are timely, accurate and complete.

During the reporting period, four statutory notifications were submitted to the CQC. All notifications were submitted within required timescales, and no concerns were raised regarding compliance with notification requirements.

Assurance Statement

The Board can take assurance that statutory notification requirements are being met and that appropriate governance arrangements are in place to monitor compliance and identify learning opportunities.

3.4. CQC Enquiries and MHA Complaints

The Trust continues to monitor enquiries received from the CQC and complaints received through Mental Health Act processes. Themes, risks and learning opportunities are reviewed through established governance arrangements to support quality improvement, regulatory compliance and organisational assurance.

No significant themes or concerns requiring escalation to Board level were identified during the reporting period.

Assurance Statement

The Board can take assurance that processes are in place to review, respond to and learn from CQC enquiries and Mental Health Act complaints.

3.6. MHA Inspections

The Trust did not receive any Care Quality Commission Mental Health Act monitoring visits or inspections during the reporting period. Arrangements remain in place to monitor compliance with Mental Health Act requirements and support inspection readiness.

Assurance Statement

The Board can take assurance that no Mental Health Act inspections were undertaken during the reporting period and that existing governance arrangements continue to oversee compliance with statutory requirements.

4.0 CQC Engagement

The Trust has established an eight-weekly CQC Engagement Meeting to provide oversight of regulatory assurance, inspection readiness, quality improvement activity and progress against inspection outcomes. The meeting brings together Executive Directors, service leads and corporate colleagues to review regulatory developments, emerging risks, progress against action plans and organisational preparedness for future CQC activity.

The forum provides a mechanism for monitoring delivery of inspection actions, reviewing evidence of improvement, sharing learning and escalating risks where additional support or intervention is required. Progress against key CQC priorities, including inspection readiness and regulatory actions, is subject to regular review and challenge.

Through this approach, the Trust maintains effective oversight of regulatory compliance, strengthens organisational accountability and supports continuous improvement across services.

Assurance Statement

The Board can take assurance that robust governance arrangements are in place to oversee regulatory compliance, monitor improvement actions, identify emerging risks and maintain organisational readiness for future CQC activity.

5.0 Mock Inspection Programme

The Trust has implemented a structured mock inspection programme to provide assurance regarding CQC readiness and support continuous quality improvement. Inspections are prioritised using a risk-based methodology, focusing on services not recently inspected, areas supporting vulnerable patient groups, and services where available intelligence indicates a need for additional scrutiny or support. This approach aligns with the CQC's own risk-based methodology for prioritising regulatory activity.

Prioritisation is informed through triangulation of quality, safety, patient experience, workforce and performance intelligence, including incidents, complaints, safeguarding concerns, staffing metrics, freedom to speak up themes, risk register entries, regulatory activity and findings from internal and external reviews. This enables the Trust to identify emerging risks, target assurance activity and provide focused support where assurance is limited.

Using the CQC Single Assessment Framework, mock inspections include review of evidence, observation of practice and feedback from patients, carers and staff. Findings are reported through the Quality Standards Group and Executive Management Team, with improvement plans developed where required. Progress is monitored through established governance arrangements, with organisational themes, learning and examples of good practice used to strengthen quality improvement and inspection readiness across the Trust.

Assurance Statement

The Board can take assurance that the mock inspection programme provides a robust and intelligence-led approach to assessing service quality, identifying risks, supporting improvement and strengthening organisational readiness for future CQC assessment activity.

5.1. Activity Undertaken

During the reporting period from 1 April to 31 August 2026, six mock inspections were completed using the CQC Single Assessment Framework, including review of quality statements, evidence categories and patient experience. These inspections were undertaken across mental health, learning disability and community services.

- Newbridges
- Fitzwilliam Ward, Malton
- Whitby Inpatient Unit
- Community Based Mental Health Services for Older People
- Ullswater/Derwent
- Scarborough Community Nursing

Reports from two services have been reviewed through the Quality Standards Group, with the remaining reports progressing through divisional governance arrangements and informing organisational learning and improvement activity.

5.2 Key Findings from Mock Inspections

The mock inspections provided assurance regarding the quality, safety and leadership of services inspected. Common strengths identified across services included:

- Visible and supportive leadership.
- Positive team culture and staff engagement.
- Effective multidisciplinary working.
- Patient-centred care and discharge planning.
- Strong commitment to quality improvement.
- Good governance awareness and incident learning.

Common improvement themes identified included:

- Consistency of documentation and record keeping.
- Governance oversight and assurance processes.
- Medicines management controls.
- Communication with patients, carers and partners.
- Staff understanding of key operational processes.
- Escalation pathways and role clarity.
- Partnership working and patient flow.
- Consistency of supervision and assurance arrangements.

Improvement plans have been developed for all inspections, with progress monitored through divisional governance arrangements and reported through the Quality Standards Group and Executive Management Team.

Assurance Statement

The Board can take assurance that the mock inspection programme continues to identify both good practice and opportunities for improvement, with recurring themes informing Trust-wide quality improvement and CQC preparedness activity.

5.4. Learning from Mock Inspections

Learning from mock inspections is systematically captured and shared through governance forums, leadership groups and quality improvement processes. Findings are used to identify organisational themes, spread good practice and target improvement activity ahead of external regulatory assessment.

To further strengthen assurance, the Trust is developing a triangulated approach that brings together findings from mock inspections, clinical audit and peer review activity. This will provide a more comprehensive assessment of service quality and support a consistent, evidence-based approach to quality improvement and CQC readiness.

Assurance Statement

The Board can take assurance that learning from mock inspections is being embedded into organisational improvement activity and is contributing to a more robust and triangulated approach to quality assurance.

5.5. Mock Inspection Forward Plan

The forward plan will continue to be delivered on a risk-based basis, focusing on services where assurance is limited, areas supporting vulnerable patient groups, and services identified through quality, safety and performance intelligence. The programme aims to strengthen organisational preparedness, facilitate shared learning and provide ongoing assurance regarding quality, regulatory compliance and readiness for future CQC activity.

The programme will be monitored through established governance arrangements and reviewed regularly to ensure inspection activity remains aligned to organisational priorities and emerging risks.

Assurance Statement

The Board can take assurance that a forward programme of mock inspections is in place to support continuous improvement and organisational readiness for future regulatory activity.

6.0 Quality Standards Group

The Quality Standards Group (QSG) is a formal subgroup of the Quality and Patient Safety Group (QPAS) and provides oversight of the Trust's compliance with the CQC Single Assessment Framework and Fundamental Standards. The group coordinates self-assessment activity, evidence review and assurance processes across the Safe, Effective, Caring, Responsive and Well-Led domains.

A key function of the group is to provide triangulated assurance by bringing together intelligence from mock inspections, clinical audit, peer review, NICE guidance reviews, benchmarking and other quality assurance activities. This supports the identification of good practice, emerging risks and areas requiring improvement.

The group also oversees CQC registration requirements and horizon scanning of inspection findings and national regulatory themes, ensuring that learning is incorporated into local improvement activity. Where gaps in compliance or assurance are identified, these are escalated through established governance arrangements.

Assurance Statement

The Board can take assurance that robust governance arrangements are in place to coordinate CQC compliance activity, triangulate sources of assurance, identify emerging risks and support organisational readiness for future regulatory assessment.

7.0 Board and Staff preparation

A comprehensive programme of CQC preparedness has been delivered across the Trust to strengthen understanding of the CQC Single Assessment Framework and support organisational readiness for assessment. This has included Board development sessions, leadership briefings, assurance discussions and engagement across divisional and corporate governance forums. Services have also completed self-assessments against the CQC Quality Statements to identify strengths, areas for development and opportunities for improvement.

To support staff readiness, guidance and resources have been made available through the Trust intranet, including information relating to the Single Assessment Framework, evidence requirements, inspection readiness and examples of good practice. Supporting sessions have also been delivered through leadership development programmes, preceptorship and student learning initiatives.

These activities have strengthened awareness of regulatory expectations, improved understanding of quality standards and supported staff and leaders to articulate how their roles contribute to the delivery of safe, effective, caring, responsive and well-led services.

Assurance Statement

The Board can take assurance that a structured programme of organisational preparedness is in place, supporting staff and leaders to understand regulatory expectations, contribute to inspection readiness and maintain a culture of continuous quality improvement.

8.0 Resources/ Policies

To strengthen regulatory compliance and support a consistent organisational approach to engagement with the Care Quality Commission (CQC), the Trust has implemented a CQC Processes Standard Operating Procedure and a CQC Inspection Response Plan. These documents clearly define organisational roles, responsibilities, escalation arrangements and processes for managing routine regulatory engagement, inspections and assessment activity.

Together, these arrangements support organisational preparedness, provide a consistent framework for regulatory engagement and strengthen the Trust's governance arrangements for managing CQC activity.

Assurance Statement

The Board can take assurance that formal policies and processes are in place to support consistent, effective and well-governed engagement with the CQC and future inspection activity.

9.0 CQC updates

The Trust maintains regular engagement with the Care Quality Commission (CQC) through routine meetings with the allocated inspector, participation in national and regional engagement events, and ongoing review of regulatory publications and guidance. These activities support early awareness of emerging regulatory expectations, assessment developments and national learning.

Intelligence gathered through these activities is shared through governance structures and leadership forums to inform local quality improvement activity, inspection preparedness and organisational assurance.

Assurance Statement

The Board can take assurance that arrangements are in place to maintain awareness of regulatory developments, strengthen organisational preparedness and ensure emerging learning is reflected in local quality improvement activity.

10.0 Conclusion

The Trust continues to maintain a proactive and structured approach to Care Quality Commission (CQC) assurance, inspection readiness and continuous quality improvement. Significant progress has been made in strengthening organisational preparedness through internal assurance reviews, delivery of a comprehensive mock inspection programme, ongoing engagement with the CQC and robust oversight of inspection action plans.

Progress has been demonstrated in addressing findings arising from previous inspections, with action plans established across relevant services and monitored through service, divisional and corporate governance arrangements. Mock inspections continue to provide valuable assurance regarding the quality and safety of services, identifying significant strengths in leadership, culture, multidisciplinary working and patient-centred care, whilst also highlighting areas where further improvement is required.

The principal area requiring enhanced oversight remains Adult Community Mental Health Services, where improvement actions continue to be delivered in response to concerns relating to waiting list oversight and physical health monitoring. Progress is being closely monitored through enhanced governance arrangements ahead of anticipated further regulatory activity and receipt of the final CQC inspection report.

The key priorities for the next quarter are delivery of the Adult Community Mental Health Services Improvement Programme, strengthening Well-Led readiness, responding to any findings arising from outstanding inspection reports, embedding learning from mock inspections and continuing to develop a triangulated approach to organisational assurance.

Overall Assurance Statement

The Board can take assurance that effective arrangements are in place to support regulatory compliance, inspection readiness, delivery of improvement actions and continuous quality improvement across the Trust. Whilst a number of actions remain in progress, particularly within Adult Community Mental Health Services and areas dependent upon estates improvement or wider system partners, governance arrangements provide confidence that risks are understood, monitored and subject to appropriate oversight.

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 16

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Model Hospital – Productivity and Efficiency
Author/s:	Peter Beckwith - Executive Director of Finance Adam Copley-Martin - Costing Accountant

Recommendation:

To approve		To discuss	
To note	✓	To ratify	
For assurance	✓		

Purpose of Paper:
Please make any decisions required of Board clear in this section:

The purpose of this report is to provide the Trust Board with an analysis of the information currently reported in Model Hospital for Trust under the banner of Productivity and Efficiency.

Key issues:

Positive Assurances to Provide:

- Total Contacts per business day for clinical staff in community nursing at 6.1 remains higher than peer and national average.
- Temporary Staffing Costs at 5.9% falls within the green category based on model hospital ratios.
- Estates and Facilities cost per m2 benchmark strongly compared to peers.
- Latest Employee Engagement Scores (via pulse survey) have improved and remain positive compared to peers and are upper quartile.

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- The Trust are seeking clarification from NHSE on methodology to determine Negative Productivity Growth Estimates.
- A programme of targeted interventions is being implemented to focus on tackling sickness, this is a collaboration between operational and people teams.
- Report continues to be updated with Trend information where available and appropriate

Key Risks/Areas of Focus:

- Negative Productivity Growth Estimates are in conflict with internal calculations.
- Sickness remains an area of focus for the Trust and has reduced from previous month but still higher than peer and national average

Decisions Made:

- The Trust Board are requested to note the content of the report and agree any areas where further assurance may be required.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)

Hospital to Community	The Trust performs well in relation to Average Length of Stay across Mental Health Inpatient units which should be seen as an enabler of the plan to shift from Hospital to Community Care
Analogue to Digital	No direct indicators can be aligned
Sickness to Prevention	No direct indicators can be aligned

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee	***Qtry***	Executive Management Team	***Mthly***
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail) Performance and Productivity	***Mthly***

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*	
Innovating Quality and Patient Safety	✓
Enhancing prevention, wellbeing and recovery	✓
Fostering integration, partnership and alliances	
Developing an effective and empowered workforce	✓
Maximising an efficient and sustainable organisation	✓
Promoting people, communities and social values	

Areas to include within the report:	
Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	X
Public Exemption:	
Is the report exempt from public disclosure	No

1 Introduction and Purpose

The purpose of this report is to provide the Trust Board with an analysis of the information currently reported in Model Hospital for the Trust under the banner of Productivity and Efficiency.

The Trust Board are asked to note the information that is currently being reported and agree any areas where further assurance or benchmarking may be appropriate.

2 Background

The NHS Model Hospital (*which now forms part of the Model Health System*) which is a digital tool for NHS providers in England, uses benchmarking to measure and improve productivity, quality, and efficiency.

The main principle of the Model Hospital is that it allows trusts to compare performance against peers and the national average, the idea being to identify areas for improvement, discover best practices and reduce unwarranted variation.

With the increased focus on productivity, NHS England has developed a 'Productivity and Efficiency' benchmarking metrics page, this presents up to 19 metrics across five different domains, all linked to productivity and efficiency.

Metrics were chosen following discussion with NHS Trusts and NHS England, however it should be noted that metrics should not be seen as targets but more a comprehensive picture of all drivers of productivity.

The 5 domains are summarised below, some of this information is currently not available for Mental Health or Community Trusts

- Headline Productivity
- Operational and Clinical Productivity
- Workforce Productivity
- Workforce Drivers
- Value for Money
- Quality

Work at NHS England is progressing to enhance the dashboard for Mental Health and Community Trusts, once these metrics have been agreed the intention is for them to be added to the dashboard to enable Trusts to identify potential opportunities to improve productivity.

3 Trust Dashboard

An extract from Model Hospital in relation to Productivity and Efficiency currently reports

One Indicator for Headline Productivity

Headline Productivity	Data period	Provider value	Peer average	National value	National value method	Chart
Productivity Growth Estimate (year-to-date compared to previous year)	Mar 2026	-10.5%	4.4%	5.1%	Provider median	

Two Indictors for Operational and Clinical Productivity

Operational and Clinical Productivity	Data period	Provider value	Peer average	National value	National value method	Chart
Average length of stay for adult mental health patients	Jun 2026	54.4	74.3	76.0	Provider median	
Average length of stay for mental health CYP beds	Jun 2026	37.0	82.8	82.8	Provider median	

One Indicator for Workforce Productivity

Workforce Productivity Custom benchmarking	Data period	Provider value	Peer average	National value	National value method	Chart
Workforce Productivity Growth Estimate (year-to-date compared to previous year)	Mar 2026	-7.5%	6.9%	6.1%	Provider median	

Eight headline indicators/Drivers for Workforce

Workforce drivers	Data period	Provider value	Peer average	National value	National value method	Chart
Overall Temporary Staff Spend as a % of Total Pay Spend	Jan 2026	5.9%	5.8%	0.0%	Benchmark value	
Registered Nurses: Sickness absence rate	Sep 2025	7.3%	6.4%	5.9%	Provider median	
Medical and Dental, Sickness absence rate	Sep 2025	3.0%	2.2%	2.1%	Provider median	
All Staff: NHS Turnover Rate	Jun 2026	13.1%	13.4%	13.5%	Provider median	
Care Hours per Patient Day - Registered Nurses and Midwives	Jun 2026	4.6	4.8	4.9	Provider median	
Total contacts per business day for clinical staff full time equivalent in community nursing	Mar 2026	6.1	5.9	5.3	Provider median	
Proportion of consultants with a job plan signed off by the clinical lead within the past 12 months	Dec 2025	81.6%	83.3%	85.0%	Provider median	
Proportion of SAS Doctors with a job plan signed off by the clinical lead within the past 12 months	Dec 2025	76.9%	79.6%	82.4%	Provider median	

One Indicator for Value for Money

Value for Money	Data period	Provider value	Peer median	Provider median	Chart
Estates & Facilities cost (£ per m2)	2024/25	£369.00/m2	£427.54/m2	£507.91/m2	

Two Indicators for Quality

Quality	Data period	Provider value	Peer average	National value	National value method	Chart
CQC Inspection Rating: Overall			Jun 2026	Good	Provider value	
Employee Engagement score	Q2 2026/27	6.7	6.3	6.4	Provider median	

4 Headline Productivity

4.1 Implied Productivity Growth (year-to-date compared to previous year)

Implied Productivity Growth is calculated by comparing output growth (*cost-weighted activity*) to input growth (*based on adjusted operating expenditure*) against a baseline period.

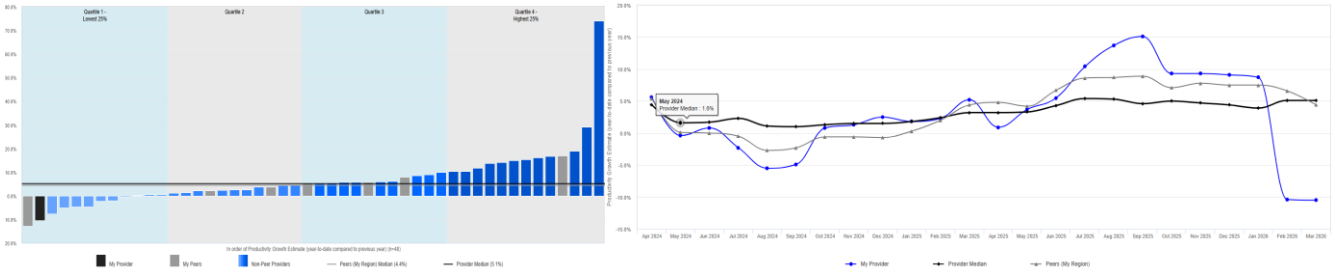
The measure examines the current year's YTD cost weighted activity and the resources used to generate the activity to the same period in the previous financial year.

- A negative value implies a decrease in productivity
- A positive value implies productivity growth.

The target is to see a positive year-on-year change in this value.

The most recent available data reported is March 2026 where the trust productivity growth was recorded as -10.5% (*February's performance was 8.8%)*. This compares with a peer median of 4.4% and National median of 5.1%, performance is summarised in the following graph for all providers

Implied Productivity Growth (March 2026)



The Trust has investigated the significant variance between the two periods to identify the factors that may have driven this percentage change.

Activity has increased year on year by 8% (Total contacts recorded on CSDS, MHSDS, IAPT, CDES and Emergency Med) and nothing was identified within the Provider Finance Return that would explain such a substantial movement (Year on Year cost increase was 2%).

The Trust has sought clarification from Model Hospital regarding this variance and requested further explanation of the factors contributing to the change (request sent on 30th July 2026). This has been followed up with Model Hospital, no response has been received at the time of writing this report.

5 Operational and Clinical Productivity

5.1 Average Length of Stay for Adult Mental Health Patients

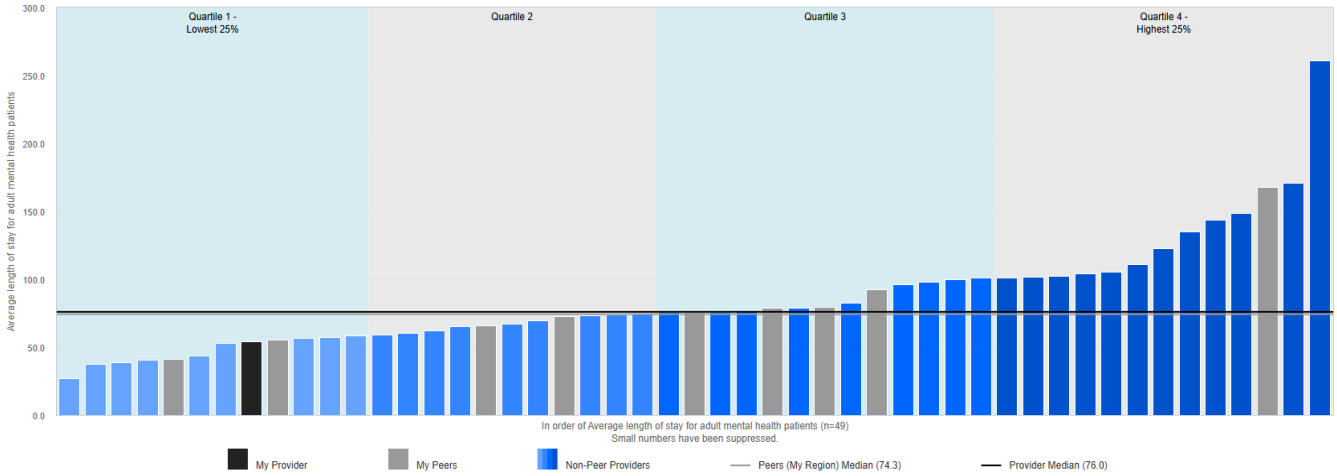
This represents the average (mean) number of days between an admission and discharge for adult patients that ended during the reporting period. This percentage can vary according to the complexity of the care required for the patients.

This gives an indication of the scale of the service which can be used for peer selection.

The most recent available data reported is June 2026 where the trust Average Length of Stay was 54.4 days (43.*3 days – May 2026*), compare with a peer median of 74.3 and provider median of 76.

Comparative performance with peers is summarised in the following graph for all providers

Average length of stay for adult mental health patients (June 2026)



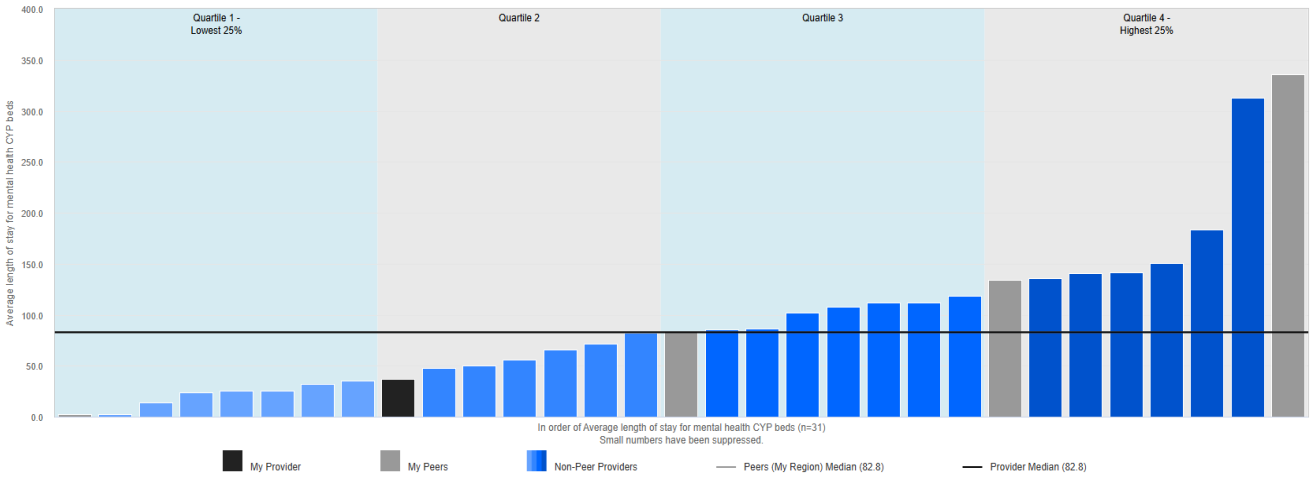
5.2 Average Length of Stay for Mental Health CYP Beds

This is the same calculation as in 5.1 but for Mental Health Children and Young people beds.

The most recent available data reported is June 2026 where the trust Average Length of Stay was 37 days (*43.3 days – June 2026*), compared with a peer median of 82.8 and provider median of 82.8.

Comparative performance with peers is summarised in the following graph for all providers

Average length of stay for mental health CYP beds (June 2026)



6 Workforce Productivity

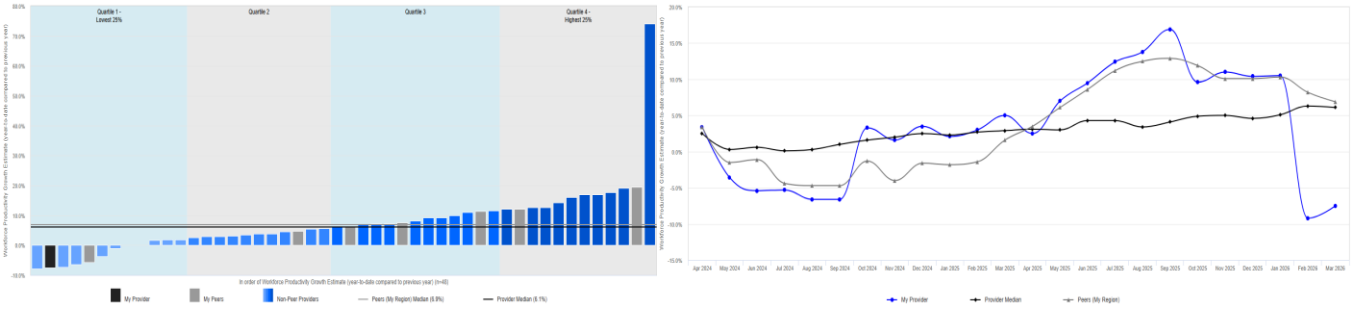
6.1 Implied Workforce Productivity Growth

Implied Workforce Productivity Growth is calculated by comparing output growth (cost weighted activity) to input growth (based on workforce) against a baseline period.

The measure examines the current year's YTD activity and workforce to the same period in the previous financial year. A negative value implies decreased productivity whilst a positive value implies productivity growth.

The most recent available data reported is March 2026 where the trust workforce productivity growth was recorded as -7.5% compared to 10.3% in February 2026. Peer median of 6.9% and National median 6.1%, performance is summarised in the following graph for all providers.

Implied Workforce Productivity Growth (March 2026)



The variance between the two periods here is linked to query that is outstanding with Model Hospital regarding Implied Productivity Growth in section 4.

7 Workforce Drivers

7.1 Overall Temporary Staff Spend as a % of Total Spend

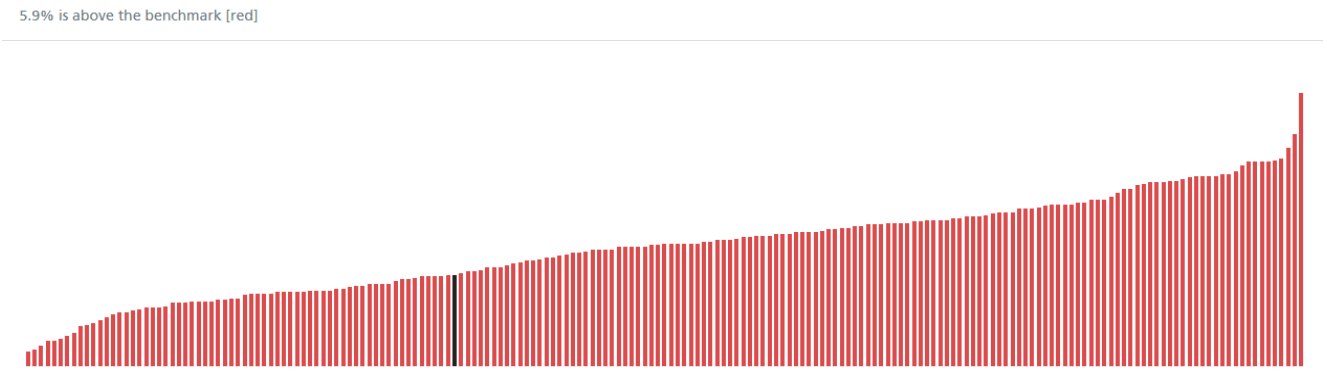
This metric is intended to highlight to organisations where they may be spending more on temporary staffing than others and should consider reducing the usage of temporary staffing as a whole, if possible.

Temporary staffing costs ideally should be kept to a minimum and the benchmark figures are set at the following values:

Green: 0 – 8.5%
Amber: 8.5 – 12%
Red: More than 12**%**

The most recent available data is January 2026 where the trust metric was recorded as 5.9.% (*was 6% in December 2025*), with a Peer median 5.8% but National Median/Benchmark currently missing (was 8.5% in Decembers data) performance is summarised in the following graph for all providers

Temporary Spend as a % of Total Spend (January 2026)



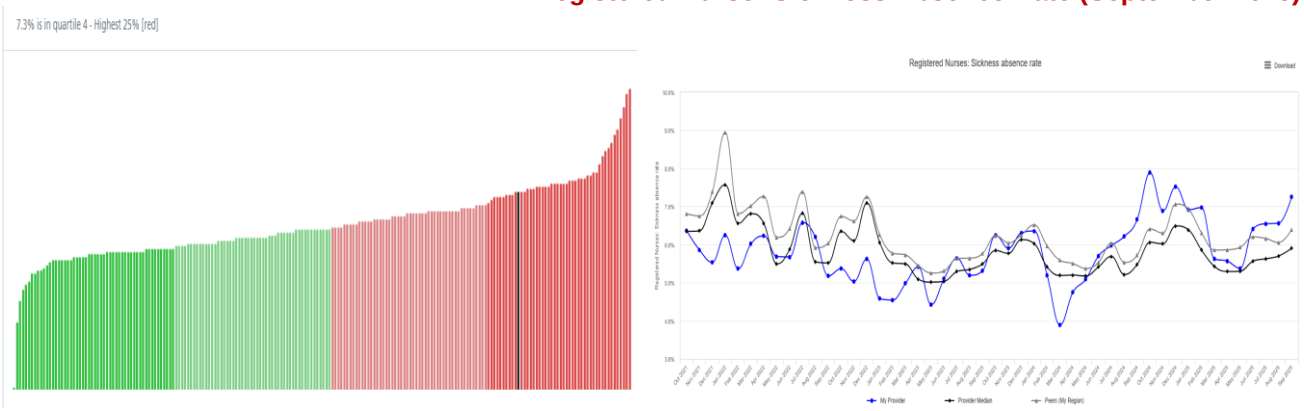
7.2 Registered Nurses: Sickness Absence Rates

This metric measures the percentage of Registered Nursing Staff sickness.

Reducing rates of sickness can have a positive impact on the efficiency of an organisation and patient care.

As at September 2025 the performance for the Trust was 7.3% (*6.6% in August 2025*) which is above both the peer median (6.4%) and the provider median (5.9%).

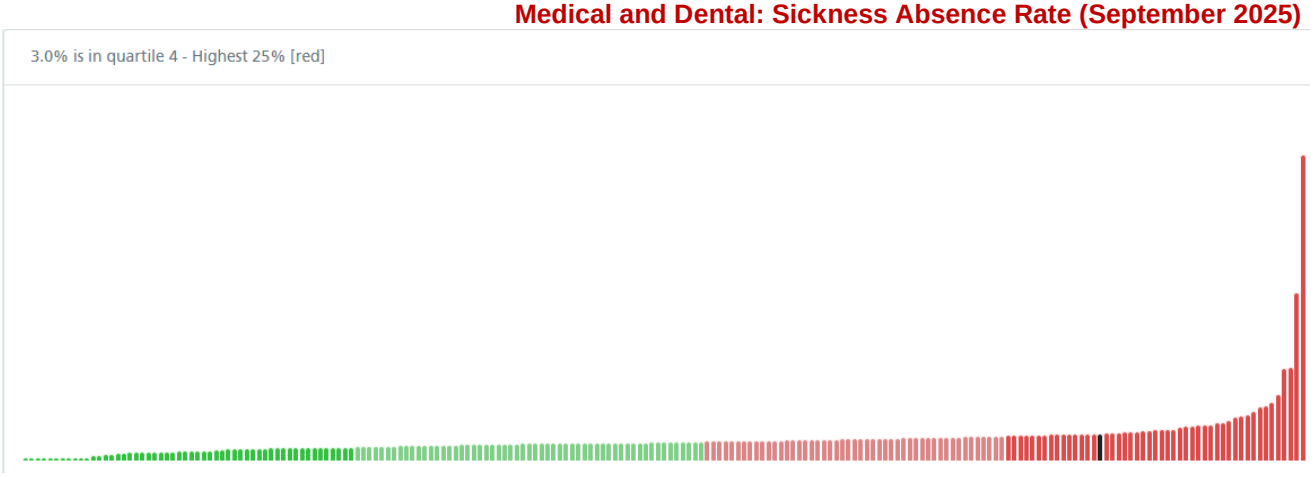
Registered Nurse: Sickness Absence Rate (September 2025)



7.3 Medical and Dental: Sickness Absence Rate

As at September 2025 the performance for the Trust was 3% (August 3.4%) which is above both the peer median (2.2%) and the provider median (2.1%).

Medical and Dental: Sickness Absence Rate (September 2025)



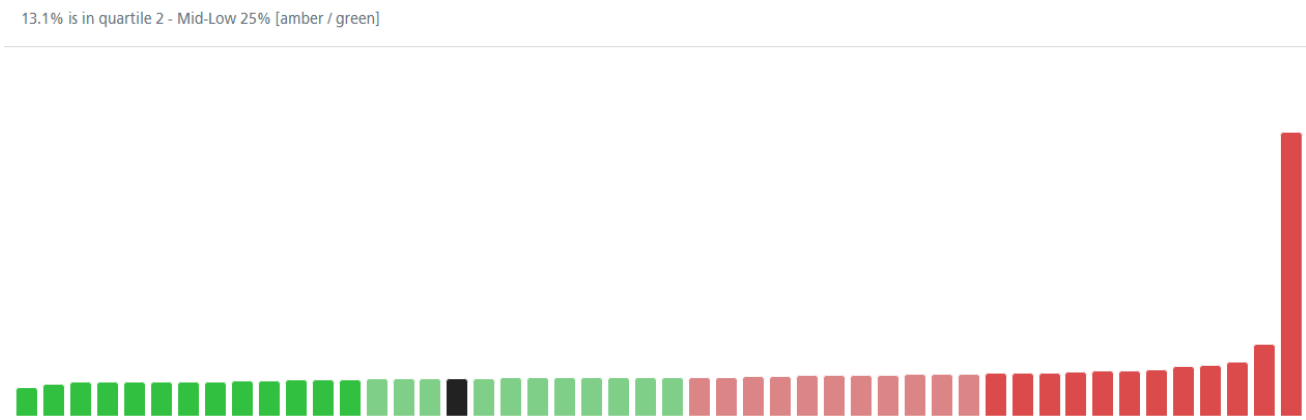
7.4 All Staff Turnover Rate

This metric measures the percentage of all staff that left an organisation to join another NHS organisation, or left the NHS over the previous 12 months.

A high turnover rate can present opportunities to explore the underlying reasons for staff departures, enabling management to implement effective retention strategies to mitigate the impact. It's important to note that turnover figures also include expected transitions, such as career progression, promotions, and voluntary resignations for personal or professional growth

As at June 2026 the performance for the Trust was 13.1% (*13.2% May*) which is comparable with peer median (13.4%) and provider median (13.5%).

All Staff: NHS Turnover Rate (June 2026)



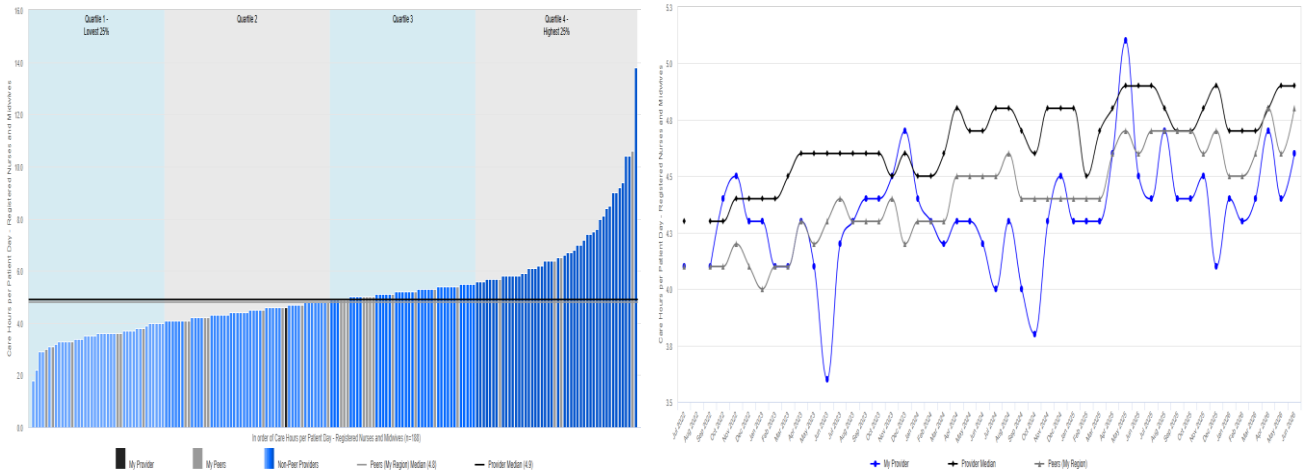
7.5 Care Hours per patient day

This metric measures the average number of actual registered nursing care hours spent with each patient per day to provide both a measure of ward level productivity and transparency on variation in staff to patient ratios across wards, specialties and organisations.

Very low rates may indicate a potential patient safety risk. Very high rates may suggest the organisation has several unproductive wards or inefficient staff rostering processes

As at June 2026 the performance for the Trust was 4.6 (*4.7 hours in May*), which is comparable with the peer median of 4.8 and provider median of 4.9 hours.

Care Hours per patient Day (Nurses and Midwives) (June 2026)



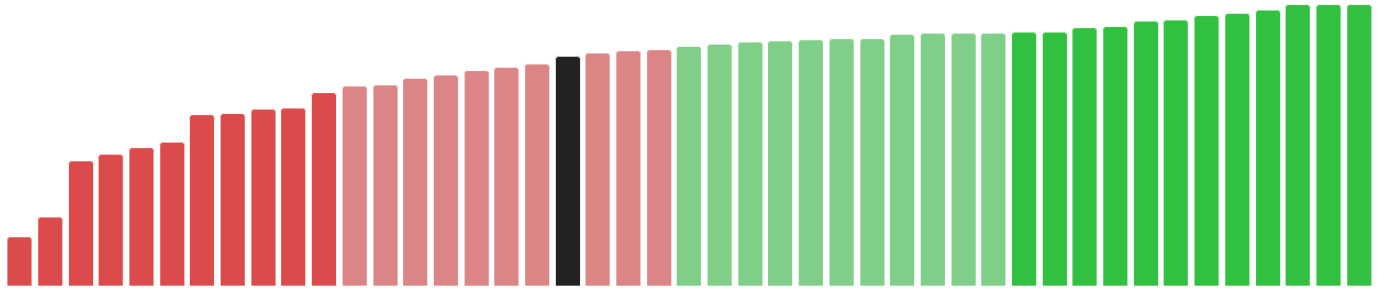
7.6 Proportion of consultants with a job plan signed off

This metric measures the percent of substantive consultants who have a job plan that has been reviewed, approved and signed off by the consultant and their clinical manger / service lead clinician or their nominee within the past 12 months

As at December 2025 the performance for the Trust was 81.6%, which compares to a peer median of 83.3% and provider median of 85.0%. (*The Trust March data recorded performance of 89% as per the PWR*).

Proportion of Consultants with a job plan signed off (December 2025)

81.6% is in quartile 2 - Mid-Low 25% [amber / red]



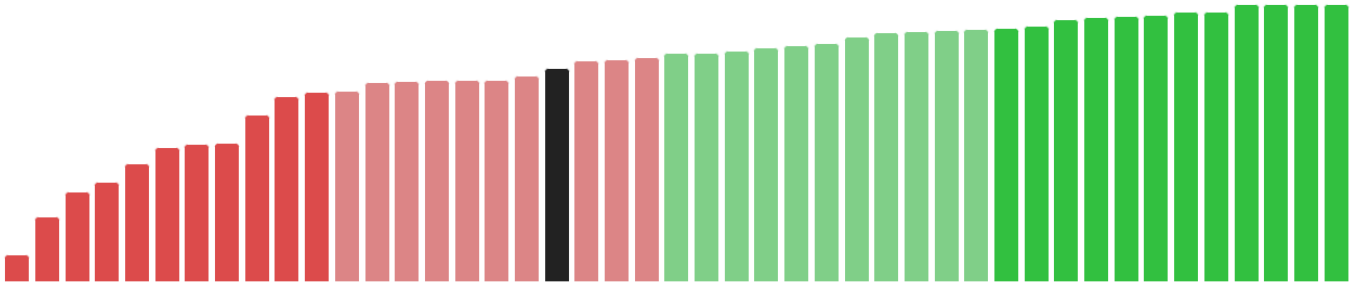
7.7 Proportion of SAS Doctors with a job plan signed off

The percent of SAS doctors who have a job plan that has been reviewed, approved and signed off by the doctor and their clinical manger / service lead clinician or their nominee within the past 12 month.

As at December 2025 the performance for the Trust was 76.9%, which compares to a peer median of 79.6% and provider median of 82.4%. (*The Trust March data recorded performance of 88% as per the PWR*).

Proportion of SAS Doctors with a job plan signed off (December 2025)

76.9% is in quartile 2 - Mid-Low 25% [amber / red]



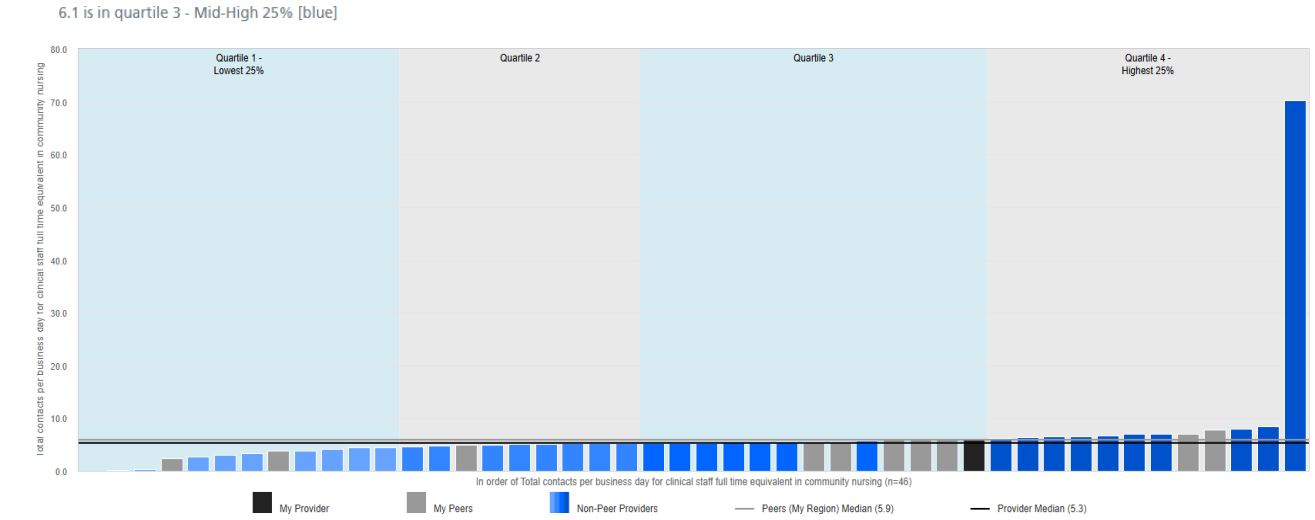
7.8 Total contacts per business day for clinical staff in community nursing

This indicator records the average number of contacts per clinical full time equivalent (FTE) per day in community nursing.

This gives an indication of the number of contacts a clinician carries out per day, accounting for different working patterns. A higher number indicates that clinical staff working in the service typically carry out more contacts each day than in similar services provided by other organisations

As at March 2026 the performance for the Trust was 6.1 (*Novembers performance 6.3*), which compares with a peer median of 5.9 and provider median of 5.3. Note, included in the numbers is one Trust that seems to have a data quality issue with 70 contacts per business day.

Total contacts per business day for clinical staff in community nursing (March 2026)



8 Non-Pay Efficiencies

8.1 Estates and Facilities Cost (£ per m2)

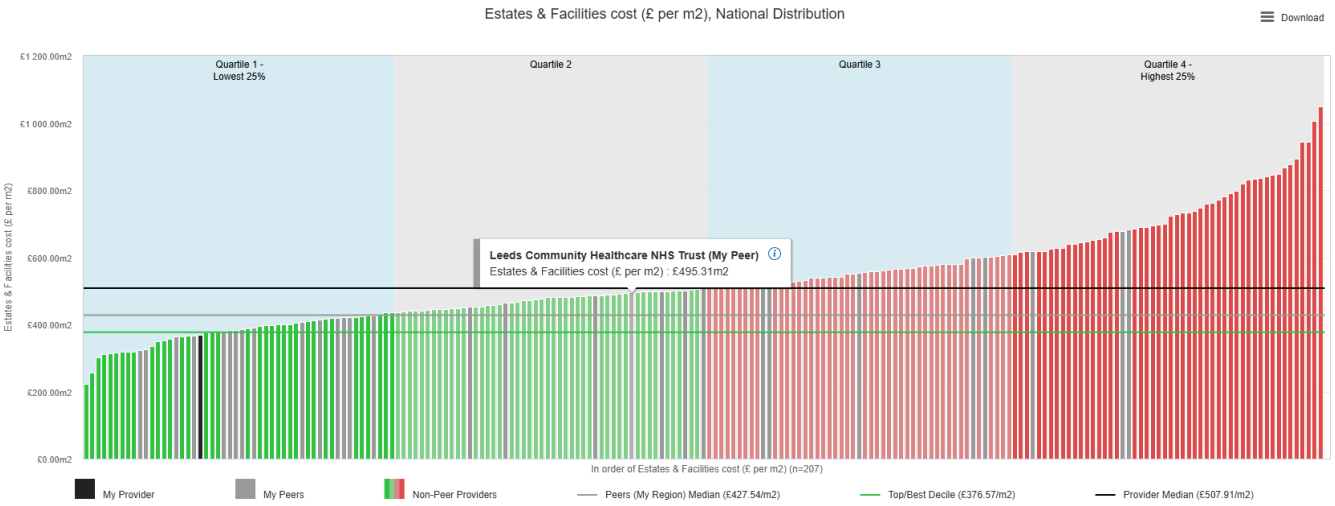
This metric compares the total estates and facilities running costs to the total occupied floor area and provides an indication of the cost efficiency of the estate (the higher the cost per m2, the lower the cost efficiency of the organisation).

The total estates and facilities running cost is the cost of running an NHS estate, including, staff and overhead costs. The total running costs consist of four parts:

- Hard Facilities Management (FM)
- Soft FM
- Management (Hard and Soft FM) costs
- Financing costs.

Information is taken from the Estates Return Information Calculation (ERIC) and is as at the end of March 2025.

Estates & Facilities cost (£ per m2 - 2024/25)



9 Quality

9.1 CQC Inspection Rating Overall

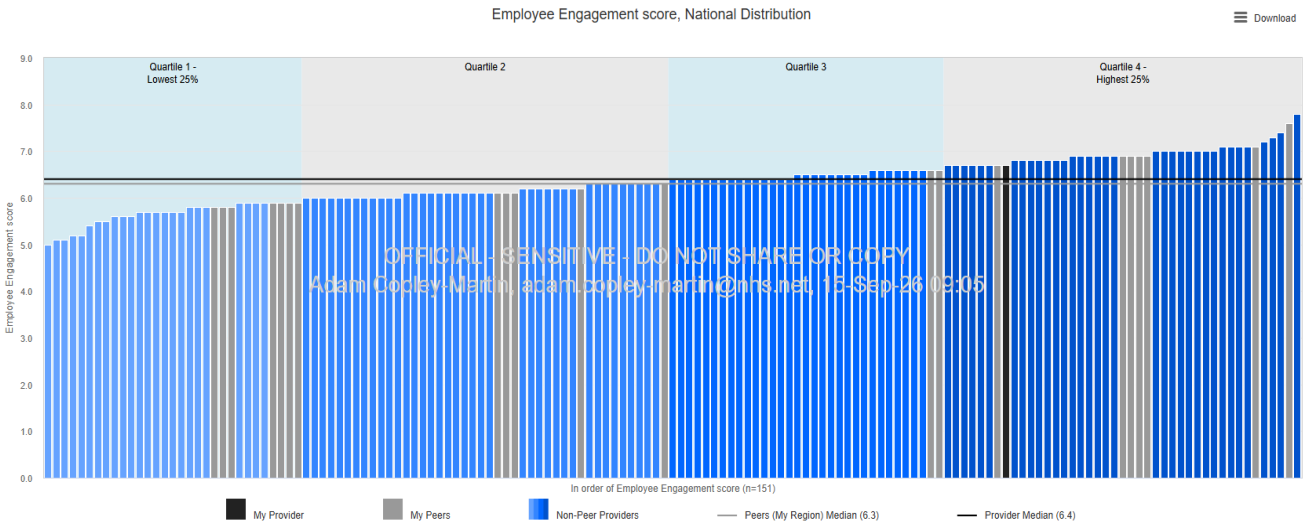
This reports the CQCs overall view of an organisation, there is no comparative data included for benchmarking or otherwise, and the score for the Trust if Good.

9.2 Employee Engagement Score

This is taken from the National Quarterly Pulse Survey Employee Engagement score which consists of three sub-scores: advocacy, involvement and motivation.

The latest data is from Q2 2026/27 where the Trust Score of 6.7 compared to a peer median of 6.3 and provider median of 6.4.

Employee Engagement score National Distribution (Q2 2026/27)



6 Conclusion and next Steps

The productivity and efficiency information from model hospital provides a useful insight into comparing the Trust with others, however the information is not new and is already considered in other trust forums, nor is it the definitive measure of productivity.

It is recommended that these metrics are discussed at EMT and the Trusts productivity group to raise awareness and coordinate with work already taking place across the Trust.

7 Recommendation

The Trust Board are requested to discuss the content of the report and agree any areas where further assurance may be required.

NHS
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Agenda Item 17

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Annual Guardian Report on Safe Working August 2026 Rotational Report on Safe Working August 2025 – July 2026
Author/s:	Dr Mohammed M Qadri Guardian of Safer Working
Recommendation:	

To approve	✓	To discuss	
To note	✓	To ratify	
For assurance			

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	To inform the Board of rota gaps and vacancies and issues relating to the safe working of junior doctors.

Key issues:

1. Medical workforces send exceptions to payroll manually each month to ensure payment

Positive Assurances to Provide: • No exception raised with immediate patient safety concern. No exceptions raised regarding attending educational sessions	**Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):** • Changes to exception reporting implemented on the 6th of February 2026.
Key Risks/Areas of Focus: • No risk areas identified. Exceptions related due to work intensity.	**Decisions Made:** • Better engagement with rota monitoring is an area of ongoing improvement.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	The report supports this shift by demonstrating how resident doctors provide care across community-based mental health services and out-of-hours psychiatric provision. The management of rotas, on-call arrangements and workforce capacity is essential to maintaining safe care closer to home and avoiding unnecessary hospital admissions. The report also highlights the importance of adequate senior support and workforce planning to sustain community-based services.

Analogue to Digital	This is the strongest alignment within the report. The introduction of the **Lantum rota management system** and migration from **Allocate to DRS-5** represent practical examples of digital transformation. These changes have improved rota transparency, accessibility, monitoring and exception reporting, supporting the wider NHS ambition to use technology to improve staff experience, productivity and organisational oversight.
Sickness to Prevention	The report demonstrates a preventative approach through: • Monitoring working hours and exception reports. • Identifying workload pressures before they become patient safety issues. • Supporting trainee wellbeing and psychological safety. • Promoting Freedom to Speak Up mechanisms. • Addressing fatigue, rest requirements and safe staffing concerns. • Strengthening governance around locum night shifts. These actions focus on preventing harm to both staff and patients rather than responding only after problems occur, which is directly consistent with the prevention agenda within the 10-Year Plan

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	August 2026
Finance Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	√
Enhancing prevention, wellbeing and recovery	√
Fostering integration, partnership and alliances	
Developing an effective and empowered workforce	√
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	√

Public Exemption:

Is the report exempt from public disclosure	~~Yes~~/No

Annual Guardian Report on Safe Working August 2026

1. Executive Summary

This report provides assurance that, during 2025-2026, Humber Teaching NHS Foundation Trust maintained effective oversight of resident doctors' safe working arrangements and continued to promote a positive culture of raising and addressing concerns.

A total of 48 exception reports were submitted during the reporting year. The majority related to working beyond rostered hours due to clinical workload, with no significant themes relating to educational opportunities or service support. Only one exception report relating to patient safety was received, and no recurring patient safety concerns were identified.

Throughout the year, the Trust managed a number of workforce challenges, including long-term sickness absence, maternity leave and less-than-full-time training arrangements. While these factors increased pressure on rota management, there was no evidence of widespread unsafe working practices. Exception reporting and trainee feedback indicated that periods of increased workload were generally managed appropriately through existing governance processes.

Significant developments during the year included the implementation of the Lantum rota management system and the transition to the DRS-5 exception reporting platform, both of which have improved transparency, accessibility and organisational oversight.

Engagement through the Resident Doctors Forum remained valuable in identifying concerns and supporting continuous improvement. However, participation in work schedule monitoring remained below the required threshold and will be a key area for improvement.

Priorities for 2026-2027 include improving monitoring compliance, strengthening oversight of rota gaps and locum arrangements, embedding the new exception reporting processes, and continuing to support resident doctor wellbeing, training and safe working.

Overall, the Trust has maintained robust governance arrangements and remains committed to ensuring resident doctors are able to work safely, receive appropriate support and deliver high-quality patient care.

2. The Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) require the Trust to produce quarterly and annual reports on rota gaps and vacancies.

Rota overview

Days on call

- Standard working days (SWD) Monday 9:00 - 17:00 – one resident covering
- Long Weekdays: SWD + 17:00 – 22:00 Non-resident on Call (NROC) - two residents covering
- Weekend days: NROC 09:00- 22:00 - two residents covering

Nights on call

- Nights for Humber: NROC 22:00 – 09:00
- 4 nights Mon- Thursday next duty day Mon 09:00
- 3 nights starting Friday finishing at 9am Monday next duty day Wednesday morning

Hours paid for on call

- Weekend Evening two residents covering 17:00 -22:00 hours paid 4:15, 45 minutes unpaid
- Weekend day two residents covering 09:00 – 22:00 paid 9 hours, 4 hours unpaid
- Night 22:00-09:00 6 hours one resident covering, 5 hours unpaid

Resident numbers:

As of August 2025:

- Full-time Core Trainees: 14
- LTFT Core Trainees: 5 (all at 80%)
- FY1s: 9 (includes 1x 70% LTFT and 1x 80% LTFT)
- FY2s: 7
- 6-month GP Trainees: 4 (includes 1x 60%)
- Higher Trainees: 14 (1x 80% and 1x 60%)

These numbers include a CT on long-term sick leave, and 3x CTs plus 1x Higher Trainee on maternity Leave.

One higher trainee qualified at the end of September and left the scheme.

All generic work schedules were sent 8 weeks prior to placement.

November 2025:

- Full-time Core Trainees: 14
- LTFT Core Trainees: 5 (4X 80% 1X 70%)
- FY1s: 9 (includes 1x 70% LTFT and 1x 80% LTFT)
- FY2s: 7
- 6-month GP Trainees: 4 (includes 1x 60%)
- Higher Trainees: 13 (1x 80% and 1x 60%)

These numbers include a CT on long-term sick leave, and 3x CTs plus 1x Higher Trainee on maternity Leave.

December 2025:

- Full-time Core Trainees: 14
- LTFT Core Trainees: 5 (4x 80% 1x 70%)
- FY1s: 11 (includes 1x 70% LTFT and 1x 80% LTFT)
- FY2s: 7
- 6-month GP Trainees: 3 (includes 1x 60%)
- Higher Trainees: 13 (1x 80% and 1x 60%)

These numbers include 1x FY1 and 1x CT on long-term sick leave, and 3x CTs plus 1x Higher Trainee on maternity Leave.

February 2026:

February Trainee Numbers:

- Full-time Core Trainees: 17
- LTFT Core Trainees: 4 (3X 80% 1X 70%)

- FY1s: 9
- FY2s: 7
- 6-month GP Trainees: 5 (includes 1x 80%)
- Higher Trainees: 13 (1x 80% and 1x 60%)

These numbers include an FY1 and CT on long-term sick leave, and 2x CTs plus 1x Higher Trainee on maternity Leave.

February Rota:
The rota was available on the 22nd of December for the February rotation, 6 weeks before rotation. Their personalised work schedules were sent on the 23rd of December. This was the first time using the Lantum system and medical workforce had to work through with Lantum to get rota rules set up correctly in the system. Moving forward, the guardian was reassured by medical workforce that the rota's will be sent between 6-8 weeks before rotation as per standard.

April 2026 Trainee Numbers:

- Full-time Core Trainees: 16
- LTFT Core Trainees: 4 (3x 80% 1x 70%)
- FY1s: 9
- FY2s: 6
- 6-month GP Trainees: 5 (includes 1x 80%)
- Higher Trainees: 13 (1x 80% and 1x 60%)

These numbers include 1x FY1 and 1x CT on long-term sick leave, and 1x CT plus 1x Higher Trainee on maternity Leave.

April Rota:
The rota was available on the 11th of February for the April rotation doctors (7 weeks before rotation), and their work schedules were sent on the 16th of February (just over 6 weeks before rotation).

Monitoring:
The recent monitoring round which took place between Monday 16th March to Sunday 29th March was non-complaint as none of the rotas received the required 75% minimum return rate.
The respective response rate was:
Rota 1 = 43%, Rota 2 = 64%, Nights = 57%

Exception reports as per quarter

Exception Reports (ER) August 2025 quarter 06/08/25 - 30/10/25
Total number of exception reports received 20
Number relating to immediate patient safety issues 1
Number relating to hours of working 18
Number relating to pattern of work 2
Number relating to educational opportunities 0
Number relating to service support available to the doctor 0

Exception Reports (ER) November quarter 01/11/25 - 31/01/26

Total number of exception reports received 11
Number relating to immediate patient safety issues 0
Number relating to hours of working 5

Number relating to pattern of work 6
Number relating to educational opportunities 0
Number relating to service support available to the doctor 0

Exception Reports (ER) February quarter 01/02/26 - 30/04/26

Total number of exception reports received 7
Number relating to immediate patient safety issues 0
Number relating to hours of working 7
Number relating to pattern of work 0
Number relating to educational opportunities 0
Number relating to service support available to the doctor 0

Exception Reports (ER) May quarter 01/05/26 – 29/07/26

Total number of exception reports received 10
Number relating to immediate patient safety issues 0
Number relating to hours of working 10
Number relating to pattern of work 0
Number relating to educational opportunities 0
Number relating to service support available to the doctor 0

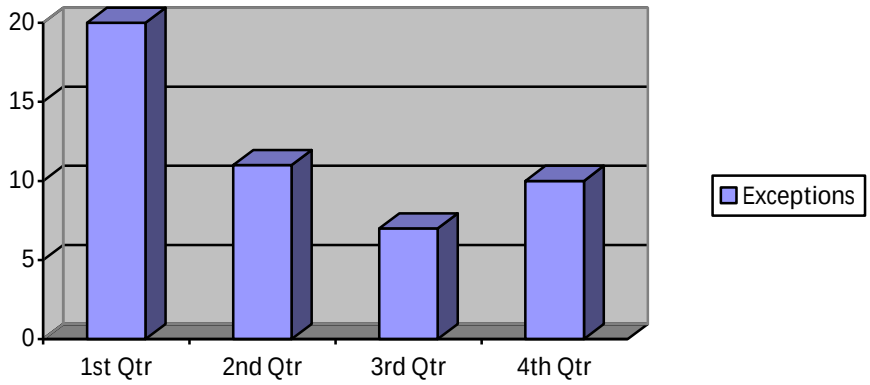


Figure 1. Number of exceptions over the last 12 months

Frequency of exception reports from August 2025 – July 2026

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Exception reports	20	11	7	10

Guardian of Safe Working Annual Report 2025–2026

Throughout the reporting year, overall, exception reporting remained relatively low, with no immediate patient safety concerns identified during the reporting periods. Where concerns were raised, these were primarily related to workload, staffing levels, extended working hours, access to exception reporting systems and the use of locum night shifts. These issues were escalated through the appropriate governance structures, with a focus on improving support, transparency and timely resolution.

Exception Reporting and Working Hours

During August 2025, 20 exception reports were submitted, representing a slight reduction from 21 in the previous quarter. The main issues related to a particularly busy on-call rota associated with increased clinical workload, particularly out-of-hours admissions. Although workload pressures were evident, no immediate patient safety concerns were reported.

During the subsequent reporting period, exception reports reduced further, with seven reports submitted compared with 11 in the preceding quarter. The reports primarily related to doctors working beyond their scheduled hours to complete clinical documentation, medication-related tasks and urgent clinical work. Some doctors also remained late when middle-grade cover was reduced because of study leave. In these cases, doctors undertook urgent clinical duties that could not safely be deferred, contributing to extended working hours.

During May to July 2026, no notable rise in exceptions were reported, with 10 reports submitted compared with seven in the previous quarter. The increase appeared to reflect periods of acute clinical workload rather than a specific emerging patient safety issue. Importantly, no immediate patient safety concerns were identified from the exception reports.

A theme concerned Foundation Year doctors employed by Hull University Teaching Hospitals (HUTH) who were undertaking placements within the organisation was noted. Five exception reports had been raised by HUTH doctors, primarily relating to extended working hours associated with documentation, medication management and periods of reduced middle-grade cover. These doctors were employed by HUTH as their lead employer and therefore submit their exception reports through HUTH's arrangements. The confidentiality of individual reports was maintained, while monthly summaries of themes were provided by HUTH Medical Workforce to support appropriate organisational oversight.

Medical Workforce reviewed the relevant NHS Employers guidance regarding the responsibilities of lead and host organisations. This highlighted the need for clarity regarding access to exception reporting systems and responsibility for the financial and governance implications of additional hours worked. Confirmation was subsequently received that there would be no additional cost associated with adding HUTH doctors to the local system, which should support improved local oversight.

One exception report involved a breach of the 13-hour working limit. HUTH Medical Workforce followed up directly with the doctor concerned, who confirmed that there were no ongoing issues and that the incident appeared to have been an isolated occurrence. One fine was issued during the reporting period in relation to the 13-hour breach.

Rota Management and Workforce Planning

Work schedules continued to be issued in a timely manner. Resident doctors received their individual rotas at least eight weeks before commencing their rotations and retained access to the live rota through the shared system. This supported transparency and enabled doctors to plan their clinical commitments and personal arrangements effectively.

The organisation also introduced the Lantum rota system, which went live in February 2026. Feedback from resident doctors was positive, with the system viewed as an improvement compared with the previous rota process. Minor issues relating to rota amendments and annual leave were identified and subsequently addressed. A quality improvement project also demonstrated increased satisfaction with the new system.

Rota monitoring remained an area requiring further attention. Engagement with monitoring exercises was below the required response rate, limiting the ability to obtain a comprehensive picture of resident doctors' working patterns and to make appropriate adjustments. Resident doctors were therefore encouraged to participate fully in monitoring exercises and to continue submitting exception reports where their working hours or working conditions did not comply with their agreed arrangements.

Operational discussions also identified concerns regarding limited rota cover, particularly when Foundation Year doctors were allocated to acute hospital rotations for four-week periods. Residents were reminded that they retained the right to apply for annual leave during these periods and that any difficulties should be escalated to Medical Workforce or the Guardian of Safe Working Hours.

The previous arrangement whereby a second on-call shift was available was reviewed by Medical Workforce in consultation with relevant stakeholders. It was confirmed that this shift would be removed from the rota because of limited utilisation.

On-Call Arrangements and Locum Night Shifts

Concerns were raised by consultants regarding the allocation of locum night shifts to resident doctors. The principal concern was the considerable variation in workload between individual night shifts. Some shifts may involve relatively low levels of clinical activity, whereas others can involve multiple acute presentations, rapid clinical decision-making and significant exposure to clinical risk.

This variability may have implications for resident doctor wellbeing, particularly where doctors are working outside their usual clinical team or environment and may also be expected to work the following day. The Guardian therefore highlighted the importance of having a clear policy framework governing the use of locum night shifts.

Medical Workforce, the Director of Medical Education and the College Tutor were made aware of these concerns, and a meeting was arranged to consider the issue. Pending the development of a clear framework, it was recommended that each locum arrangement should be risk assessed in advance. This assessment should consider the expected workload, the resident doctor's stage of training, the level of senior supervision available and the arrangements for clinical escalation.

It was also recommended that rotas should provide adequate rest and recovery time and remain compliant with working time regulations. Locum night shifts should not become a substitute for addressing substantive workforce shortages. Where resident doctors undertake additional cover, arrangements relating to payment, indemnity, supervision and clinical accountability should be clear, consistent and compliant with GMC and Trust requirements. Feedback from resident doctors following locum night shifts should also be collected to identify workload patterns and inform future workforce and rota planning.

Exception Reporting System and DRS-5

The Trust continued preparations for changes to the exception reporting process following the regional Guardian conference. The implementation of the revised national policy was initially anticipated for September 2025 but was subsequently delayed until February 2026 and that from the 4th of February 2026, NHS England reforms to exception reporting aimed at simplifying the process and removing barriers to reporting. Exception reports for additional hours now go directly to HR/Medical Workforce and the Guardian of Safe Working Hours, rather than requiring clinical or educational supervisor approval, while educational exceptions go to the Director of Medical Education. Doctors can choose payment or TOIL for additional hours

(subject to safe-working requirements), and the Guardian retained oversight of all reports to identify patterns and systemic concerns. The reforms also included geo-tracking and strengthened confidentiality, introduce new fines where doctors are prevented from reporting or their information was improperly shared, and required Guardians to monitor these issues through quarterly reporting, with the overall aim of improving safe working, ensuring doctors are properly compensated, and identifying systemic rota/workload problems.

The Trust also upgraded its compliance and exception reporting software from Allocate to DRS-5. The new system became operational from 11 May 2026, with resident doctors receiving login details before implementation. All exception reports submitted from that date are to be recorded through DRS-5.

The transition to the new system was monitored through the Resident Doctors Forum. No significant problems were reported during the transition. The introduction of the new system should improve accessibility, monitoring and organisational oversight of exception reporting.

Some supervisors had previously experienced difficulties accessing Allocate, which required the Guardian to approve exceptions to facilitate appropriate remuneration. It was anticipated that the move to DRS-5 and the revised policy arrangements will reduce the likelihood of these issues recurring.

Resident doctors were also reminded that exception reporting should be used whenever they are unable to work within their agreed hours or are unable to attend scheduled teaching and training because of clinical workload. There were no significant reports of missed teaching or training during the year.

Resident Doctor Forum and Trainee Engagement

The Resident Doctors Committee continued to provide an important forum for identifying concerns and discussing improvements to working conditions as per the training contract requirement. The committee meeting chaired by the Guardian on 2 October 2025 provided an opportunity for resident doctors to raise concerns directly.

A number of actions were identified to strengthen trainee support. An invitation was proposed for a BMA representative to attend a future meeting to provide additional advice and advocacy. Concerns were also raised that some resident doctors felt reluctant to contact consultants when overwhelmed while working on call. This issue was subsequently raised at the Medical Staffing Committee to reinforce the importance of accessible senior support and appropriate escalation when workload becomes excessive.

Resident doctors also suggested collecting switchboard data to better understand the frequency of calls received by resident doctors and to provide a more objective assessment of workload patterns. This was relayed to the Medical Staffing Committee for consideration.

The Resident Doctors Committee subsequently met on 22 April 2026 in the Lecture Theatre, with representatives from Medical Education, Medical Staffing and resident doctors attending. The Guardian provided an update on the exception reporting process and confirmed that no significant issues had been identified during the transition to the new reporting arrangements.

Medical Workforce highlighted concerns regarding low engagement with monitoring exercises. The Guardian emphasised that reliable data was essential to identifying workload pressures and improving resident doctor wellbeing. Foundation doctors were reminded to continue using the exception reporting process and to notify the Guardian and Medical Staffing with any concerns.

The committee also received positive feedback regarding the Lantum rota system. Resident doctors were encouraged to engage with future rota preference submissions and ensure that annual leave requests were submitted and approved in advance.

The committee expressed appreciation to resident doctors who maintained clinical service during periods of industrial action. There were no specific updates from the Local Negotiating Committee or BMA at the meeting.

The committee also received a presentation on the Yorkshire and Humber Trainee Forum, highlighting opportunities for mentoring, support with raising concerns and involvement in regional educational and quality improvement projects. Trainees were encouraged to engage with the forum and consider applying for executive positions.

Trainee Support, Wellbeing and Freedom to Speak Up

Supporting resident doctors to raise concerns safely remained a key priority throughout the year. The Guardian continued to work closely with the Freedom to Speak Up Guardian to ensure that concerns relating to working conditions, workload and trainee wellbeing could be appropriately heard and addressed.

Resident doctors were reminded that they could raise concerns through a range of routes, including their clinical or educational supervisor, Training Programme Director, Director of Medical Education, Guardian of Safe Working Hours or Freedom to Speak Up Guardian. Where a resident felt unable to raise an issue through their usual supervisory arrangements, direct access to the Guardian remained available.

The importance of proactive communication was repeatedly reinforced. Resident doctors were encouraged to raise concerns at an early stage rather than waiting until workload pressures became unmanageable. Similarly, supervisors and senior clinicians were encouraged to provide accessible support and appropriate escalation pathways when residents experienced excessive workload or clinical pressure.

Remuneration and Administrative Issues

Where payment issues arose, including retrospective payments for additional work, resident doctors were advised to contact the Guardian and Medical Workforce so that these could be investigated and resolved promptly.

Industrial Action

There were several periods of resident doctor industrial action in England during the reporting year, reflecting the ongoing national dispute regarding pay restoration, jobs and training opportunities. The industrial action was monitored as part of the Trust's wider workforce and safe working arrangements, with particular attention to maintaining appropriate staffing levels and ensuring patient safety.

During the reporting period, resident doctors undertook five days of industrial action from 14 to 19 November 2025, followed by a further five-day period from 17 to 22 December 2025. In the following year, resident doctors undertook a further six days of industrial action from 7 to 13 April 2026, followed by four days from 15 to 19 June 2026.

Governance and Future Work

The Guardian continued to attend relevant governance meetings and worked collaboratively with Medical Workforce, Medical Education, the Resident Doctors Forum, the Medical Staffing Committee and the Freedom to Speak Up Guardian.

A programme of work was undertaken to review the most recent working-hours monitoring exercise. The Director of Medical Education, Dr Mayet, also planned to chair quarterly operational meetings to provide a more structured mechanism for identifying and resolving resident concerns at an early stage.

Future priorities included improving engagement with rota monitoring, ensuring effective use of DRS-5, reviewing exception reporting trends, strengthening oversight of resident doctors employed by external organisations, and developing a clear framework for locum night shifts.

Particular attention will continue to be given to workload intensity, adequate senior supervision, rest and recovery, access to teaching and training, and the timely resolution of remuneration issues. The Guardian will also continue to work with resident doctors and senior colleagues to ensure that concerns are escalated appropriately and that lessons from exception reports are translated into practical improvements.

Conclusion

Overall, the reporting year demonstrated continued progress in monitoring and addressing safe working concerns for resident doctors. Although exception reporting fluctuated throughout the year, the exception reports related to workload and extended working hours rather than immediate patient safety concerns or educational issues.

The introduction of Lantum and DRS-5 represents a positive step towards improving rota management and exception reporting. Continued engagement from resident doctors, supervisors and Medical Workforce will be essential to ensure that these systems provide accurate and meaningful information about working conditions.

The Guardian will continue to promote a culture in which resident doctors feel able to raise concerns openly and at an early stage. Through continued collaboration with Medical Education, Medical Workforce, the Resident Doctors Forum, the Freedom to Speak Up Guardian and wider Trust governance structures, the aim remains to ensure that resident doctors are supported to work safely, sustainably and effectively, while maintaining high standards of patient care.

Dr M | M Qadri
Guardian of safer working
13.08.2026

Humber Teaching NHS Foundation Trust

Agenda Item 18

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	A Framework of Quality Assurance for Responsible Officers and Revalidation Annex A- Annual Board Report and Statement of Compliance 2025/26
Author/s:	Dr Kwame Fofie, Executive Medical Director & Responsible Officer Dr Srikanth Sajja, Appraisal Lead Gillian Wicks, Head of Medical – Education, Business & Staffing Jane Lloyd, Appraisal & Revalidation Officer
Recommendation:	

To approve	√	To discuss	√
To note		To ratify	
For assurance	√		

Purpose of Paper:
Please make any decisions required of Board clear in this section:

This report summarises appraisal, revalidation and professional standards activity undertaken during 2025/26 in line with NHS England's *Framework of Quality Assurance for Responsible Officers and Revalidation*.

The framework enables Responsible Officers and Designated Bodies to demonstrate compliance with statutory requirements and provides assurance regarding the quality, effectiveness and continuous improvement of appraisal and revalidation arrangements.

The Board is asked to:

- Receive and note the Annual Board Report and Statement of Compliance for 2025/26.
- Note that the report will be submitted to the Higher-Level Responsible Officer at NHS England.
- Note that the Statement of Compliance confirms Humber Teaching NHS Foundation Trust remains compliant with the Medical Profession (Responsible Officers) Regulations 2010 (as amended).
- Provide assurance that it has reviewed the contents of the report and supports the submission of the Statement of Compliance.

The report will be signed on behalf of the Trust by the Chief Executive in accordance with NHS England requirements.

Key issues:	
Positive Assurances to Provide: Key assurances include: • 100% appraisal compliance achieved during 2025/26 (58 of 58 eligible doctors appraised). • All GMC revalidation recommendations submitted within required timescales. • No late recommendations and no non-engagement referrals. • Completion and approval of the revised Medical Revalidation and Appraisal Policy during 2025/26. • Continued delivery of appraisal quality assurance arrangements, appraisal forums and appraiser development programmes. • Progress in establishing a reciprocal peer review process with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. • Strong organisational commitment to professional standards, Freedom to Speak Up, equality, diversity and inclusion, and continuous professional development. • Continued support for doctors through appraisal, medical education and revalidation processes in line with Good Medical Practice 2024.	**Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):** • Continue delivery of annual appraisal and revalidation processes. • Continue appraisal forums, appraiser refresher training and training for newly appointed appraisers and appraisees. • Progress and embed the reciprocal external peer review programme. • Maintain robust appraisal quality assurance arrangements and dissemination of organisational learning. • Continue collaboration with the Trust EDI Lead to promote an inclusive, fair and supportive culture. • Continue engagement with Freedom to Speak Up initiatives and medical workforce engagement mechanisms. • Continue recruitment, development and retention of trained medical appraisers to ensure future sustainability and resilience of appraisal capacity.
Key Risks/Areas of Focus: Areas of ongoing focus include: • Maintaining adequate appraiser capacity through recruitment and succession planning. • Sustaining 100% appraisal compliance. • Embedding reciprocal peer review arrangements and learning. • Maintaining alignment with national guidance and Good Medical Practice 2024 requirements. • Continuing to strengthen quality assurance and organisational learning processes.	**Decisions Made:** • No significant new actions have been identified. • Existing actions have been retained and focus principally on sustaining current standards, maintaining regulatory compliance, workforce development, quality assurance and continuous improvement. • The Board is invited to endorse the report and provide assurance regarding compliance with Responsible Officer Regulations.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	Whilst not directly focused on service delivery transformation, effective appraisal, revalidation and professional standards arrangements support safe and effective care across all clinical settings.
Analogue to Digital	The Trust continues to utilise electronic appraisal and revalidation systems to support compliance monitoring, appraisal processes and governance reporting.
Sickness to Prevention	The appraisal and revalidation process supports reflective practice, professional development, quality improvement and early identification of potential concerns, contributing to prevention of harm and improved patient safety.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	08/09/26
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	√
Enhancing prevention, wellbeing and recovery	√
Fostering integration, partnership and alliances	√
Developing an effective and empowered workforce	√
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	√

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	√

Public Exemption:

Is the report exempt from public disclosure	No

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of: **Humber Teaching NHS Foundation Trust**

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	No new actions for 2025/2026 – Retained action to continue to attend any updates/refresher training as part of the RO Network.

Comments:	In full compliance with the regulations, Dr Kwame Opoku-Fofie is the designated Responsible Officer (from 1st November 2023), he has completed all necessary training for his role and is also a member of the Regional Responsible Officers network. Dr Opoku-Fofie is compliant in relation to his own revalidation and appraisal.
Action for next year:	No new actions for 2026/2027 – Retained action to continue to attend any updates/refresher training as part of the RO Network

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	To continue to utilise all resources effectively to ensure the RO can carry out the full responsibilities of his role.
Comments:	The Appraisal Lead was appointed in April 2018; the post holder receives 1PA remuneration for the role. The Appraisal Lead and Responsible Officer are supported by a part time Revalidation Officer and by the Head of Medical – Education, Business and Staffing. The Trust currently has 6 trained appraisers and is undertaking a recruitment campaign to recruit a further 4 appraisers to bring the total up to 10. This ensures that all doctors receive an annual appraisal (where appropriate). The L2P system is fully embedded in the Trust this system supports doctors to collect all required and supporting information for appraisal and ensures sufficient time to participate in annual appraisal effectively.
Action for next year:	Retained Action – To continue to utilise all resources effectively to ensure the RO can carry out the full responsibilities of his role.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	To continue to update and maintain information systems as necessary.

Comments:	The L2P system is fully embedded in the Trust and this system is used effectively to manage appraisals and record appraisal compliance (including engagement/completion of 360 multisource appraisals), individual doctors' details in relation to their continuing professional development (CPD), preparation for, and completion of, appraisal and any issues or concerns raised during the appraisal process. The system also hosts a medical educator's module available to all doctors and medical educators in the Trust. This system, and information contained within the system, is maintained by the Revalidation Officer. The record of licensed medical professionals held with the L2P system is regularly cross-checked/validated with the record of licensed medical practitioners held on GMC Connect.
Action for next year:	Retained action – Continue to update and maintain information systems as necessary.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Amend policy if required, in line with any changes to the Trust and national guidance. Formal Policy review required by March 2026.
Comments:	Full, formal, review of the Trust Medical Revalidation and Appraisal Policy was undertaken and completed in March 2026 and approved by the Local Negotiating Committee (LNC) and QPaS in April 2026. The Trust Medical Revalidation and Appraisal Policy is designed to incorporate the principles outlined in the NHS England Revalidation Policy, National Guidance, and guidance with the GMC. This policy also complies with equality and diversity legislation.
Action for next year	Amend policy if required, in line with any changes to Trust and national guidance. Next formal policy review due March 2029.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes

Action from last year:	To agree and implement reciprocal peer review process in collaboration with colleagues at Cumbria Northumberland Tyne and Wear Mental Health Foundation Trust.
Comments:	Dialogue commenced with Deputy Medical Director/Revalidation and Medical Development, Cumbria Northumberland Tyne and Wear Mental Health Foundation Trust with regards to establishing a reciprocal peer review process. An initial discussion was held on 31st July 2025 and formal quarterly meetings commenced on the 12th February 2026, mutually agreed Terms of Reference (ToR) agreed on 15th May 2026, action log in place.
Action for next year:	To continue to progress reciprocal peer review process in collaboration with colleagues at Cumbria Northumberland Tyne and Wear Mental Health Foundation Trust.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	Implementation of the Medical Agency Locum-Recruitment and Compliance Checklist. The Trust will continue to request that all long-term locums will confirm that they have had a necessary appraisal and continue sharing their appraisals with the Trust. Appraisal Lead to meet with new agency doctors to discuss the process.
Comments:	All doctors employed by the Trust on either a substantive or fixed term basis are expected to comply with the local Medical and National Revalidation Policy. Short term doctors are treated in the same way as permanent medical staff in relation to expectations about appraisal and revalidation. Agency Locum doctors (not employed by the Trust but working in the Trust) are supported to meet their CPD requirements and attend the weekly Postgraduate Teaching Programme and peer group meetings, however, their responsible officer requirement sits with their agency Responsible Officer. It is requested that Locum Doctors share with the Revalidation Team their most recent appraisal in PDF Format. All agency locums are required to comply with the NHSE Information Flows guidance. Routine information, in the form of the

	doctors most recent appraisal, should be supplied by the doctor to the Trust. Also, anything of note will be expected to flow from doctors RO to the Trust RO and vice versa. This is routine information as required by the Trust to enhance patient safety, ensure good governance, and maintain good practice and will also support the doctor. A Medical Agency Locum-Recruitment and Compliance Checklist was developed and is currently in use by the Flexible Workforce Team (FWT). This stipulates the requirement for the Trust to receive information such as, agency locum's revalidation date and the requirement to be provided with a copy of the last two years appraisal.
Action for next year	The Trust will continue to request that all long-term locums will confirm that they have had a necessary appraisal and continue sharing their appraisals with the Trust. Appraisal Lead to meet with new agency doctors to discuss the process.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	To maintain existing standards to comply with Medical Revalidation and Appraisal Policy.
Comments:	A 5th Appraisal Forum is being planned for early 2027 for all appraisees and appraisers in the Trust. As per previous, the Responsible Officer will deliver an update, and a full Appraisal Lead session will be held. Guest speakers will be invited as required (GMC attended in 2025). In compliance with the local 'Medical Revalidation and Appraisal' Policy all doctors, prior to their appraisal are provided with pertinent information from the Risk Management Department relating to Serious Incidents (SI's)/significant events/clinical incidents and complaints in which they have been named. The focus is mainly on discussion in the appraisal meeting even if there is minimum supporting information submitted by the appraisee. This information is included within the appraisal and reviewed by the appraiser.

Action for next year:	To maintain existing standards to comply with Medical Revalidation and Appraisal Policy.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	No
Action from last year:	N/A
Comments:	Not applicable – see response to Question 1B(i) above
Action for next year:	N/A

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Next formal policy review is due by March 2026; however, it is accepted that the policy may require earlier review in line with any local or national changes in policy and/or guidance.
Comments:	Full, formal, review of the Trust Medical Revalidation and Appraisal Policy was undertaken and completed in March 2026 and approved by the Local Negotiating Committee (LNC) and QPaS in April 2026. The Trust Medical Revalidation and Appraisal Policy is designed to incorporate the principles outlined in the NHS England Revalidation Policy, National Guidance, and guidance with the GMC. This policy also complies with equality and diversity legislation.
Action for next year:	Next formal policy review is due by March 2029; however, it is accepted that the policy may require earlier review in line with any local or national changes in policy and/or guidance.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	Continue to ensure appraisals are completed in a timely manner and maintain/increase the number of qualified Appraisers.
Comments:	Medical Appraisers are recruited and selected by the Trust in accordance with national guidance. The Trust currently has 6 trained appointed appraisers to meet and is currently recruiting to 4 additional posts. However, there is an ongoing need to recruit appraisers to fill the gaps when some appraisers are unable to continue in their appraiser role due to various reasons. This meets need and ensures that all doctors receive an annual appraisal (where appropriate) in a timely manner. A continuous recruitment plan is in situ. Appraiser allocation takes place on an annual basis; this is led by the Appraisal Lead and ensures adequate notice for Appraisees
Action for next year:	Retained action - Continue to ensure appraisals are completed in a timely manner and maintain/increase the number of qualified Appraisers.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Retained action - Continue to maintain and expand on existing good practice. An Appraisal Forum will be arranged in 2025/26. Appraiser refresher training, new appraiser training and training for new Trust employed doctors for their first appraisals will also be continued.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	RO, Appraisal Lead, Head of Medical - Education Business and Staffing and Revalidation Officer regularly attend regional network meetings and disseminate relevant information through local appraiser forums to facilitate personal development of the appraisers and maintain the standards of the appraisal process. All medical appraisers have completed a suitable training programme delivered in-house by the Appraisal Lead before undertaking any appraisals. All Appraisers have access to medical leadership and support from the Appraisal Lead and RO, and the Trust operates a regular Appraiser meeting which allows peer review and learning to take place. There is a system in place to obtain feedback for Appraisers on the appraisal process; the Appraisal Lead facilitates this process and gives the feedback to the appraisers. A 5th Appraisal Forum is being planned for early 2027 for all appraisees and appraisers in the Trust. As per previous, the Responsible Officer will deliver an update, and a full Appraisal Lead session will be held. Guest speakers will be invited as required (GMC in 2025). The Trust Appraisal Lead has devised the training session for new appraisees for their first appraisal and also has been providing a training session for the new appraisers.
Action for next year:	Retained action - Continue to maintain and expand on existing good practice. An Appraisal Forum will be arranged in 2026/27. Appraiser refresher training, new appraiser training and training for new Trust employed doctors for their first appraisals will also be continued.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	Continue to maintain and build on local appraisal quality assurance processes and ensure the dissemination of learning.
Comments:	The Trust Appraisal Lead delivered a 4th Appraisal Forum in March 2025 addressing the issues related to complying with quality assurance process by conducting the appropriate audits, surveys and forums, when necessary, this includes giving regular feedback to appraisers and discussing the

	audit process in the appraisal forum, sharing the findings with appraisers and appraisees. A 5th Appraisal Forum is being planned for early 2027 for all appraisees and appraisers in the Trust. As per previous, the Responsible Officer will deliver an update, and a full Appraisal Lead session will be held. Guest speakers will be invited as required (GMC in 2025).
Action for next year:	Retained action - Continue to maintain and build on local appraisal quality assurance processes and ensure the dissemination of learning.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Continue to maintain standards of good practice and remain compliant.
Comments:	The RO makes timely recommendations to the GMC as required in line with protocol. The RO ensures that the Trust Board are informed/advised of any late or missed recommendations with an explanation and reasons for any deferral submissions
Action for next year:	Retained action - Continue to maintain standards of good practice and remain compliant.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Continue to maintain standards of good practice.

Comments:	All recommendations made to the GMC are confirmed in a timely manner with the doctor along with the reason/s for the recommendation. Discussion is held with individual doctor/s before the submission of a recommendation as required.
Action for next year:	Retained action - Continue to maintain standards of good practice.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	No changes anticipated for 2025/26.
Comments:	For appraisal doctors are routinely provided with information regarding complaints, SI's, etc. in which they have been named and a reflection is included in the appraisal. The Responsible Officer has quarterly booked meetings with the employer liaison adviser (ELA) from the GMC which discusses ongoing developments and challenges.
Action for next year:	No changes anticipated for 2026/27.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	No changes anticipated for 2025/26.
Comments:	For appraisal doctors are routinely provided with information regarding complaints, SI's, etc. in which they have been

	named, and a reflection is included in the appraisal. The Responsible Officer has quarterly booked meetings with the employer liaison adviser (ELA) from the GMC which discusses ongoing developments and challenges
Action for next year:	No changes anticipated for 2026/27.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	To maintain existing standards and implement a reciprocal peer review process with Cumbria Northumberland Tyne and Wear Mental Health Foundation Trust
Comments:	The performance of all doctors is monitored as part of the annual job planning process the coordination of which sits under the management of Revalidation and Appraisal Officer. Systems are in place to monitor the fitness to practice of doctors working in the Trust. Relevant information is also shared with other organisations in which a doctor works, where necessary. The Trust also has a system in place to link complaints, SI's, incidents etc. to individual doctors and appraisees are provided with this information for appraisal. Appraisal reviews and re-audits have been completed by the Appraisal Lead in the Trust. This has been expanded moving to include peer review. Dialogue commenced with Deputy Medical Director/Revalidation and Medical Development, Cumbria Northumberland Tyne and Wear Mental Health Foundation Trust with regards to establishing a reciprocal peer review process. An initial discussion was held on 31st July 2025 and formal monthly meetings commenced 12 February 2026, mutually agreed Terms of Reference (ToR) and action log in place.
Action for next year:	To maintain existing standards and continue to benefit from the reciprocal peer review process agreed with Cumbria Northumberland Tyne and Wear Mental Health Foundation Trust.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to

concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	Next formal review of the Medical Revalidation and Appraisal Policy is due March 2026. It is accepted that the policy may require earlier review in line with any local or national changes in policy and/or guidance.
Comments:	The local Medical Disciplinary Policy is in line with, and based on, Maintaining High Professional Standards in the Modern NHS (MHPS). This policy outlines the process by which to respond to concerns relating to fitness to practice and includes process arrangements for investigation and intervention for capability, conduct, health and fitness to practice concerns. The policy has been ratified through the Local Negotiating Committee (LNC) and by Executive Management Team (EMT). Links with the PPA are well established, and regular meetings take place between the Medical Director and the GMC Employer Liaison Adviser (ELA). Trust policy ensures there is a formal procedure in place which allows colleagues to raise concerns. Following audit and scrutiny the local policy was reviewed and updated. Full, formal, review of the Trust Medical Revalidation and Appraisal Policy was undertaken and completed in March 2026 and approved by the Local Negotiating Committee (LNC) and QPaS in April 2026. The Trust Medical Revalidation and Appraisal Policy is designed to incorporate the principles outlined in the NHS England Revalidation Policy, National Guidance, and guidance with the GMC. This policy also complies with equality and diversity legislation.
Action for next year:	Amend policy if required, in line with any changes to Trust and national guidance. Next full policy review March 2029.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	Continue to maintain existing standards of practice
Comments:	In relation to concerns relating to a doctor/s the Medical Director provides regular report to the Trust Board detailing information, concerns, types of concern and outcome. Consideration of protected characteristics of the doctors is reviewed by the HR Department and presented at various trust committees such as Workforce and OD committee.
Action for next year:	Retained action – Continue to maintain existing standards of practice.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	Continue to maintain good practice, the Directorate will continue to work with the Primary Care group to ensure similar standards are maintained across the organisation for either locums or trust salaried GP's (these have a different RO network as they are on the Performers list which is a distinct entity for General Practitioners)
Comments:	All Consultant and SAS doctor appointments are subject to pre-employment checks in line with the NHS Employment Check Standards. As part of these checks the Trust insists on a sharing of the doctor's appraisal history and portfolio from the previous RO and the completion of transfer of appraisal information form (MPIT form). All conditional employment offer letters request that the prospective employee provides contact details of their RO. In the case of Agency doctors, feedback is provided to their RO in the form of an exit form once their placement with the Trust ends
Action for next year:	Continue to maintain good practice, the Directorate will continue working to ensure similar standards are maintained across the organisation for medical locums.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	No action for 2025/2026
Comments:	The Medical Revalidation and Appraisal Policy and the Disciplinary policy and other Trust policies are subject to Equality Health Impact and Inclusion Assessment (EHIIA). Policies contain the right of appeal where relevant. Advice on cases relating practice concerns is discussed with the Practitioner Performance Advice (PPA) and with the GMC ELA as required and in line with policy.
Action for next year:	No action for 2026/2027

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Maintaining good practice
Comments:	The Responsible Officer attends various committees to share information from national reviews, reports and enquiries, and integrates these into the organisation's policies, procedures and culture whilst also sharing learning with the medics e.g. 'Obtaining a Second Consultant Psychiatrist/GP Opinion and Transfer of Care' Policy - inclusion of Martha's Rule. The Trust's approach to learning from patient safety incidents is delivered in line with the Patient Safety Incident

	Response Framework (PSIRF). The Quality and Patient Safety Team: • Work with teams to identify system improvements, share learning across the organisation, and strengthen safety practices to reduce the risk of future harm. • Coordinate the daily Corporate Safety Huddle, ensuring timely escalation, shared situational awareness, and system learning across operational and clinical teams. • Support the dissemination, implementation, and assurance of NICE guidance and Quality Standard • Co-ordinates learning events, 2026 saw the first annual patient safety conference • Etc.
Action for next year:	Retained action: Maintaining good practice

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	No action from 2024/25
Comments:	Our doctors actively engage with local clinical governance systems, and we have 100% compliance with annual medical appraisal. GMP 2024 standards are embedded in our local appraisal system and Appraisal Forums are in place to share learning, support and develop our medical workforce. Peer groups are in place in all specialties across the Trust, our doctors are supported and encouraged to attend. We have a healthy medical study leave budget and actively encourage our doctors to engage in CPD activities. This is further enhanced by the local postgraduate medical education programme offered to all of our doctors, who have protected time to attend on a weekly basis. As a Trust we commit to promoting equal opportunity and fairness standards. We aim for our doctors to work in an

	environment which is free from discrimination, in which they are respected and valued. The Trust offers a range of workshops, courses and accredited qualifications for skills development that enable people leaders to become more effective at process management and engaging employees to achieve success, such as, 'Essential People Leadership & Management Skills' and the PROUD Leadership Programme'. External courses on Leadership and Management are also supported for doctors through the Medical Study Leave budget.
Action for next year:	Maintain good practice.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	Maintain compliance and standards of good practice.
Comments:	All Trust doctor appointments, substantive or temporary, are made in line with the NHS Employment Check Standards, this includes checks relating to qualifications and experience, reference checks (including information relating to local investigations and management of concerns), identity and right to work checks, etc. GMC registration is also verified and GMC information relating to fitness to practice, conditions/restrictions/ revalidation and doctor history is checked. A Disclosure and Barring Service (DBS) check is conducted for new starters. All checks as listed are checked and verified for agency doctors through the Tempre system before the medic commences employment within the Trust. A Medical Agency Locum-Recruitment and Compliance Checklist has been implemented which stipulates the requirement for the Trust to receive information such as, agency locum's revalidation

	date and the requirement to be provided with a copy of the last two years appraisal.
Action for next year:	Retained action – Maintain compliance and standards of good practice.

1F – **Organisational Culture**

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	Continue to maintain standards of good practice.
Comments:	We have substantially expanded our local postgraduate Psychiatry training scheme. Our 2026 GMC National Training Survey (NTS) has highlighted excellent trainer feedback, consistently ranking our Trust 1st in the UK in this area (1st in 2024 and 2nd 2025). NHS England Education also confirmed no reports of bullying or undermining by doctors in training. We have increased our number of medical educators and have developed a range of senior medical educator roles within our medical education structure. Recruitment and retention in these posts is excellent. We embrace the NHS England Workforce Educator Strategy in Medical Education. We also proactively completed a self-assessment against the NHS England Safe Learning Environment Charter. Our doctors regularly take part in training and development, we have a very strong, active Medical Education Department which develops a programme of events annually, content influenced by our own medical workforce. We have a healthy medical education budget. We engage in the NHS England and our local Medical School (Hull York Medical School) Quality Assurance Process. Feedback from both engagement visits in 2025/26 was excellent.

	We have made significant progress in terms of implementing 10 Point Plan for Improving Resident Doctors Working Lives action reaching 96% at the 12-week review point (confirmed by NHS England Education). Board Assurance Framework is firmly embedded.
Action for next year:	Continue to maintain and build on standards of good practice.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	Continue to work with the Trust EDI Lead to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels
Comments:	The Trust has embedded values-based recruitment and refreshed our policies on bullying, harassment and discrimination. We have introduced in-house bullying and harassment training for all managers and leaders, and Recruitment and selection training. In November 2023, the Trust launched its Respect campaign, and since then we have seen a substantial increase in referrals for bullying, harassment, and discrimination. This demonstrates that the Trust is creating a safe space for staff to report bullying and harassment. This gives colleagues in the People and OD team and those across the organisation the opportunity to address these concerns in a fair and consistent manner. The Trust have developed a No Excuse for Abuse framework, which is guidance drawn from a range of policies and SOP's and is designed to help managers provide effective support to staff who have been subjected to unacceptable abuse from patients. The guidance went out for consultation in late June to gain stakeholder feedback and ensure the guidance is fit for purpose. In July, the guidance was pulled together into a practical toolkit for staff and embedded throughout the organisation over the year. A formal launch event will take place in late September with a communications campaign designed to reach stakeholders across the organisation.

	The Trust has signed up to the Act Against Racism Charter from the Royal College of Psychiatrist, the Executive Medical Director leads on this with the EDI Lead Coordinating. The Charter has 15 aims, and progress on these domains are reported to the Trust Executive Management Team every quarter as part of quarterly EDI Assurance reporting. Also, for the first time, all HR Managers have an EDI Objective as part of their appraisals for this window. Similarly, in line with NHS England's EDI Improvement Plan, all EMT and board members now have an EDI objective as part of their appraisals, again to ensure that the board are fully engaged with the Trust EDI workstreams. We have an established International Medical Graduate Lead and have appointed a Resident Doctor IMG Champion, they feed through to the Royal College Tutor and into the medical Education Assurance & Governance Group.
Action for next year:	Continue to work with the Trust EDI Lead to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	To continue to engage medical staff in Freedom to Speak up forums which will also include our Consultant Freedom to Speak Up Ambassador
Comments:	The Trust has established a culture in which our doctors feel able to raise concerns in situations where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies, and procedures in the organisations. They are enabled and supported to do so via several different routes e.g. medical appraisal, Freedom to Speak Up Guardian, Consultant Freedom to Speak Up Ambassador, Medical Staff Committee, peer group/s, Local Negotiating Committee (LNC), or through direct contact with Human Resources. We operate an open-door policy where our doctors are free to contact medical managers directly,

	including the Executive Medical Director, operational managers etc. Doctors in Training have open access to our experienced Guardian of Safe Working and can also engage with colleagues through the Junior Doctors Forum. A process of exception reporting is established in the Trust, no patient safety concerns have been raised. Junior Doctors are encouraged to have a voice, they have a seat of various Trust committees and are empowered to consult with the Director of Medical Education, College/Foundation/GP/Higher Tutors and/or Clinical/Educational Supervisors on any matters of concern. The Trust has a process of Datix reporting in place, adverse incidents are used for the purpose of learning.
Action for next year:	Retained action: To continue to engage medical staff in Freedom to Speak Up Forums which will also include our Consultant Freedom to Speak Up Ambassador.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	To continue to engage medical staff in Freedom to Speak Up Forums which will also include our Consultant Freedom to Speak Up Ambassador.
Comments:	The Trust has established a culture in which our doctors feel able to raise concerns in situations where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies, and procedures in the organisations. They are enabled and supported to do so via several different routes e.g. medical appraisal, Freedom to Speak Up Guardian, Consultant Freedom to Speak Up Ambassador, Medical Staff Committee, peer group/s, Local Negotiating Committee (LNC), or through direct contact with Human Resources. We operate an open-door policy where our doctors are free to contact medical managers directly, including the Executive Medical Director, operational managers etc. Resident Doctors have open access to our experienced Guardian of Safe Working and can also engage with colleagues through the Resident Doctor Forum. A process of

	exception reporting is established in the Trust; no patient safety concerns have been raised. Resident Doctors are encouraged to have a voice, they have a seat of various Trust committees and are empowered to consult with the Director of Medical Education, College/Foundation/GP/Higher Tutors and/or Clinical/Educational Supervisors on any matters of concern. The Trust has a process of Datix reporting in place, adverse incidents are used for the purpose of learning.
Action for next year:	To continue to engage medical staff in Freedom to Speak Up Forums which will also include our Consultant Freedom to Speak Up Ambassador.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	To continue to maintain existing standards and good practice.
Comments:	The People and OD team have established a working group to examine harm caused by formal investigations process and implement proportionate actions to address via multi stakeholder involvement. Processes around investigations around concerns and/or disciplinary processes have recently been reviewed to improve collaborative approaches. The Trust signed up to the Act Against Racism Charter from the Royal College of Psychiatrists, the Executive Medical Director leads on this with the EDI Lead coordinating. The Charter has 15 aims, and progress on these domains are reported to the Trusts Executive Management team EMT every quarter as part of quarterly EDI assurance reporting.
Action for next year:	To continue to maintain existing standards and good practice.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards

processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	To continue to maintain networking and support our doctors as mentioned above to maintain professional standards as recommended by Good Medical Practice 2024 and implement a reciprocal peer review process.
Comments:	We are part of the Regional RO and Appraisal Lead Network sharing good practice and information about Quality Review processes to make sure our professional standards processes are consistent with other organisations. The standards of new Good Medical Practice 2024 have been introduced in our Appraisals following the attendance of Responsible officer, Appraisal Lead and Appraisers at the Regional Network Meeting which included the presentation from a speaker from GMC on GMP 2024. Appraisal Lead organised 4th Appraisal Forum in March 2025 which facilitated further discussion about GMP 2024 with appraisees and appraisers. A 5th Appraisal Forum is planned for early 2027. Doctors are regularly supported in improving their competence levels by supporting them in attending CPD events, participating in internal development programmes, obtaining 360 MSF, completing QIA and patient surveys, planning and completing their PDPs, refreshing their knowledge and skills through training and providing Appraisal Forum platform in order to maintain their high professional standards. RO engages with higher-level responsible officer and GMC Liaison officer for support when necessary. Dialogue commenced with Deputy Medical Director/Revalidation and Medical Development, Cumbria Northumberland Tyne and Wear Mental Health Foundation Trust with regards to establishing a reciprocal peer review process. An initial discussion was held on 31st July 2025 and formal monthly meetings commenced 12 February 2026, mutually agreed Terms of Reference (ToR) and action log in place.

Action for next year:	To continue to maintain networking and support our doctors as mentioned above to maintain professional standards as recommended by Good Medical Practice 2024 and further progress the reciprocal peer review process.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	58
Total number of appraisals completed	58
Total number of appraisals approved missed	0
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	10
Total number of late recommendations	0
Total number of positive recommendations	9
Total number of deferrals made	1
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	9
Total number of trained case managers	1
Total number of concerns received by the Responsible Officer[2] -	1
Total number of concerns processes completed – query was this a concern from the previous year?	1
Longest duration of concerns process of those open on 31 March (working days)	137
Median duration of concerns processes closed (working days)[3]	137
Total number of doctors excluded/suspended during the period	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	8
Total number of new employment checks completed before commencement of employment	8
Total number claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld[4]	In process

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
General review of last year's actions: There were no major actions arising in 2025/26 except actions around the maintenance of standards and good practice, and compliance with policy and quality assurance process. The Trust Appraisal Lead continues to provide first appraisal training for the new appraisees. The Trust Appraisal Lead and Revalidation Team continues with the cycle of Appraisal Forums with a 5th forum planned to take place early 2027. Work has commenced in progressing the reciprocal peer review process – meeting cycle established, Terms of Reference agreed, action log in place. The Medical Revalidation Team will continue to deliver regular Revalidation/Appraisal meetings, Appraisal Forums and continue to organise training courses to include new appraiser training and appraiser refresher training.
Actions still outstanding

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

No actions currently outstanding.
Current issues
No current issues to report.
Actions for next year (replicate list of ‘Actions for next year’ identified in Section 1):
1. To utilise all resources effectively to ensure the RO can carry out the responsibilities of his role fully. Explore mechanisms to aid the recruitment of additional appraisers and retain existing appraisers. 2. To continue to update and maintain information systems as necessary. 3. Amend Trust Medical Revalidation and Appraisal policy if required, in line with any changes to the Trust and national guidance. Formal Policy review required by March 2029. 4. To continue engagement with partner organisation to fully embed the reciprocal peer review process. 5. The Trust will continue to request that all long-term locums will confirm that they have had a necessary appraisal and continue sharing their appraisals with the Trust. Appraisal Lead to meet with new agency doctors to discuss the process. 6. To maintain existing standards to comply with Medical Revalidation and Appraisal Policy. 7. Continue to ensure appraisals are completed in a timely manner and maintain/increase the number of qualified Appraisers. 8. Continue to maintain and expand on existing good practice. Appraiser refresher training, new appraiser training and training for new Trust employed doctors for their first appraisals will also be continued. 9. Continue to maintain good practice.

10. Continue to maintain and build on local appraisal quality assurance processes and ensure the dissemination of learning.

11. To maintain existing good practice with regards to the provision of all necessary information for our doctors in a convenient format to include at their appraisal.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

During 2025/26 the Trust remained fully compliant with the requirements of the Medical Profession (Responsible Officers) Regulations and achieved 100% appraisal compliance for doctors with a prescribed connection. The Trust successfully completed a full review of the Medical Revalidation and Appraisal Policy, continued to strengthen appraisal quality assurance arrangements, and made significant progress in establishing a reciprocal peer review process with Cumbria Northumberland Tyne and Wear NHS Foundation Trust. Significant investment and expansion of the Trust's medical education and educator infrastructure has continued, alongside ongoing development of appraisal, revalidation and professional standards systems. The Trust has also maintained a strong focus on organisational culture, equality, diversity and inclusion, speaking up, and creating a supportive learning environment for doctors.

The main focus for 2026/27 will be to further embed the reciprocal peer review process, continue the evaluation and development of revalidation and appraisal arrangements, strengthen learning from colleague and patient feedback, maintain the quality assurance framework, address concerns and complaints in a timely and proportionate manner, and continue delivering training, development and support for substantive and locum doctors.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Humber Teaching NHS Foundation Trust

Name:	Michele Moran
Role:	Chief Executive
Signed:	
Date:	

Name of the person completing this form:	Dr Kwame Fofie
Email address:	Kwame.fofie@nhs.net

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 19

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	2026 National Staff Survey launch plan
Author/s:	Karen Phillips – Executive Director of People & OD
Recommendation:	

To approve		To discuss	√
To note	√	To ratify	
For assurance	√		

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	To provide the Board with an overview of the 2026 National Staff Survey (NSS) launch plan.

Key issues:

Positive Assurances to Provide:

- The NSS 2025 achieved the highest response rate yet for the Trust (64%) and higher than both the national average and benchmarking average.
- It is the intention for the 2026 NSS launch plan to maintain, but build upon, the successful approach of the previous 3 years.
- Following the successes from the significantly improved 2023, 2024 and 2025 response rates, an overview of the communications plan is attached below, which reflects similar approach and builds upon previous years. As with previous years, this has been co-produced with the comms team. It is a living plan, which is collectively discussed on a weekly basis throughout the window to allow any amends / additions / react to areas of slower response rates.
- It is suggested again incentives will be provided to encourage higher response rates in the form of 'love to shop' or 'amazon' vouchers (choice of the winner) awarded to randomly selected respondents each week. With one iphone and one ipad winner drawn at the end of the survey.

2026 NSS requirements:

- We have contracted the same provider as previous years, providing the same services, methodology and reports:
- Keeping the structure the same as the previous year in terms of groupings of staff for our own data.
    - There will be an additional breakdown at request of divisions, which breaks down

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Communications team have updated posters, messaging and visuals for 2026.
- The 'Year-Round Approach' 'Shared Voice, Shared Action', whilst separate from this launch plan, will run alongside and support all future NSS launches. The year-round work involves publishing local stories of actions taken following NSS / feedback throughout the year.
- Response rate league table:
    - Managers know their people best, including motivators / hesitations, and is best placed to drive response rates locally. Like last year a 'dynamic, interactive league table' of response rates will be available. Intended for managers to be able to see in real time, their response rates in their department with a variety of different comparisons, including with other departments.
- Offering any interested divisions / departments bespoke support.
    - Throughout the window, a working group of People Experience Team, Communications Team, HRBPs, Equality Diversity and Inclusion Lead, Flexible Workforce Manager, meet each week and review real-time response rate dashboards. As with previous years, the group will proactively reach out to those areas that might be a little slower in uptake to offer bespoke support whilst reaching out to areas

last years department level groups, further down. This is a new 'additional' breakdown and doesn't impact or remove previous years breakdowns. • Keeping the same breakdown categories for the 2 NHS published reports. • As with previous years, Bank survey is included with SMS text reminders. • Keeping with the same methodology i.e. online (with a very small number of postal surveys sent out for colleagues with no email, e.g. a small number of Hotel services staff members and those on maternity leave with inactive email accounts. • As with previous year 2025, It is understood final presentation to EMT or the Board by our contractor is no longer required, given the extensive internal coverage of the results and presentations. • A review of the only other alternative staff survey contractor provider was undertaken, finding a less than positive reputation.	that are successful for learnings / good practice to share. • 2025 National Staff Survey - Turning Your Feedback into Meaningful Action. The team Listening Exercise's and the resulting EMT sponsored task and finish groups that arose from last years 2025 survey, has the potential to continue to grow our workforce confidence feedback is acted on and so to take part. • Poll - What would encourage you to take part? – a 'poll' is underway, sent to all staff via communications team, as to what most encourages colleagues to take part in the survey. The results can help inform the 2026 comms plan before and throughout the window - and future survey windows.
Key Risks/Areas of Focus: • Focus is for an improved year-on-year response rate, and further improve the 2025 response rate of 64% • Proposed targets from most desirable: o Improvement on 64% response rate ▪ Achieve >50% response rate for each division ▪ Improvement of response rate for each division o Maintain Trust 64% response rate • 2025 response rates provide areas of focus across divisions for the communications plan and actions throughout the survey window: there is the opportunity to improve upon 2025 response rates for the following directorates which were below both the Trust average and 50%: o Older People MH Unplanned Care o Postgraduate Medical Trainees o Hotel Services • As with previous years, the experiences of colleagues in underrepresented groups remains a area of focus, which can directly influence our work within the Workforce Disability Equality Standard and the Workforce Race Equality Standard. Involvement of the EDI lead throughout the survey window re; how we are encouraging our colleagues who identify in these groups to participate is important.	**Decisions Made:** • EMT shared feedback and approved the launch plan. • Board are asked to note, discuss and be assured of the plan – and of course any further feedback on the plan for 2026 is welcome.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	N/A
Analogue to Digital	Digital methodology and distribution. Automated league tables. Digital promotional resources.
Sickness to Prevention	Employee Engagement, NHS People Promises, including, We are safe and healthy, We are compassionate and inclusive, We Work Flexibly.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	31.07.26
Mental Health Legislation Committee		Operational Delivery Group	Jul-26
Collaborative Committee		Other (please detail) Board	30/09/26

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	✓
Enhancing prevention, wellbeing and recovery	✓
Fostering integration, partnership and alliances	✓
Developing an effective and empowered workforce	✓
Maximising an efficient and sustainable organisation	✓
Promoting people, communities and social values	✓

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	✓

Public Exemption:

Is the report exempt from public disclosure	No

Overview of the 2026 National Staff Survey (NSS) Launch Plan

1. Survey launch and close date

The 2026 National Staff Survey (NSS) launches on Monday 5th October 2026, running until Friday 30th November 2026. This mirrors previous years.

2. National changes to the 2025 NSS

There are no fundamental changes made nationally by the national coordination centre that impact the Trusts launch plan.

- The 2026 survey will include a new question asking about line management responsibility.
- Update to the socio-economic background question. In 2025, the survey introduced a set of socio-economic background questions. For 2026, this question set will be replaced by a single socio-economic background question. This question is used to understand whether people from different socio-economic backgrounds different experiences have of working for the NHS.
- The 2026 Staff Survey has revised its questions on sex, gender identity and gender reassignment to ensure legal compliance with the Supreme Court ruling on the definition of sex under the Equality Act 2010. The updated questions capture sex at birth and gender reassignment as a protected characteristic, alongside a separate broader question on trans and non-binary identities.
- In addition to the ESR data previously provided as part of staff lists, organisations will be required to provide Grade information from ESR this year.

3. Communications plan

Following the successes of the previous three Trust NSS response rates, from the significantly improved 2023 response rate, the further slight increase in the 2024 and significant response rate improvement in 2025, the attached communication plan reflects, but builds upon, the same approach as the last two NSS launches.

- NSS 2025 launch and communications / engagement plan achieved the highest response rate yet for the Trust (64%), higher than both the national average and benchmarking average and a significant increase from the Trust's NSS 2025 (56%).

- An overview of the communications plan is attached, which reflects and builds upon previous years. This is intended as a living and evolving plan throughout the window.

This includes timelines for the project and gives an overview of artwork / visuals that has been / is being updated by the communications team.

Note, this is a living plan which is discussed in a weekly meeting throughout the survey window, involving communications team, people experience team, Flexible Workforce Manager, Strategic HR Business Partners, Equality Diversity and Inclusion lead and as required, member(s) of staff side and the P&OD senior leadership team.

There is the opportunity to improve response rates for the following areas which saw 2025 response rates below the Trust average:

- Older People MH Unplanned Care, Postgraduate Medical Trainees and Hotel Services – the only three areas that were less than the Trust average and less than 50% response rate.

- Throughout the survey window, the communications plan involves working closely with HRBPs feeding into divisional ODG. The response rates are regularly reviewed for all areas on a weekly basis, and particular support can be focused on lower responding areas during the window in real time.

As with previous years, the experiences of colleagues in under-represented groups are an important area of focus, which can directly influence our work within the Workforce Disability Equality Standard and the Workforce Race Equality Standard.

- Throughout the survey window, the communications plan involves working closely with the Equality Diversity and Inclusion Lead on a weekly basis, regarding what actions we can take that might ensure colleagues who identify as being a member of an under-represented group are encouraged to take part.

4. Incentive proposal

Further to the successful introduction of the incentive scheme in 2023 and its seemingly positive impact on 2023, 2024 and 2025 response rates, the proposal has been reviewed by EMT with the incentive agreed to reflect last years as below:

- A weekly prize draw will be issued whereby a staff member who has completed the survey that week will be pulled at random by the survey contractor (IQVIA) to win a choice of a £75 Love to Shop or £75 amazon shopping voucher.

IQVIA will confirm the name of winner on the Friday of each week.

- In addition, funds will be made available to provide refreshments for staff to take a break and complete the survey

- At the end of survey, an additional draw for one iPhone and one iPad will take place:

‘There's even more reason to take part with the opportunity to enter a weekly draw to receive the choice of a £75 Love to Shop voucher or a £75 Amazon voucher, drawn at random by our contractor to ensure confidentiality. As a further thank you for your participation, there’s also a chance to win an iPad and an iPhone, all participants that complete the survey by the closing date, 30th November, can be included in the two prize draws and two lucky winners will be announced by the contractor’.

- People and OD Directorate will share the news with the winner internally and ask for their consent for them to feature within Global communications.

5. Methodology

As with previous years:

- Online: all eligible staff will be invited to participate via an online survey to NHS email addresses and will receive additional six reminder emails as with previous years.

With the exception of a small number of postal invites: the suggestion is for our contractor to send the survey out via post to home address to a very minimal group of employees as we have done in previous years. This will cover some staff in Estates / Hotel Services who may not have email accounts and staff who are on maternity / other new parent leave who may not have active email accounts.

In 2025, a total of 73 surveys were sent by post to home address.

- Weekly reporting on uptake and response rates at divisional level as with previous years.

This allows providing data on areas of low engagement and share with divisions and comms for targeted action.

In 2025, a new Department level breakdown was introduced. For 2026, P&OD have offered divisions the opportunity to request any further 'additional' breakdowns that would allow reporting of response rates and results even further down from department level, to drive more locally. Reporting of results will be subject to minimum thresholds to avoid anonymity suppression and so it not guaranteed at this lower level, please be reassured all previous years breakdowns remain unchanged, this is an additional breakdown only.

6. Bank staff

We are obliged to participate in the NSS for bank staff in 2026, as we have in previous years.

- In 2025, there was a total of 307 bank staff invited to take part and achieved a 35% response rate, placing the Trust second nationally for Bank Staff Survey response rates.
- We expect approx. 300 bank workers to be eligible to participate in 2026.
- As with previous years, bank staff will be invited to participate via an online survey to NHS email addresses will receive additional six reminders and also SMS text notifications.

7. National breakdown categories

Organisations have the option of two internal breakdowns that are used for the national reports that are published by NHSE.

- It is proposed to retain the same reporting categories as the 2025 survey and previous years.

8. Other notable separate plans / bodies of work, which supports any NSS launch in 2024 and future years

Shared voices, shared actions

The year-round approach' 'Shared Voice, Shared Action', whilst separate from this launch plan, will run alongside and support all future NSS launches. The year-round work involves publishing local stories of actions taken following previous NSS / feedback throughout the year.

Response rate league table

Managers know their people best, including motivators / hesitations, and is best placed to drive response rates locally. Like last year a ‘dynamic, interactive league table’ of response rates will be available. Intended for managers to be able to see in real time, their response rates in their department with a variety of different comparisons, including with other departments.

Offering any interested divisions / departments bespoke support.

Throughout the window, a working group of People Experience Team, Communications Team, HRBPs, Equality Diversity and Inclusion Lead, Flexible Workforce Manager, meet each week and review real-time response rate dashboards. As with previous years, the group will proactively reach out to those areas that might be a little slower in uptake to offer bespoke support whilst reaching out to areas that are successful for learnings / good practice to share.

- **Mandated National Staff Survey (and Flu) agenda item on every organisational business meeting throughout the survey window.**

This mandated action for teams will encourage discussion, raise the profile and support managers to share wider related communication at team level.

- **What would encourage you to take part? colleague poll**

  A ‘poll’ is also underway, sent to all staff via communications team, as to what most encourages colleagues to take part in the survey. The results can help inform the 2026 comms plan before and throughout the window - and future survey windows.

- **2025 National Staff Survey - Turning Your Feedback into Meaningful Action**

  The Listening Exercise task and finish groups that arose from last years 2025 survey, has the potential to continue to grow our workforce confidence feedback is acted on and so to take part.

  Following the 2025 National Staff Survey, over 120 teams participated in Trust-wide listening conversations to identify practical changes that would help colleagues feel more valued. Feedback has directly informed the development of six Executive-sponsored task and finish groups;

  - Communication, Engagement and Staff Voice
  - Feedback, Recognition and Team Culture
  - Managers Development and Support
  - Leadership Visibility and Trust
  - Leadership Culture and Behaviours
  - Creating the Conditions for Teams to Thrive

  Using teams’ responses, groups are now working on a range of quick wins, medium-term improvements and longer-term ambitions based on what teams and colleagues said would make a difference to feeling valued. These groups have been recently formed throughout June and July, and further information will be made available to the workforce.

Appendix 1 - 2025 substantive response rates broken down

NationalBreakdown2	Total Sent	Completed	Not Returned	Response Rate	Response rate % compared with 2024
ICB MH and LD Collaborative	18	17	0	100.00%	16.67%
Chief Executive	23	23	0	100.00%	4.35%
Finance	52	50	1	98.04%	19.19%
Nursing and Quality	63	59	2	95.16%	10.41%
People and OD	75	68	4	93.15%	1.26%
Chief Operating Officer	25	21	1	91.30%	8.69%
Commissioning	14	12	2	85.71%	-14.29%
Informatics and Business Intelligence	65	55	10	84.62%	1.50%
Older People MH Planned Care	116	87	28	75.65%	0.88%
Estates	53	35	15	68.63%	3.32%
Forensic Services	251	168	73	68.02%	11.97%
Medical	95	63	32	66.32%	-7.43%
Community Services	414	271	136	66.10%	9.41%
Childrens Services	723	474	239	65.92%	9.12%
Trust	**3473**	**2168**	**1201**	**63.71%**	**7.48%**
Psychology Students	80	36	23	61.02%	23.32%
Adult MH Unplanned Care	492	272	205	56.31%	11.29%
Learning Disability Services	201	112	86	56.28%	9.48%
Adult MH Planned Care	378	200	162	54.64%	3.39%
Older People MH Unplanned Care	136	65	65	48.51%	0.97%
Postgraduate Medical Trainees	33	13	18	41.94%	7.46%
Hotel Services	166	67	99	40.36%	0.72%

Appendix 2: Communications Plan

Note, this is a living plan which is discussed in a weekly meeting throughout the survey window, involving communications team, people experience team, Flexible Workforce Manager, Strategic HR Business Partners, Equality Diversity and Inclusion lead and as required, member(s) of staff side and the P&OD senior leadership team.

MARKETING PLAN & ACTION LOG

Title of request	National Staff Survey (NSS) 2026
Timeline	National Survey Launch date (provisional) Monday 5th October and closing date Friday 27th November 2026

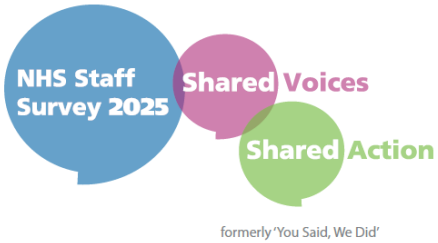
As an organisation we are committed to Caring, Learning and Growing and we remain passionate about supporting our colleagues to be healthy, engaged and empowered to make a difference. Everyone who works for the Trust plays a part in achieving this.
The annual national staff survey is an opportunity for our people to provide open, honest, and confidential feedback about their experience of working at Humber.

Following the successes from the significantly improved National Staff Survey (NSS) 2023 response rate, the further slight increase in the 2024 response rates and our best ever response rate in 2025, again incentives will be provided to encourage higher response rates in the form of vouchers awarded to randomly selected respondents each week. Winners will be drawn by the survey contractor (IQVIA) to ensure anonymity. NSS 2025 achieved a higher than national and benchmarking response rate, and the highest response rate yet for the Trust (64%) and this has provided insights into the views of our people. Therefore, the focus for NSS 2026 must be to continue to ensure the response rate and therefore benefitting from meaningful insights from the staff survey, are reflective of the majority of our workforce.

Strategic Aims:	Achieve a majority response % rate across all divisions of national staff survey to continue efforts to improve patient care and services across the Trust.
Key Messages:	• **Everyone** contributes to patient care – we value each employee. It's your hard work that makes the Trust a success

Caring, Learning & Growing Together

	• The Survey is an official statistic, it's independently facilitated outside of the Trust and NHS England and to the highest standards of quality and accuracy. • What our people say and input into the survey is completely confidential and anonymous – but the results can make a real difference to improving patient care and making the Trust a better place to work • The survey results shape Trust action plans and local actions plans, that can make a real difference and impact what it's like to work in the Trust and the NHS, the survey format is used by numerous organisations, as well as your own organisation, to make things better for you - your colleagues, and our patients and service users. • There will be an incentive for participation in the form of weekly winners of vouchers (winners drawn by IQVIA) • This is supported by the National Quarterly Pulse Survey; a much smaller and more concise survey intended as a more regular pulse check of the thoughts and feelings of our people. We include local questions which focus on topics important to our people, such as areas of focus to improve from the last annual National Staff Survey and how we are progressing against them. • League Table: managers can see in real time, their response rates in their team with comparisons with other teams, creating sense of ownership of their response rate. Managers know their people best, including motivators / hesitations, this helps drive response rates locally.
Client Expectations:	• Bring staff on the journey with us as we continue to improve patient care and achieve our wider Trust objectives • Showcase the great projects and local action plans that have made a difference to people experience and patient care. • Showcase any work and Trust wide action plans regarding the 4 areas of focus the Trust identified from the 2024 NSS results.
Deadline:	Campaign (provisionally requested from our survey provider) runs Monday 5th October and closing date Friday 27th November 2026 - confirmed
Budget	£0
Angle:	NHS Staff Survey 2026 – How are we doing? NHS Staff Survey 2026 – Shared Voices, Shared Action NHS Staff Survey 2026 – Complete to compete

	Graphics to be updated.   
Audiences:	Staff
	Bank staff
Stakeholders:	All staff – respondents to the survey Leadership – to advocate survey Senior Managers – to advocate survey and drive response rate Direct Line Managers – to advocate survey and drive response rate
Actions:	Brief outline – see table for detail
Measure of Success:	• Maintain / Improvement on 64% response rate in NSS 2026 • Improvement of response rate for each division in NSS 2026 • Achieve >50% response rate for each division in NSS 2026
Risks/Challenges:	• Perception that the survey is not anonymous.

- Perception that no or little change will take place to improve the Trust or patient care following their survey input.
- To counteract this, reassurances at Trust comms level and two-way communication at manager level is key to ensure that staff feel assured that their views and comments are making a difference to patient care and the overall success of the Trust. This will be echoed throughout the pre survey launch phase, where we aim to share positive news stories of how the Trust has improved since the 2024 survey was conducted.

Lower uptake areas:

- 11 areas were below the Trust average in 2025 below.

NationalBreakdown2	Total Sent	Completed	Not Returned	Response Rate	Response rate % compared with 2024
Psychology Students	80	36	23	61.02%	23.32%
Finance	52	50	1	98.04%	19.19%
ICB MH and LD Collaborative	18	17	0	100.00%	16.67%
Forensic Services	251	168	73	68.02%	11.97%
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		Older People MH Planned Care	116	87	28	75.65%	0.88%
		Hotel Services	166	67	99	40.36%	0.72%
		Medical	95	63	32	66.32%	-7.43%
		Commissioning	14	12	2	85.71%	-14.29%
Owner (comms team):	Nick Northcott-Orr (Communications) Fiona Chapman (Workforce Projects Assistant) and Justin Marjoram, People Experience Manager)						
Supporters:	Communications Team, People and OD Directorate, EMT, Operational General Managers, other corporate divisions						
Next Steps:	• Comms plan approval • NSS 2025 Survey roll out						

Action log (Green = complete)

Area	**Task**	**Action/Owner**	**Date required**	**Status**
Recruit People Promise champions	Recruit volunteers • From each division • From each department	People Experience / HRPBs	August / September	**In progress**
Coming soon	Short Global piece – August/Sept 2025 NSS Divisional Action Plan – highlights in global for each division 2025 NSS listening exercise – highlights in global for each working group	HRBPs to gather (copy Lynn Parkinson in) / comms People Experience / comms	August/Sept	**In progress**
Listening Exercise	Second COMING SOON	People Experience Team /	August/Sept	**In progress**

	2025 NSS listening exercise – highlights in global for each working group	Comms to draft a summary of what is coming out of the groups using the MS Form that was sent to the groups		Infographic created. Goals being captured from the working groups via MS Form ahead of an EMT update. Deadline is end of August.
League Table	Preparation	Fiona Chapman / Digital team	August/Sept	**In progress**
NSS Weekly Action Meeting	Set up a weekly meeting whereby the comms plan actions and response rates are regularly monitored and acted upon. This includes People Experience, Head of People Experience, Communications, HRBPs, Flexible Workforce Manager (bank), Equality Diversity and Inclusion lead, People Promise Champions. Other stakeholders can be invited as and when its helpful e.g. operational managers of an area of focus.	People Experience Team	TBA	Booked. Champions need adding when allocated to us.

Global/Managers Newsletter/ODG	Graphics to be updated to 2026 Short Global piece – October 2025 sees the start of NSS 2025 – look out for more information in the coming weeks Ask via HRBPs for teams to finalise any action working plans within their directorate following the 2024 survey **Managers newsletter** to Include a call to action – asking what support managers feel they may need to make this happen: Global scheduling dates – weekly incentive winner is announced on a Friday – Prior to any Global comms, HR to contact the winners, let them know and ensure that they are happy to have their names published in the Global	Comms – Wednesday or Friday P&OD and HRBPs - Ongoing People Experience Team P&OD SLT (Vickie Murray) and HRBPs P&OD SLT manager (Alison Meads / other)	TBA	   

	Discussion at September ODG and ongoing divisional ODG's Raise awareness at Senior Leadership Form			 
Global/Managers Newsletter/ODG	Short Global piece – October 25 sees the start of NSS 2025 – look out for more information in the coming weeks Ask for teams to finalise any action working plans within their directorate following the 2023 survey **Managers newsletter** to Include a call to action – asking what support managers feel they may need to make this happen Global scheduling dates – weekly incentive	Comms – Wednesday or Friday throughout September P&OD and HRBPs - Ongoing People Experience	TBA	Visuals as above.

	winner is announced on a Friday – Prior to any Global comms, HR to contact the winners, let them know and ensure that they are happy to have their names published in the Global Discussion at September ODG and ongoing divisional ODG's	P&OD SLT (Vickie Murray) and HRBPs		
CEO message - Message from Michele	Short message from the CEO which can be used, as with previous years, to encourage participation. Prepare message from Michele to share with staff to launch Staff Survey (as with previous years) Including the message that staff are encouraged to spend the first 15 minutes of their team meeting to complete the survey – providing time to do this to encourage survey uptake Separate Bank CEO message – TBA?	Comms – Nick / Rachel Kirby Comms to prepare and seek approval. To be shared as a one-off email and /or lead global article as the survey launches.	w/c 7th September 2026?	

Intranet banners / posters / design assets	Prepare or update 2025 campaign digital assets	Comms to complete and share w/c 15th September 25	w/c 7th September 2026?	
Intranet page	Create intranet page with key information & messages and videos (shared in the global)	People Experience to supply content and Comms to create. (i.e. update the existing staff survey page with the updated graphics)	w/c 7th September 2026?	
ESR	Share ESR web banners from previous campaigns showcased on the ESR platform and incorporate this banner into the wider comms plan to encourage survey uptake Reinforce the message that it's not possible to identify comments made by individual staff members.	Fiona / John Wilson HR to supply visual examples and measurements for the ESR opportunities (ie banners) (ESR measurements to create Understand if the banner measurements can be briefed into comms to ensure they are in the	w/c 7th September 2026?	

		same 'look and feel' as all campaign elements		
Staff Side Meeting	Staff side meeting takes place every 2 weeks to discuss policies – Health and Safety Committee and Wellbeing group attend.	People Experience Team and a HRBP to share survey updates and launch date at this forum to encourage uptake.	September 2026	
Managers Pack	Tailor the messaging for teams incorporating key messaging from CEO -- Michele Including the message that staff are encouraged to spend the first 15 minutes of their team meeting to complete the survey – providing time to do this to encourage survey uptake Ask for help to reinforce the message that it's not possible to identify comments made by individual staff members. (People Experience to include a focus on staff who don't access emails	Nick/ Fiona. People Experience to review and if needed update Managers Pack and messaging Comms to add To be updated and with CEOs updated message for 2025.	w/c 14th September 2026 – send to managers	To be updated and with CEOs updated message for 2026. **NSS Roller Banners** create an order form that would allow managers to order a roller banner/banners to be displayed at Trust locations. A deadline for ordering these would be given to ensure they can be supplied in good time to divisions.

	– e.g. HCAs and to promote as a remedy, using the next team meetings (or 1-2-1 meetings) to protect 15 minutes of quiet time to complete survey for all people)	.		
Posters	Update digital posters for 2025. Share posters digitally with admin staff to ask for them to print and display in their staff areas.	Comms Comms	w/c 15th September	
Divisional - Messaging	The Local - Personalised messaging from each of the service managers x 4 - (allows division managers to see results from their first month) – mid Oct - Reinforce the message that it's not possible to identify comments made by individual staff members.	HRBPs – Stacey and Julie (TBC) Fiona – provide response rates mid october.	TBA	

Bank Staff	Capture good news stories and statistics from Bank	Graham/ Fiona/ Nick	TBA	
Induction process	Summarise within the induction process re. the importance of the National Staff Survey in continuing to improve patient care excellence	People Experience Team	Induction takes place on the first Monday of every month therefore to be mentioned September through to November	
Humber member magazine	Sharing best practice - (shared voice, shared action) put together a DRAFT for Georgia Campbell for the external members magazine	Nick / Fiona	TBA	
Intranet Banner Weekly Content (rolling)	Desktop wallpaper Teams background	Comms	TBA	
Launch in Global Weekly Content (rolling)	All Staff Q&A session	POD (People Experience and other, e.g. POD SLT) HR to lead a virtual, all staff Q&A session later in October – HR to create invite	TBA	

		and Comms to share invite with all staff and share in the Global		
Outlook diary protected time – sent via global			TBA	Dear Colleague, If you are able to, please take ten minutes today to complete your **NHS Staff Survey**. We use the results to guide actions on culture, leadership, inclusion, and everyday support. Tell us what is good and what could be improved about your staff experience here and as part of the wider NHS. The survey is completely confidential, and most people finish within ten minutes. If you have already completed it, thank you, please use this time to encourage a colleague. Thank you

During window

Success Story 'Shared Voice, Shared Action'	1 x story a month.	People Experience and Comms (leads to be captured via divisions / HRBPs)	1 x a month throughout a window (and throughout year)	
League Table TBC – work in progress	League Table; made available in real time for managers. League Table: managers can see in real time, their response rates in their department with comparisons with other departments, creating sense of ownership of their response rate. Managers know their people best, including motivators / hesitations, this helps drive response rates locally. Encourage at ODG / Divisional ODG regular accessing of league table.	People Experience team – download response rate report from the portal and provide to Mark Ward. Mark Ward - Data Warehouse Manager populates the league table POD SLT (ODG) / HRBP	Throughout the survey window Encourage at ODG / Divisional ODG accessing of this	

		(Divisional ODG)		
WEEK 2 w/c XX	Weekly prize winner announced	HR to confirm winner – comms to share via the Friday Global - TBC	**Friday Global**	
	Good news story – Shared Voice, Shared Action	HR to supply – comms to share via Global and intranet news	**Friday Global – if available**	
	The Local	Staff survey to be included in all divisional locals		
	We will be sharing league table weekly	HR to share completion rates for league table Comms to create table and share.	**Wednesday Global**	
	Weekly league table sent to managers – top performing departments	Asking to share what they feel has made a difference, and other managers could learn from. Add to		

		managers resource area		
	Weekly league table sent to managers – lowest performing departments	Reminder / reach out to help – send resources and links and their current response rates		
WEEK 3 w/c XX	Message from divisional leaders	Comms to prep standard messages with divisional leaders (General Managers / Heads of Services) to add a short message to colleagues within their division.		
	Weekly prize winner announced	HR to confirm winner – comms to share via the Friday Global - TBC	**Friday Global**	
	All Staff Q&A session	HR to lead a virtual, all staff Q&A		

	We will be sharing league table weekly	HR to share completion rates for league table – Comms to create table and share.	**Wednesday Global**	
	Weekly league table sent to managers – top performing departments	Asking to share what they feel has made a difference, and other managers could learn from. Add to managers resource area		
	Weekly league table sent to managers – lowest performing departments	Reminder / reach out to help – send resources and links and their current response rates		
WEEK 4 w/c XX	Weekly prize winner announced	HR to confirm winner – comms to share via the Friday Global - TBC	**Friday Global**	
	We will be sharing league table weekly	HR to share completion rates for league table – Comms to	**Wednesday Global**	

		create table and share.		
	Good news story – Shared Voice, Shared Action	HR to supply – comms to share via Global and intranet news	**Friday Global – if available**	
WEEK 5 w/c XX	• Ask the Exec (date TBC) • Global	Comms - Send briefing notes prior to Ask the Exec. Key messages, completion rates.		
	We will be sharing league table weekly	HR to share completion rates for league table – Comms to share.	**Wednesday Global**	
	Good news story – you said we did	HR to supply – comms to share via Global and intranet news	**Friday Global – if available**	
	Weekly prize winner announced	HR to confirm winner – comms to share via the Friday Global - TBC	**Friday Global**	

	Weekly league table sent to managers – top performing departments	Asking to share what they feel has made a difference, and other managers could learn from. Add to managers resource area		
	Weekly league table sent to managers – lowest performing departments	Reminder / reach out to help – send resources and links and their current response rates		
WEEK 6 w/c XX	We will be sharing league table weekly	HR to share completion rates for league table – Comms to create table and share.	**Wednesday Global**	
	(Ask the Exec) October – date TBC.			
	Weekly prize winner announced	HR to confirm winner – comms to share via the Friday Global - TBC	**Friday Global**	

	Weekly league table sent to managers – top performing departments	Asking to share what they feel has made a difference, and other managers could learn from. Add to managers resource area		
	Weekly league table sent to managers – lowest performing departments	Reminder / reach out to help – send resources and links and their current response rates		
WEEK 7 w/c XX	We will be sharing league table weekly	HR to share completion rates for league table – Comms to create table and share.	**Wednesday Global**	
	Good news story – you said we did	HR to supply – comms to share via Global and intranet news		
	Weekly prize winner announced	HR to confirm winner – comms to share via the Friday Global - TBC	**Friday Global**	

	Weekly league table sent to managers – top performing departments	Asking to share what they feel has made a difference, and other managers could learn from. Add to managers resource area		
	Weekly league table sent to managers – lowest performing departments	Reminder / reach out to help – send resources and links and their current response rates		
WEEK 8 w/c XX	• Ask the Exec (date TBC) • Global Intranet Banner Change daily as a countdown to the end of the survey.	Comms - Send briefing notes prior to Ask the Exec. See Survey Day actions section		
			Wednesday Global	
	Weekly prize winner announced	HR to confirm winner – comms to share via the Friday Global - TBC	**Friday Global**	
	Staff Survey finished this week – countdown on intranet		Wednesday 27 Nov.	

	Global messaging (both Globals) – there's still time to take part!		Friday 29 November	

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 20

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Equality Delivery System (EDS22) 2026
Author/s:	John Duncan – Equality, Diversity and Inclusion Partner
Recommendation:	

To approve	√	To discuss	
To note		To ratify	
For assurance			

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	To approve the Trust's Equality Delivery System (EDS22) Report for 2025/26, providing assurance that the Trust has undertaken a robust self-assessment against the EDS22 framework, engaged appropriately with staff, patients and stakeholders, and accurately reflected progress made in advancing equality, diversity and inclusion across workforce, leadership and service delivery.

Key issues:

Positive Assurances to Provide: • With a score of 30, the Trust is *achieving* its EDS22 aims and improving on a score of 29 last year • The Trust is excelling at Domain 3 and achieving for Domains 1 and 2 • Extensive workforce and patient EDI work over the past 12 months	**Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):** • Multiple service area projects and initiatives to address patient EDI • PCREF • Culture of Care and Trauma-Informed Care • Health Inequalities Framework • Respect • No Excuse for Abuse • ECHR Code of Practice
Key Risks/Areas of Focus: • Bullying and Harassment towards staff by patients – addressed through No Excuse for Abuse/Respect in care framework. • Presentism with disabled staff	**Decisions Made:** • WRES/WDES/GPG action plans agreed • Trans Inclusion Action Plan agreed • Services area transformation and QI Projects agreed • EMT and People & OD Committee approved the report • Board ratification required.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)

Hospital to Community	***Outcome 1A and 1B***
Analogue to Digital	***Outcome 1D and 3C***
Sickness to Prevention	**Outcome 1A, 1B, 1C, 2A, 2B, and 2C**

Caring, Learning
& Growing Together

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	12/08/14
Finance Committee		Executive Management Team	28/07/26
Mental Health Legislation Committee		Operational Delivery Group	27/07/26
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	
Enhancing prevention, wellbeing and recovery	✓
Fostering integration, partnership and alliances	
Developing an effective and empowered workforce	✓
Maximising an efficient and sustainable organisation	
Promoting people, communities and social values	✓

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	✓

Public Exemption:

Is the report exempt from public disclosure	~~Yes~~/No

Classification: Official

Publication approval reference: PAR1262

NHS England

NHS Equality Delivery System (EDS22)

Humber Teaching NHS Foundation Trust 2026

Version 1, 15 August 2022

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation	Humber Teaching NHS Foundation Trust	Organisation Board Sponsor/Lead
		Karen Phillips –Executive Director People and OD
Name of Integrated Care System	Humber and North Yorkshire	

EDS Lead	John Duncan/Suze Elmore		At what level has this been completed?	
				*List organisations
EDS engagement date(s)	13/02/25 16/07/26		Individual organisation	
			Partnership* (two or more organisations)	
			Integrated Care System-wide*	Humber and North Yorkshire Health and Care Partnership Hull City Heath Care Partnership East Riding of Yorkshire Council Health Watch Hull (and East Riding) PACE Forums

Date completed	17/07/26	Month and year published	September 2026
Date authorised	TBC	Revision date	TBC

Completed actions from the previous year
Action/activity
Key Achievements 2025/26 • **Relaunched the Respect and No Excuse for Abuse initiatives**, strengthening reporting, support and prevention of bullying, harassment, discrimination and abuse, contributing to significant improvements in staff survey results. • **Maintained full compliance with NHS England's EDI Improvement Plan**, including Board-level accountability, strengthened workforce data analysis, robust governance and national recognition for EDI best practice. • **Embedded the Being Humber behavioural standards framework**, promoting inclusive leadership, psychological safety, respect and belonging across the organisation. • **Achieved Silver Defence Employer Recognition Scheme accreditation**, demonstrating commitment to supporting veterans, reservists and the armed forces community. • **Strengthened staff voice through staff networks**, including enhanced support for Anti-Racism, Disability and LGBTQ+ Networks, with increased executive sponsorship and leadership capacity. • **Completed all actions within the Trans Inclusion Action Plan** and maintained a supportive, legally compliant approach while awaiting updated national guidance. • **Implemented NHS England guidance on tackling hatred and discrimination**, including adoption of the IHRA working definition of antisemitism and preparation for enhanced equality training requirements. • **Introduced additional staff safety measures** in response to national unrest, reinforcing the Trust's zero-tolerance approach to racism, antisemitism, Islamophobia and other forms of discrimination. • **Launched the Sexual Misconduct Policy** as part of the NHS Sexual Safety in the Workplace campaign, improving reporting routes, support mechanisms and awareness of sexual safety.

- **Established the Care, Culture and Equity Steering Group**, bringing together culture, health inequalities, trauma-informed care, patient experience and race equality programmes under a single governance structure.
- **Progressed implementation of the Patient and Carer Race Equality Framework (PCREF)** through self-assessment, stakeholder engagement, race equity training and development of the Trust's first PCREF report.
- **Expanded Culture of Care initiatives**, delivering co-produced improvement projects alongside Autism-Informed, Trauma-Informed and Anti-Racism-Informed training and development.
- **Delivered all 13 EDI workforce objectives**, embedding EDI as business as usual through leadership development, governance, workforce reporting and targeted improvement actions.
- **Increased workforce diversity and representation**, with continued growth in ethnically diverse, disabled and LGBTQ+ staff and significant increases in representation within senior leadership roles.
- **Improved Workforce Race Equality Standard (WRES) outcomes**, outperforming national benchmarks in most indicators, increasing ethnic diversity in senior roles and reducing inequalities in recruitment, development and staff experience.
- **Improved Workforce Disability Equality Standard (WDES) outcomes**, strengthening disabled staff representation, progression, workplace adjustments and overall staff experience.
- **Continued action to address the Gender Pay Gap**, maintaining performance above national benchmarks while focusing on career progression, flexible working and workforce inclusion.
- **Strengthened anti-racism and inclusive leadership capability** through race equity training, workshops, reflective learning opportunities and targeted cultural development programmes.
- **Enhanced EDI governance and assurance**, providing regular reporting to EMT and Board and ensuring equality, diversity and inclusion remain embedded within organisational decision-making.

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	• Expansion of MHSTs to improve access to emotional wellbeing support and mental health services • Inclusion Champions scheme continues to grow and has expanded to cover the whole ICB footprint • Enhanced 27/4 mental health crisis access for Older People to prevent unnecessary admission • Co-location of PCN services within Whitby Hospital, including an enhanced access GP within the UTC, building pathways between the services and diverting demand • Introduction of a Transition discharge advanced practitioner to smooth pathways from Forensic services into CMHTs and PICUs, enabling access to least restrictive model of care • The Neuro Core Needs Service offers early, needs-led and functionally focused support for children and young people with neurodevelopmental differences in mainstream secondary schools, without requiring diagnosis or statutory assessment. It forms a holistic part of the local graduated response, sitting below specialist and assessment-based provision.	**Achieving activity**	Service Managers.
	1B: Individual patients (service users) health needs are met	• Introduction of paid Expert by Experience patient representative in Forensics inpatient units to improve patient voice and raise health/care related concerns • New targeted mental health and wellbeing service to support farmers in North Yorkshire	**Achieving activity**	Service Managers.

		• Health visitors now provide vaccination via home visits in parts of Hull and the East Riding, targeting areas of deprivation as part of the Pathfinder project • Armed forces neuro support pilot, supporting families at Leconfield, East Riding by working with schools to provide wraparound support • CAMHS CLEAR programme developed a new model of care centred on streamlined first contact, family partnership and workforce optimisation to reduce documentation time. • The Trust led on a collaborative project to produce video advice for parents and children on how to manage and improve night time enuresis.		
	1C: When patients (service users) use the service, they are free from harm	• Sustained high levels of incident reporting, with 97.11% of patient safety incidents reported as no or low harm (April 2025–March 2026), demonstrating a strong and transparent safety culture. • Continued embedding of the Patient Safety Incident Response Framework (PSIRF), with the Trust receiving a 'Good' assurance rating in the internal PSIRF audit, demonstrating that systems and processes are well established and effectively embedded. • Strengthened Learning from Deaths processes, with improved reporting capturing gender, age, and ethnicity, enhancing understanding of inequalities • We proactively collect data relating to health inequalities for all initial incident reviews (IIRs) which are reviewed by the Trust Clinical Risk Management Group • Strong medicines optimisation practices, evidenced by a very low proportion of medication-related incidents resulting in harm. • Continued focus on parity of physical and mental health, supported through delivery of the Physical Health Strategy. • The Trust's three patient safety priorities continues to strengthen safety systems: workforce wellbeing following incidents, safer	**Excelling activity**	Clinical leads and Patient safety and Safeguarding team

		transfers of care through improved joint working, and greater involvement of patients, families, and carers in care journeys. • Completion of a self-assessment against the Violence Reduction and Prevention Standards, supporting a safer environment for patients and staff. • Development of the Self-harm and suicide strategic plan • Positive assurance from CQC inspections at Inspire (Children and Young People's Mental Health Inpatient Unit) and Townend Court (Learning Disability Wards), with services achieving an overall rating of Good. • Ongoing programme of mock CQC reviews across services to ensure readiness for future inspections and continuous improvement. • Review and refinement of the PSIRF Plan and Policy to ensure alignment with national guidance and organisational learning. • Comprehensive risk management plans in place for service users, alongside effective use of Divisional Risk Registers to escalate and manage risks impacting safe care delivery. • Accessible complaints and feedback mechanisms in place, enabling patients and families to influence service improvement. • Proactive safeguarding oversight, with daily review of incidents by the Safeguarding Team, ensuring timely action and appropriate multi-agency referrals. • Clear frameworks to support staff behaviour and conduct, including Humber Behaviour Standards and application of PIPOT and LADO procedures where required. • The Safeguarding Team continues to provide expert advice and early intervention support, enhancing preventative approaches to safety, evidenced through high levels of service engagement.		

	1D: Patients (service users) report positive experiences of the service	• Friends and Family Test – the website features ReachDeck software, which includes text-to-speech, reading, and translation support. Provides instant access to assistive features, helping to reduce barriers between our digital content and diverse online audiences. FFT online form to assist in collecting feedback from our ethnically diverse communities. https://www.humber.nhs.uk/Services/friends-and-family-test.htm • National Community Mental Health Service User Survey – The Community Mental Health (CMH) Service User Survey working group which is overseen by the CMH Service User Steering group who both meet regularly to identify and implement actions to address areas where improvements can be made. A robust governance process is in place to support the delivery of the action planning process. • National GP Survey – The Primary Care division collaborates with the Patient Participation Groups of the three practices to support action planning in response to the survey results. • Friends and Family Test Dashboard - Staff can access the FFT survey, qualitative and quantitative feedback, and data on our Trust's FFT Dashboard. The Trust has a Power BI FFT Dashboard which utilises thematic and sentiment analysis of FFT feedback to facilitate a streamlined and structured process for determining Quality Improvement (QI) initiatives. All four divisions have strengthened their systems and processes for collecting FFT feedback. • Patient, Service User and Carer stories are shared at Trust Board meetings and other forums/meetings during the year. The Patient and Carer Experience team has involved patients, service users and carers to co-produce a refreshed and strengthened version of the sharing of patient, service user and carer stories framework.	**Excelling activity**	Assistant Director of Patient and Carer Experience/Patient and Carer Experience Team

		• Patient and Carer Experience forums, visit the Trust's website for further information: https://www.humber.nhs.uk/Services/patient-and-carer-experience.htm • Patient and Carer Experience Annual Report (2024/25) including Complaints and Feedback showcases how patients, service users and carers report on their positive experiences of our services and informs on the variety of initiatives taking place across services: https://www.humber.nhs.uk/Services/patient-and-carer-experience.htm. • The 25/26 annual report including a film for accessibility is currently in production. • Compliments are recorded within the Trust's Quality Dashboard. They are where patients, service users, carers and families sometimes compliment our staff, offering their gratitude and thanks for the outstanding services they provide. • The Trust has a Survey Landing page on the Trust website to help individuals to navigate the various surveys available: Surveys | Humber Teaching NHS Foundation Trust. • There is an intrinsic link between staff satisfaction and the direct impact on patients and the standard of care they receive - the Trusts 2025 staff survey results share a very positive picture of staff experience, which directly enhances patient care and satisfaction, ultimately highlighting a supportive and effective healthcare environment.		
Domain 1: Commissioned or provided services overall rating			10	

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• Occupational Health provision offering assessment, advice and ongoing support for staff with long-term health conditions. • New sickness policy that incorporates supportive approaches for long-term health conditions and disability. • Reasonable adjustment records demonstrating adjustments made for staff with obesity, diabetes, asthma, COPD and mental health conditions. • Access to staff counselling services, psychological support, and Employee Assistance Programmes (EAP). • Health and wellbeing MOT's promoting healthy weight management, physical activity, smoking cessation and healthy eating. • Flexible working arrangements and phased return-to-work programmes for staff managing chronic health conditions. • Occupational Health referrals and case management data demonstrating ongoing workplace support. • Health promotion campaigns focusing on health and mental wellbeing. • Staff survey results demonstrating awareness of and satisfaction with workplace health and wellbeing support. • Workforce Disability Equality Standard (WDES) and NHS Staff Survey findings showing organisational support for staff with health conditions and disabilities. • Examples of workplace adjustments such as altered duties, adjusted shift patterns, hybrid working, additional breaks, ergonomic equipment or protected time for medical appointments. • Equality Impact Assessments showing consideration of staff with long-term health conditions. • Records of wellbeing events, health checks, vaccination programmes and chronic disease awareness campaigns. • Staff network groups (e.g., Disability Network) providing support and feedback on workplace experiences.	**Excelling activity**	Health and Wellbeing team/ Occ Health team

		• Feedback and testimonials from staff demonstrating effective workplace support for managing obesity, diabetes, asthma, COPD or mental health conditions. • Monitoring and reporting mechanisms showing uptake of wellbeing services and outcomes for staff with long-term health conditions. • Clear signposting on the intranet to Occupational Health, mental health resources, wellbeing services and external support organisations.		

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• Respect, No Excuse for Abuse and Respect in Care frameworks, addressing Bullying and Harassment, that set out zero-tolerance expectations. • Attendee on the Violence and Prevention Community of Practice, Violence and Aggression Prevention and Reduction Policies covering abuse from patients, service users, visitors, contractors and colleagues. • Freedom to Speak Up arrangements, including evidence of active Freedom to Speak Up Guardians and Ambassadors. • Procedures for reporting incidents of bullying, harassment, discrimination, abuse and physical violence. • Datix data demonstrating reporting, investigation and action taken following incidents. • Evidence of board-level oversight and monitoring of violence, bullying and harassment incidents. • Risk assessments identifying areas or roles with increased risk of violence or aggression and controls implemented to mitigate risks. • Workplace safety measures such as security personnel, CCTV, panic alarms, lone worker devices and safe staffing arrangements. • Staff training on conflict resolution, de-escalation techniques, managing violence and aggression, and recognising bullying and harassment. • Mandatory Equality, Diversity and Inclusion (EDI) training that includes respectful workplace behaviours and addressing discrimination. • Evidence of campaigns promoting respectful behaviour and zero tolerance of abuse towards staff. • Staff communications from senior leaders reinforcing expectations around dignity, respect and inclusion. • NHS Staff Survey results relating to bullying, harassment, discrimination and violence at work, including action plans to address concerns.	**Achieving activity**	EDI Lead/ Workforce and OD Operational team/Trust Board/Medical Workforce/Training

		• Workforce Race Equality Standard (WRES) data and action plans addressing experiences of harassment and discrimination. • Workforce Disability Equality Standard (WDES) findings and actions relating to workplace bullying, harassment and inclusion. • Clear escalation routes for staff experiencing abuse, harassment, bullying or violence. • Access to mediation, employee relations support and informal resolution processes where appropriate. • Employee Assistance Programme (EAP), counselling services and psychological support for affected staff. • Trade union and staff-side endorsement of No Excuse for Abuse framework. • Staff networks (e.g., Disability, Anti-racism, LGBTQ+) providing support and opportunities to raise concerns. • Records of investigations and organisational learning arising from incidents of bullying, harassment or violence. • Evidence of disciplinary action taken where allegations are substantiated. • Exit interview feedback processes used to identify themes relating to bullying, harassment or workplace culture. • Regular staff wellbeing and culture surveys measuring psychological safety, inclusion and workplace behaviour. • Leadership development programmes promoting inclusive leadership and positive workplace cultures. • In house Bullying and Harassment training on handling complaints of bullying, harassment, discrimination and violence. • Documentation demonstrating compliance with the NHS Violence Prevention and Reduction Standard. • Visible workplace signage and public communications stating that abuse towards staff will not be tolerated.		

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment and physical violence from any source	• Employee Assistance Programme (EAP) providing confidential, independent counselling, advice and support services. • Access to external counselling and psychological support services independent of line management. • Occupational Health services offering confidential assessments and referrals for stress, mental health concerns and workplace-related issues. • Freedom to Speak Up Guardian arrangements providing independent support and advice for staff raising concerns. Freedom to Speak Up Ambassadors available across the organisation. • Trade union representatives available to provide independent advice, advocacy and support. • Professional body support services and helplines available to registered staff groups. • Access to mediation services delivered by trained impartial mediators. • Staff-side representatives involved in supporting staff experiencing workplace concerns. • Domestic abuse support pathways and signposting to specialist external organisations. • Access to legal advice services through employee benefits programmes or external providers. • Independent reporting mechanisms for bullying, harassment, discrimination and violence. • Intranet resources signposting staff to internal and external support organisations. • Support and referral pathways, Respect and No Excuse for Abuse, for staff affected by hate crime, harassment or discrimination. • Staff networks (e.g., Disability, Anti-racism, LGBTQ+ Networks) that provide peer support and independent guidance. • Evidence that staff are routinely informed about available support services through inductions, training and communications.	**Excelling activity**	Occupational Health/Wellbeing/Workforce Operational HE team

		• Trauma support, debriefing services and psychological first aid following significant incidents. • NHS Staff Survey results demonstrating staff awareness of support mechanisms and confidence in accessing them. • Guidance for managers on signposting staff to independent sources of help. • Clear procedures for obtaining support following incidents of physical violence, including access to counselling, and occupational health support.		

	2D: Staff recommend the organisation as a place to work and receive treatment	• NHS Staff Survey results relating to:
		  • Recommendation of the organisation as a place to work.
		  • Recommendation of the organisation as a place to receive treatment.
		  • Staff engagement scores.
		  • Staff morale and motivation indicators.
		  • Overall staff experience measures.
		• Local staff survey results demonstrating positive perceptions of the organisation as an employer and healthcare provider.
		• NSS findings showing improvements in culture, wellbeing and engagement.
		• Benchmarking data comparing organisational performance with national, and regional organisations.
		• Staff retention rates demonstrating that employees choose to remain within the organisation.
		• Reduction in staff turnover rates over time.
		• Vacancy and recruitment data showing the organisation's attractiveness to prospective employees.
		• Evidence of effective staff wellbeing initiatives that contribute to positive staff experiences.
		• Staff engagement strategies and action plans developed in response to survey feedback.
		• Freedom to Speak Up data showing staff feel safe to raise concerns and contribute to improvements.
		• Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) results demonstrating progress in creating an inclusive workplace.
			Excelling activity	Workforce Experience Team / People Promise (Staff Survey) / Divisions (actions)

		• Evidence of leadership visibility and staff engagement events, such as:
		  • Staff Networks.
		  • Listening exercises.
		  • Executive walkabouts.
		  • Culture conversations.
		• Recognition and reward schemes celebrating staff achievements and contributions.
		• Patient Experience and Friends and Family Test results that align with staff recommendations regarding quality of care.
		• Care Quality Commission (CQC) inspection findings highlighting positive organisational culture and patient care.
		• Induction, learning and development opportunities that support career progression and contribute to positive staff experiences.
		• Flexible working arrangements and wellbeing support that improve staff satisfaction.
		• Results from appraisal and personal development reviews showing staff feel supported and valued.
		• Board reports and People Committee papers reviewing workforce experience, staff survey outcomes and improvement actions.		

Domain 2: Workforce health and well-being overall rating			11	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Board-approved People Strategy with clear leadership accountability. • Board-approved Health Inequalities Strategy and action plan. • EDI objectives are embedded within Board member objectives. • Board and executive committee minutes demonstrating regular discussion of EDI and health inequalities. • Named Executive Lead for EDI. • Clearly defined leadership responsibilities for EDI within executive portfolios. • The Board receive regular EDI performance reports via the EDI insight Report and the EDI Assurance Report, alongside annual reporting via the WRES, WDES, GPG, EDSS and EDI Annual Report, demonstrating progress against equality objectives. • Board development sessions focused on EDI and health inequalities. • EDI Annual Report provides compliance with the Public Sector Equality Duty (PSED). • Workforce Race Equality Standard (WRES) reports reviewed and acted upon by the Board. • Workforce Disability Equality Standard (WDES) reports reviewed and acted upon by the Board. • Gender Pay Gap reporting and associated improvement actions overseen by senior leaders. • Publication and monitoring of EDS22 objectives and outcomes. • Equality Impact Assessments signed off or reviewed by senior leaders for major decisions, policies and service changes. • Board members act as sponsors of staff networks and champion inclusion initiatives. • Senior leaders attending staff network meetings and listening events. • Executive walkarounds and engagement sessions focused on hearing experiences from underrepresented groups. • Leadership communications promoting equality, inclusion and reducing health inequalities.	**Excelling activity**	Executive leads

		• Visible support for awareness campaigns such as Disability History Month, Black History Month, LGBTQ+ History Month and Mental Health Awareness Week. • Inclusion objectives incorporated into leadership appraisals and performance reviews. • Evidence of action taken in response to WRES, WDES, NHS Staff Survey and patient experience findings. • Health inequalities impact assessments considered during service redesign and transformation programmes. • Collaboration with Integrated Care System (ICS) partners to address population health inequalities. • Staff survey results demonstrating confidence in compassionate leadership.		

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• Board and Committee minutes demonstrating discussion of equality and health inequalities implications before decisions are made.
		• Examples of Board papers where EDI risks were identified, challenged and addressed.
		• Evidence that Equality Impact Assessments are completed for:
		  • Major service redesigns.
		  • Policy changes.
		  • Workforce initiatives.
		  • Cost improvement programmes.
		  • Transformation projects.
		• Evidence that Health Inequalities Impact Assessments are undertaken for service changes affecting patient populations.
		• Board papers containing demographic analysis of affected populations and workforce groups.
		• Risk registers that include equality, diversity, inclusion related risks.
		• Corporate Risk Register entries addressing:
		  • Workforce inequalities.
		  • Access inequalities.
		  • Discrimination risks.
		• EDI Steering Group assurance reporting discussing EDI workstreams risks and actions.
		• Board Assurance Framework entries linked to equality and health inequalities objectives.
		• Annual reporting presenting WRES, WDES, Gender Pay Gap and NHS Staff Survey findings to Board and Committees.
		• Minutes demonstrating challenge from Non-Executive Directors regarding equality impacts and risk management.
			Excelling activity	Divisional leads / Policy authors / EDI Lead / Strategic Partnerships Manager / Assistant Director of Patient and Carer Experience and Co-production

		• Service change papers demonstrating assessment of impacts on underserved populations and inclusion health groups. • Reports analysing differential outcomes by ethnicity, disability, sex, age, deprivation and other protected characteristics. • Quality Impact Assessments linked with Equality and Health Inequalities Impact Assessments for major programmes.		

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• Board-approved EDI action plan via EDI Annual Report with clear objectives, performance measures and reporting arrangements. • Board-approved Health Inequalities Strategy with defined outcomes, milestones and accountability structures. • Equality, diversity, inclusion included in the board members strategic objectives. • Clearly identified Executive and Non-Executive leads responsible for EDI performance. • Board Assurance Framework containing EDI risks and performance indicators. • Corporate performance dashboards, via ESR and BI, that include workforce and patient equality metrics. • Regular Board and Committee reports monitoring progress against EDI objectives including WRES, WDES, GPG alongside EDI Insight and Assurance reporting. • People Strategy provides key performance Indicators relating to workforce equality, inclusion, measuring outcomes rather than activity alone. • Workforce Race Equality Standard (WRES) reports reviewed and monitored by Board and Committees. • Workforce Disability Equality Standard (WDES) reports reviewed and monitored by Board and Committees. • Gender Pay Gap reporting with oversight of improvement plans and progress. • NHS Staff Survey results routinely reviewed by senior leaders with measurable action plans. • EDI Steering Group and People and OD committee monitoring equality and inclusion performance. • Progress reports against EDS22 objectives presented to Board and Committees.	**Excelling activity**	Associate Director for People and OD / Executive Medical Director/Patient Safety Lead/PCREF Lead/Assistant Director of PACE

		• Annual EDI Report demonstrating progress against organisational equality objectives.
		• PACE Reports on patient experience data segmented by demographic group to identify inequalities.
		• Leaders receive and review disaggregated workforce data, including:
		  • Recruitment
		  • Retention
		  • Disciplinary processes
		  • Grievances
		  • Bullying and harassment
		  • Learning and development access
		• Health inequalities action plans with assigned executive ownership and progress reporting.
		• Use of benchmarking data to compare performance against peer organisations and national standards.		

Domain 3: Inclusive leadership overall rating			9	
Third-party involvement in Domain 3 rating and review				
Trade Union Rep(s): Staff Side Reps		Independent Evaluator(s)/Peer Reviewer(s): Miriam Sykes City Healthcare Partnership		

EDS Organisation Rating (overall rating):

Total score 30 - Achieving

Organisation name(s):

Humber Teaching NHS Foundation Trust

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**

Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**

Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**

Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Patient Equality Team
NHS England and NHS Improvement
england.eandhi@nhs.net

Humber Teaching NHS Foundation Trust

Agenda Item 21

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	NHS Leadership and Management Framework and NHS Staff Standards Implementation Plan
Author/s:	Pete Cook – Head of Learning and Development
Recommendation:	

To approve	✓	To discuss	✓
To note		To ratify	
For assurance			

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	To provide the Board with an overview of the NHS Leadership and Management Framework and NHS Staff Standards, outline Humber Teaching NHS Foundation Trust's proposed approach to implementation during 2026/27, and provide assurance regarding leadership development, management capability and organisational readiness. On 4th August 2026, EMT supported the proposal, endorsed the phased implementation approach, and approved the key messages contained within the communications plan. EMT also requested further work to explore opportunities to enhance the PROUD Leadership Model in support of the proposed approach.

Key issues:

Positive Assurances to Provide:

- The Trust already demonstrates strong alignment with many of the principles contained within the NHS Leadership and Management Framework and the new NHS Staff Standards.
- Existing arrangements including Being Humber, the behavioural framework, PROUD, appraisals, coaching and leadership development provide a strong foundation for implementation.
- The Trust is actively engaging with national guidance and implementation requirements.
- Governance arrangements are already in place through existing workforce, leadership and People & OD structures.
- A phased implementation approach will ensure alignment with national expectations whilst maintaining local flexibility.

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Phased implementation of the NHS Leadership and Management Framework aligned to existing Trust processes.
- Mapping completed/underway to align current leadership and management activity with national standards.
- Framework being embedded within appraisal, leadership development and talent management processes.
- Leadership programmes, including PROUD, coaching and mentoring, being aligned to the framework.
- Communications, engagement and executive sponsorship activity being developed and launched.
- Ongoing review of NHS England reporting requirements and evaluation measures.

Key Risks/Areas of Focus:

Decisions Made:

• Maintaining a developmental focus and avoiding the framework being perceived as a compliance exercise. • Ensuring alignment between existing Trust leadership approaches and evolving national requirements. • Managing expectations around NHS England reporting arrangements and the current limitations of available organisational data. • Sustaining engagement across all leadership and management groups throughout implementation. • Embedding the framework within existing processes such as appraisal, leadership development and talent management, rather than creating additional bureaucracy. • Securing visible senior leadership sponsorship to support adoption and culture change. • Monitoring impact and effectiveness through appropriate evaluation measures as implementation progresses.	• On 4th August EMT noted the content of this report and received assurance that the Trust is well prepared for adoption of the national framework when released. • No further decisions are required at this stage.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)

Hospital to Community	N/A
Analogue to Digital	N/A
Sickness to Prevention	N/A

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	04/08/26
Mental Health Legislation Committee		Operational Delivery Group	27/07/26
Collaborative Committee		Other (please detail) Board	30/09/26

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

✓ *Tick those that apply*

Innovating Quality and Patient Safety	
Enhancing prevention, wellbeing and recovery	
Fostering integration, partnership and alliances	
Developing an effective and empowered workforce	✓
Maximising an efficient and sustainable organisation	
Promoting people, communities and social values	✓

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity	✓

Public Exemption:

Is the report exempt from public disclosure	No

NHS Leadership and Management Framework and NHS Staff Standards Implementation Plan

Background

In July 2026 NHS England launched both the NHS Leadership and Management Framework and the NHS Staff Standards. Together these initiatives establish a national framework for leadership, management, staff experience and organisational culture.

The NHS Leadership and Management Framework provides a common set of standards for those with leadership and management responsibilities across NHS funded services. The framework is designed primarily as a development tool and is expected to be embedded through appraisal, leadership development, recruitment, talent management and career development processes.

The NHS Staff Standards establish a series of expectations relating to staff experience and line management and will form part of future NHS Oversight Framework arrangements.

The Trust welcomes both developments and recognises the opportunity to further strengthen leadership capability, management practice and staff experience.

Current Position

The launch of the national framework does not require the Trust to replace existing arrangements. Instead, it provides an opportunity to demonstrate how local approaches align with national expectations.
Current activity already supporting delivery includes:

- Being Humber values and behaviours framework.
- PROUD leadership development programme.
- Leadership coaching and mentoring.
- Career development planning resources.
- Annual appraisal process.
- Compassionate and inclusive leadership approaches.
- Talent and succession planning activity.
- Management development provision.
- Leadership and organisational development interventions.

A mapping exercise has commenced to identify alignment between Trust provision and the national standards. Early analysis suggests strong alignment across leadership behaviours, management capability and development opportunities.

Strategic Approach

The Trust's implementation approach is based upon three principles:

1. **Alignment**
   Ensuring local leadership, management and workforce development activity aligns with national standards whilst retaining successful local approaches.
2. **Development**
   Positioning the framework as a developmental opportunity rather than a compliance exercise.
3. **Integration**
   Embedding the framework within existing processes and conversations rather than creating additional standalone requirements.

Self-Assessment Approach

The national framework includes a self-assessment tool which NHS England expects leaders and managers to utilise as part of ongoing appraisal and development conversations.
The Trust has undertaken testing of the national tool and continues to work with NHS England to better understand future reporting arrangements and organisational data availability.
At present:

- The assessment is hosted on a national platform.
- Individual level completion data is not available to organisations.
- Reporting arrangements are still evolving.
- Early organisational reporting is expected to focus primarily on participation rates.
- More detailed organisational learning needs analysis is anticipated during 2027/28.

Whilst colleagues wishing to undertake the self-assessment will be encouraged to do so, the Trust's immediate priority is not the promotion of assessment completion rates. Instead, our focus will be on supporting meaningful development conversations, reflective practice and career planning.

As national reporting arrangements mature, the Trust will review opportunities for wider adoption and integration within appraisal processes.

Governance and Assurance
Implementation will be overseen through existing governance structures.

Executive Leadership
- Executive Director of People and OD
- EMT oversight

Workforce Governance
- Staff Standards reporting arrangements
- People and Organisational Development Committee
- Workforce performance reporting

Programme Governance
- Learning and Development Team
- Leadership and Management Trainer
- People Experience Team

Progress will be reported through existing People and Organisational Development updates.
The Leadership and Management Framework will be incorporated into the Trust's wider Staff Standards implementation programme, ensuring a single coordinated approach to leadership, management and staff experience.

Proposed Timeline

Autumn 2026
Awareness and Alignment
- Leadership framework communications launched.
- Mapping exercise completed.
- Leadership and management offer reviewed.
- Executive sponsor communications.
- Development of manager conversation guidance.

Winter 2026/27
Engagement and Learning
- Staff engagement sessions.
- Leadership forums.
- Senior leadership discussions.
- Alignment of PROUD curriculum.
- Introduction of Management Fundamentals Programme proposals.

Spring 2027
Embedding and Integration
- Incorporation into appraisal guidance.
- Development planning resources refreshed.
- Review of available national data.
- Local evaluation arrangements established.

Summer 2027
Evaluation and Continuous Improvement
- Initial impact assessment.
- Review of implementation progress.
- Future recommendations developed.

Communications and Engagement Plan
We recommend adopting a consistent narrative throughout implementation.

Core Message 1
The framework supports and strengthens what Humber already values.
The framework aligns strongly with Being Humber, our values, behaviours and commitment to compassionate leadership.

Core Message 2
This is about development, not compliance.
The purpose is to support manager and leader growth, confidence and capability rather than create additional bureaucracy.

Core Message 3
Leadership happens at every level.
The framework applies equally to clinical and non clinical colleagues with leadership and management responsibilities.

Core Message 4
Great leadership improves staff experience, quality and patient care.
Leadership development remains a key organisational priority.

Recommended Planned Engagement Activity

Executive Sponsorship –

The overall strategic message could be along the lines of:

"The NHS Leadership and Management Framework does not change who we are. It gives national recognition and structure to the leadership culture Humber has already been working hard to build through Being Humber and PROUD."

There is an opportunity for our Senior Leaders to be at the front of this, to reassure and champion our workforce.

Regular articles and communications from EMT and ODG highlighting our existing performance:
- “Leadership, culture and patient experience”
- “Leading Being Humber”
- “Why leadership matters at Humber”
- “Our commitment to delivering Leadership development’
- “Compassionate leadership in practice”
- “Clinical leadership and quality improvement”
- “Great management delivers great services”
- “My interpretation of the National Leadership and Management Framework”

Leadership Meetings
Quarterly discussions focusing on:
- Framework implementation.
- Leadership capability.
- Management practice.
- Organisational culture.

Focus Groups
Targeted engagement with:
- New managers.
- Clinical leaders.
- Operational managers.
- Corporate leaders.
- Experienced leaders.

Development Programmes
Integration within:

- PROUD.
- Future Management Fundamentals Programme.
- Leadership workshops.
- Coaching and mentoring.

External Promotion
Use of the framework and associated activity within:

- Recruitment campaigns.
- Employer branding.
- Annual reporting.
- NHS case studies.
- Leadership and workforce awards submissions.

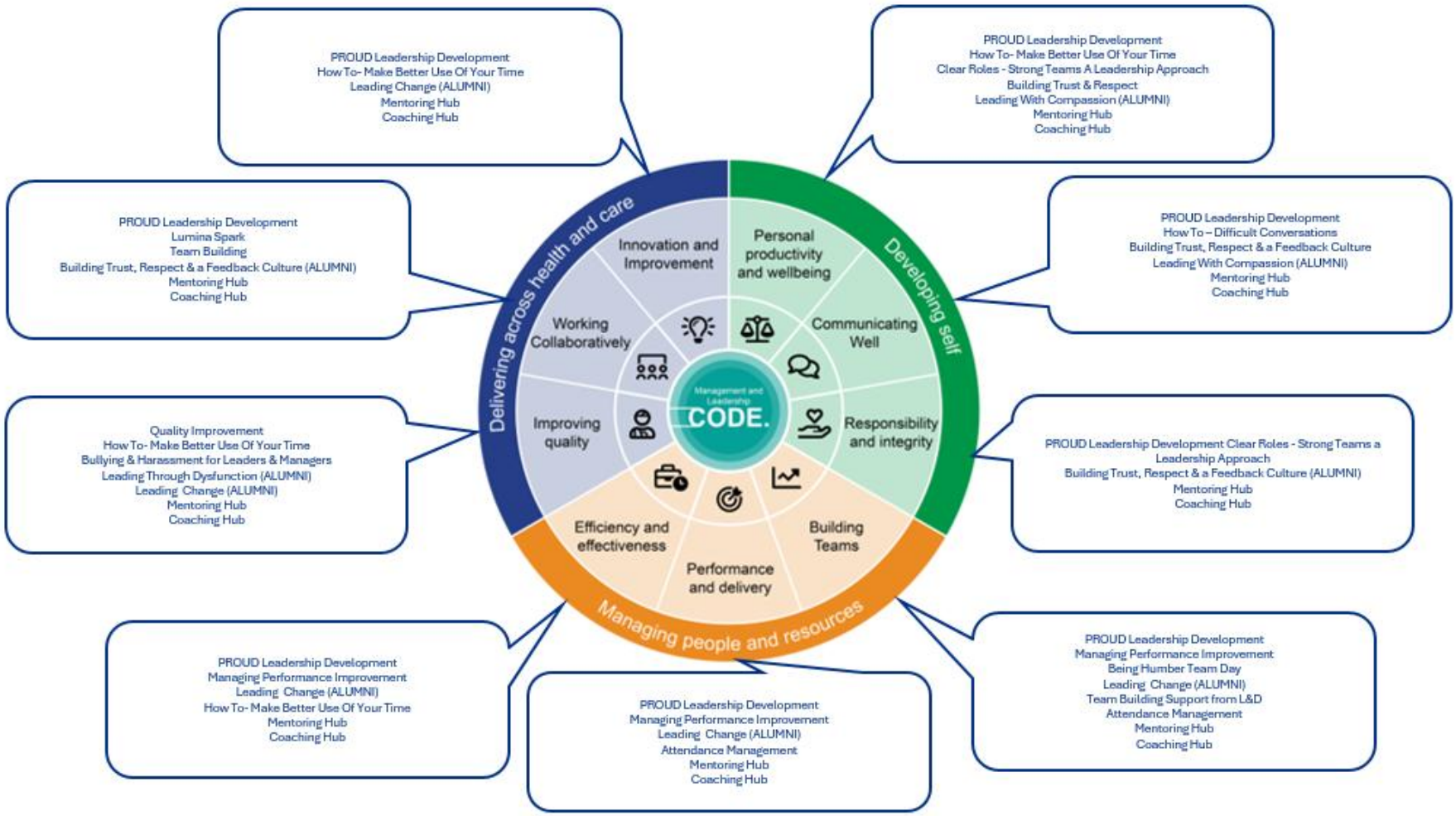
Key Risks / Areas of Focus

- Maintaining a developmental rather than compliance focused approach.
- Ensuring alignment between local and national requirements.
- Managing expectations regarding national reporting and data availability.
- Maintaining engagement across all leadership groups.

Decisions Made
EMT supported the following recommendations at the meeting on 4th August 2026:

- Note the NHS Leadership and Management Framework
- Support the proposed phased implementation approach.
- Endorse the key messages in our communications plan.
- Receive assurance that implementation will be aligned to existing leadership, appraisal and workforce governance arrangements as the framework resources evolve
- Note that further updates will be provided through established governance routes.

Appendix A
Mapping of NHS Leadership and Management Framework against current Humber Leadership and Management Training Offer



Caring, Learning
& Growing Together

Humber Teaching NHS Foundation Trust

Agenda Item 22

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	NHS Staff Standards 2026
Author/s:	Karen Phillips – Executive Director of People & OD
Recommendation:	

To approve		To discuss	
To note	√	To ratify	
For assurance	√		

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	To provide the Board with an update on the Trust's preparedness and implementation approach in response to the NHS Staff Standards published in July 2026, including the outcome of the Trust's readiness assessment, agreed executive sponsorship arrangements, progress with implementation planning and the governance framework through which ongoing assurance will be provided.

Key issues:

Positive Assurances to Provide:

- The Trust has completed a comprehensive assessment against all six NHS Staff Standards and is able to demonstrate strong alignment with many of the national requirements.
- Existing arrangements relating to Health and Wellbeing, Sexual Safety, Equality, Diversity and Inclusion, Leadership Development and Staff Experience provide a strong foundation for implementation.
- The Trust's current NHS Staff Standards score on Model Hospital (7.79) is above both peer and provider median performance.

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Development of a Trust-wide NHS Staff Standards implementation plan.
- Review and refresh of the Being Humber framework to strengthen alignment with the NHS Staff Standards.
- Establishment of a quarterly NHS Staff Standards assurance dashboard through the People Insight Report.
- Alignment of implementation with the NHS Leadership and Management Framework.

• Executive sponsorship arrangements have now been agreed for five of the six standards, strengthening accountability and oversight. • The Trust has adopted an integrated implementation approach through the Being Humber framework, avoiding unnecessary duplication and embedding the standards within existing organisational culture and leadership arrangements. Governance, reporting and assurance arrangements are being developed through existing EMT, People Committee and Board structures.	• Continued engagement with Trade Unions, Staff Networks and relevant governance groups. • Development of assurance arrangements linked to the NHS Oversight Framework. Further work to determine executive ownership and implementation requirements for the Violence Prevention and Reduction Standard.
Key Risks/Areas of Focus: • Demonstrating sustained improvement against national workforce metrics and Staff Survey indicators. • Ensuring consistent implementation across all services and directorates. • Responding to evolving national reporting and assurance requirements. • Strengthening governance and accountability arrangements for Violence Prevention and Reduction. • Avoiding duplication by embedding the standards through existing organisational frameworks and programmes. • Maintaining engagement and ownership across leadership teams, managers and staff groups.	**Decisions Made:** • The Board is asked to take assurance that: • The Trust has undertaken and completed a comprehensive readiness assessment against all six NHS Staff Standards. • Executive accountability arrangements have been established and implementation activity is underway. • Existing governance structures provide an appropriate framework for oversight and assurance. • The Trust remains well positioned to meet the requirements of the NHS Staff Standards and to respond to future NHS Oversight Framework expectations.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	The standards support the Trust's ability to attract, retain and develop a workforce capable of delivering care across community, neighbourhood and home-based settings through effective leadership, wellbeing support and flexible working arrangements.
Analogue to Digital	The implementation programme includes development of workforce dashboards and enhanced use of workforce intelligence to monitor staff experience, risks and organisational improvement.
Sickness to Prevention	The Standards place significant emphasis on wellbeing, inclusion, violence prevention, sexual safety and effective management practice. Collectively these support a preventative approach to workforce health, improve staff experience and contribute to improved retention, attendance and organisational performance.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	11/08/26 01/09/26
Mental Health Legislation Committee		Operational Delivery Group	27/07/26
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	✓
Enhancing prevention, wellbeing and recovery	
Fostering integration, partnership and alliances	
Developing an effective and empowered workforce	✓
Maximising an efficient and sustainable organisation	
Promoting people, communities and social values	

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	✓

Public Exemption:

Is the report exempt from public disclosure	No

NHS Staff Standards 2026 - Board Assurance Update

Executive Summary

The NHS Staff Standards were launched nationally in July 2026 and establish a new mandatory framework setting out the minimum employment standards expected across NHS organisations. The standards are designed to improve staff experience, strengthen organisational culture and provide clearer accountability for workforce wellbeing, inclusion, leadership and safety. Performance against the standards will form part of the NHS Oversight Framework and will be assessed through a combination of NHS Staff Survey measures, workforce metrics, organisational evidence and regulatory assurance arrangements.

A comprehensive assessment of Humber Teaching NHS Foundation Trust's current position against all six standards has been completed. This assessment demonstrates that the Trust has strong foundations in place and is already delivering many of the requirements through existing programmes, governance arrangements and cultural initiatives. Significant strengths are evident in Health and Wellbeing, Sexual Safety, Leadership Development and Equality, Diversity and Inclusion.

The Executive Management Team has considered the national requirements, reviewed the Trust's readiness assessment and agreed executive sponsorship arrangements for five of the six standards to provide clear accountability and oversight. Work is now progressing to develop a formal implementation plan, establish assurance reporting arrangements and align the standards with the Trust's Being Humber framework.

Overall assurance is that the Trust is well positioned to meet the requirements of the NHS Staff Standards and has a clear implementation programme in place to address identified gaps and strengthen organisational assurance.

Background and National Context

The NHS Staff Standards were introduced by the Department of Health and Social Care and NHS England following commitments within the 10 Year Health Plan. They establish minimum expectations regarding how NHS staff should be supported, managed and treated at work, creating a more consistent approach to staff experience across the NHS.

The six standards are:

1. Line Management
2. Health and Wellbeing
3. Violence Prevention and Reduction
4. Tackling Racism
5. Championing Sexual Safety
6. Promoting Flexible Working

The standards complement and reinforce a number of existing national workforce initiatives including the NHS People Promise, NHS Equality, Diversity and Inclusion Improvement Plan, Sexual Safety Charter, Violence Prevention and Reduction Standard and the NHS Leadership and Management Framework. Trust Boards are expected to demonstrate oversight, governance and evidence of delivery against each of the standards.

Trust Readiness and Current Position

An assessment against the six standards has been undertaken and reviewed through EMT. The assessment concluded that the Trust has significant strengths and established arrangements across a number of the standards.

Notable areas of strength include:

- Comprehensive health and wellbeing support arrangements.
- Established wellbeing governance and Wellbeing Guardian arrangements.
- Strong sexual safety governance and implementation of the NHS Sexual Safety Charter.

- Mature Equality, Diversity and Inclusion governance and reporting arrangements.
- Established Freedom to Speak Up processes.
- Leadership development programmes including PROUD, coaching and mentoring.
- Strong appraisal performance and management development activity.
- Workforce reporting and governance arrangements through EMT and People Committee.

The Trust's current NHS Staff Standards score on Model Hospital is 7.79, which is above both peer and provider median performance, providing assurance that the organisation is starting from a comparatively strong position.

Current overall assessment is:

Standard	Position
Health and Wellbeing	Strong position
Championing Sexual Safety	Strong position
Tackling Racism	Strong position
Line Management	Good foundations with further implementation required
Flexible Working	Good practice in place with governance enhancements required
Violence Prevention and Reduction	Further assessment and ownership being developed

Governance and Executive Sponsorship

The NHS Staff Standards require organisations to establish clear ownership, accountability and governance oversight arrangements. While EMT considered whether each standard should be assigned to a separate Executive Director, it was recognised that many of the standards are intrinsically connected through workforce culture, leadership, staff experience and organisational performance. As the Executive Director of People & OD is the Trust's Senior Responsible Officer for the NHS Staff Survey, People Promise, workforce experience and associated assurance frameworks, EMT concluded that overall coordination, reporting and oversight of the Standards would sit most effectively within a single executive portfolio. This approach supports coherence of implementation, minimises duplication and enables a consistent approach to assurance through existing workforce governance arrangements.

EMT also recognised that some standards already benefit from well-established leadership, sponsorship and governance arrangements. In particular, Health and Wellbeing and Tackling Racism are supported by mature governance structures, active steering groups and established sponsorship roles. Retaining these arrangements was considered both proportionate and beneficial, allowing the Trust to build on existing leadership, expertise and engagement rather than introducing additional governance mechanisms. This approach provides continuity, aligns with current organisational structures and strengthens accountability through leadership arrangements that are already visible and embedded across the Trust.

Following consideration by EMT, the following Executive Sponsors have been agreed:

Staff Standard	Executive Sponsor
Line Management	Karen Phillips
Health and Wellbeing	Lynn Parkinson (Karen Phillips in her absence)
Tackling Racism	Sarah Smyth
Championing Sexual Safety	Karen Phillips
Promoting Flexible Working	Karen Phillips
Violence Prevention and Reduction	To be confirmed following further EMT consideration

EMT further agreed that the Executive Director of People & OD will act as the overall Executive Lead for implementation of the NHS Staff Standards, providing strategic coordination of delivery, reporting and assurance arrangements. Progress will be monitored through existing workforce governance structures, including EMT, the People Committee and Board reporting mechanisms. This approach builds upon

established sponsorship, guardian and network arrangements, ensuring the Standards are embedded within existing organisational processes and culture rather than creating separate governance structures.

Integration with Being Humber

A key principle of the Trust's implementation approach is that the NHS Staff Standards will be embedded through existing organisational culture and leadership arrangements rather than being treated as a standalone compliance exercise.

There is significant alignment between the standards and the Being Humber behavioural framework, particularly in relation to:

- Compassionate leadership.
- Inclusion and belonging.
- Integrity and respect.
- Effective communication.
- Teamwork and collaboration.
- Safety and psychological wellbeing.

A review of Being Humber is therefore underway to strengthen alignment with the new standards and ensure national expectations are fully reflected within local behavioural expectations, leadership development activity and appraisal conversations.

Key Implementation Activity

The following actions are now underway:

- Completion of detailed gap analysis against all six standards.
- Development of a Trust-wide NHS Staff Standards implementation plan.
- Establishment of governance and accountability arrangements.
- Alignment of Being Humber with NHS Staff Standards requirements.
- Development of a quarterly NHS Staff Standards dashboard.
- Alignment with the NHS Leadership and Management Framework.
- Continued engagement with Trade Union colleagues and staff networks.
- Integration of Standards reporting within existing Board and People Committee assurance arrangements.

In addition, the Violence Prevention and Reduction Standard is being aligned with wider organisational work including No Excuse for Abuse, Equality Diversity and Inclusion programmes and preparations for the strengthened duty under the Employment Rights Act 2025 requiring employers to take all reasonable steps to prevent third-party harassment.

Assurance and Reporting

To support ongoing oversight, a dedicated NHS Staff Standards dashboard is being developed for inclusion within the quarterly People Insight Report. This will provide assurance against the workforce metrics and staff survey indicators that contribute to national assessment through the NHS Oversight Framework.

Reporting will focus on:

- Staff Survey indicators.
- Flexible working measures.
- Leadership and management metrics.
- Health and wellbeing indicators.
- Sexual safety measures.
- Violence and abuse reporting.
- WRES and WDES indicators.
- Freedom to Speak Up themes.
- Workforce experience and retention measures.

Risks and Areas of Focus

The principal risks identified are:

- Failure to demonstrate progress against nationally defined standards and workforce metrics.
- Inconsistent implementation across services.
- Increased national expectations regarding reporting and evidence of compliance.
- Potential duplication if implementation is not effectively aligned with Being Humber and existing workforce programmes.
- The need to reinforce governance and accountability arrangements in areas such as Violence Prevention and Reduction and Flexible Working.

Board Assurance Statement

The Board can take assurance that:

- The Trust has undertaken a comprehensive assessment against all six NHS Staff Standards.
- Existing arrangements demonstrate strong alignment with many of the national requirements.
- Executive sponsorship arrangements have been established for five of the six standards, with the final sponsorship arrangement to be confirmed through EMT.
- A formal implementation programme is underway.
- Assurance, reporting and governance arrangements are being strengthened through existing structures.
- The Trust is performing above peer and provider median performance on the national NHS Staff Standards score.
- The Trust is embedding the standards through Being Humber, leadership development, wellbeing, inclusion and workforce improvement programmes, supporting sustainable implementation rather than a compliance-led approach.

Overall Assurance Rating: Substantial Assurance. The Trust has strong foundations in place and is well positioned to deliver the NHS Staff Standards, with implementation activity now focused on strengthening governance, reporting and evidencing delivery against emerging national requirements.

Humber Teaching NHS Foundation Trust

Agenda Item 23.1

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Cyber Security Briefing
Author/s:	Lee Rickles, Chief Information Officer and Deputy Senior Information Risk Owner Peter Beckwith, Executive Director of Finance, Resources Estates and Digital
Recommendation:	

To approve	✓	To discuss	
To note	✓	To ratify	
For assurance	✓		

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	The purpose of this paper is to provide assurance to the Trust Board regarding the increasing cyber security threat facing the Trust and to seek approval for a strengthened cyber resilience, business continuity and recovery programme. The paper outlines how the cyber threat landscape is changing because of increasing geopolitical instability, growing dependence upon digital technologies, increased interconnectedness of NHS systems and the emergence of Artificial Intelligence (AI)-enabled cyber threats.

Key issues:

Positive Assurances to Provide:

- The Trust continues to maintain a strong cyber security foundation supported by established governance, technical security controls and ongoing assurance activities.
- The Trust recently received a Low Risk Assurance rating with High Confidence following independent assessment of the Data Security and Protection Toolkit (DSPT).
- Existing controls include vulnerability monitoring, network security controls, phishing awareness activities, penetration testing, disaster recovery testing and information governance oversight arrangements.
- The Trust's Digital Strategy identifies cyber security, resilience, governance and

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Review of Trust cyber resilience arrangements against the NHS England Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit objectives and the seven NHS England cyber resilience domains.
- Preparation for the transition to the CAF 4.0 standard and the tightening of DSPT requirements expected from September 2026.
- Further strengthening of business continuity, digital disruption and recovery planning following recommendations from the Digital Disruption Internal Audit review.

compliance as core foundations supporting safe digital transformation. • The Trust has an active digital governance structure with oversight through BeDigital, Information Governance and Audit arrangements.	• Review of organisational preparedness for AI-enabled cyber threats including advanced phishing, social engineering, deepfake technology and supply chain vulnerabilities. • Development of enhanced Board cyber assurance reporting covering recovery capability, resilience testing, critical system dependencies and organisational readiness.
Key Risks/Areas of Focus: • **Escalating Cyber Threats:** Geopolitical instability and increased targeting of healthcare organisations are increasing the likelihood and potential impact of cyber attacks on NHS services. • **AI-Enabled Attacks:** Advances in Artificial Intelligence are enabling more sophisticated cyber attacks, including accelerated vulnerability discovery, automated exploitation, phishing, social engineering and deepfake-enabled fraud. • **Operational Dependence on Digital Services:** The Trust's growing reliance on digital systems, cloud services, suppliers and electronic patient records increases the potential impact of any significant cyber incident on patient care and operational delivery. • **Business Continuity and Recovery Resilience:** Further assurance is required that critical services can continue and recover effectively following prolonged digital disruption, cyber attack or supplier failure.	**Decisions Made:** • Progress the recruitment of a cyber security information officer.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	
Analogue to Digital	Yes
Sickness to Prevention	

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee	21.07.26	Executive Management Team	21.07.26
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		BeDigital Group	12.08.26

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	
Enhancing prevention, wellbeing and recovery	
Fostering integration, partnership and alliances	
Developing an effective and empowered workforce	
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	Y

Public Exemption:

Is the report exempt from public disclosure	No

Cyber Security Briefing

1 Introduction and Purpose

The purpose of this paper is to provide assurance to the Finance Committee regarding the increasing cyber security threat facing the Trust and to seek approval for a strengthened cyber resilience, business continuity and recovery programme.

The paper outlines how the cyber threat landscape is changing because of increasing geopolitical instability, growing dependence upon digital technologies, increased interconnectedness of NHS systems and the emergence of Artificial Intelligence (AI)-enabled cyber threats.

2 Background and Strategic Context

The NHS continues to accelerate its digital transformation agenda. Electronic patient records, digital clinical workflows, data sharing, cloud services, remote working technologies and digital citizen services are becoming fundamental to service delivery across the health sector.

Whilst these developments provide substantial benefits for patients and staff, they also increase dependency on technology and therefore increase organisational exposure to cyber attack

NHS England has specifically advised Boards (Appendix A) to assure themselves that cyber security risks are being managed effectively through appropriate governance, resilience planning and continuous improvement.

Organisations should ensure comprehensive assurance against seven key cyber resilience domains: Asset Management, Supply Chain Security, Identity and Access Management, Vulnerability Management, Backups and Recovery, Security Monitoring, and Incident Response.

3 The Evolving Cyber Threat Landscape

3.1 Geopolitical Tensions and Healthcare Risk

Healthcare providers remain attractive targets for cyber criminals, organised crime groups and state-sponsored threat actors. The increasing geopolitical instability observed internationally has contributed to rising levels of hostile cyber activity directed towards public sector organisations and critical national infrastructure.

3.2 Artificial Intelligence and Advanced Cyber Threats

Artificial Intelligence is fundamentally changing cyber security. Historically, identifying software vulnerabilities required specialist resources, extensive technical expertise and considerable time.

Advances in AI now enable increasingly complex systems to be analysed rapidly and at scale.

Additionally, as the Trust increasingly integrates systems such as Google Cloud Platform, Large Language Models like Microsoft 365 Copilot, and ambient voice systems into clinical and corporate architectures, our attack surface shifts. This necessitates robust data governance to prevent accidental information exposure or exploitation.

3.3 AI-Enabled Fraud, Phishing and Deepfakes

AI is also making social engineering attacks more convincing and more difficult to detect. Voice-cloning technology has advanced significantly and can be used to imitate trusted individuals convincingly. Combined with AI-generated content and deepfake technologies, malicious actors can potentially create fraudulent communications appearing to originate from executives, colleagues, suppliers or trusted partners.

4. Current Trust Assurance Position

The Trust has established a strong foundation for cyber security and information governance with clearly defined accountability governance and escalation processes.

Supporting this the Trust has a well organised and controlled policy framework with regular review cycles to ensure alignment with national guidance.

A recent independent review of the Data Security and Protection Toolkit (DSPT)concluded with the following assessment

i. The over risk assurance rating associated with the security and governance of information is **'low'**.
ii. Confidence in the veracity of the evidence for the DSPT submission was '**High**'.

The audit all found and highlighted many areas of good practice.

The Trust maintains a range of technical and operational cyber controls including:

- Network and device security controls.
- Multi-factor authentication (MFA) and privileged access management.
- Phishing awareness activities.
- Vulnerability monitoring and penetration testing.

- Information governance oversight and cyber security planning.
- Disaster recovery testing.

5. Business Continuity and Recovery

The most significant risk to the Trust is not simply the occurrence of a cyber incident, but the inability to recover quickly and safely from such an incident. Recent events across the NHS have demonstrated that organisations may experience prolonged disruption following major cyber attacks.

The Trust must ensure that business continuity plans remain current, digital disruption procedures are regularly reviewed, and critical service dependencies are understood.

The Trust has completed a desktop business continuity and disaster recover exercise using a prolonged IT outage to test response arrangements, escalation, communications and service continuity planning.

6. Strengthening Organisational Resilience

To address the changing threat landscape, a strengthened cyber resilience programme is proposed.

Key priorities should include:

- **Cyber Assurance:** Alignment of Trust assurance arrangements to the seven NHS England cyber resilience domains, and formal preparation for the shift to Cyber Assessment Framework 4
- **Asset Management:** Maintenance of a complete Information Asset Register (IAR) identifying hardware, software, cloud services, and data dependencies mapped against the Trust's essential functions.
- **Recovery Planning:** continued annual review and testing of recovery plans for critical systems together with Board-level reporting of outcomes and assurance.
- **Business Continuity Exercises:** Expanded testing programme covering cyber attack scenarios, supplier outages, cloud service failures, and extended periods of manual operation.
- **Supply Chain Assurance:** Enhanced review of supplier cyber resilience, embedding minimum security requirements into contracts, monitoring compliance, and enforcing secure offboarding.

7. Cyber Security Capability and Resources

The increasing sophistication of cyber threats is creating additional assurance and specialist resource requirements across the NHS. The Trust should therefore undertake a review of whether current cyber capability remains sufficient to provide the level of assurance expected by regulators, NHS England and the Board.

8. Recommendations

The Trust Board are asked to:

1. **Note** the increasing cyber risk arising from geopolitical instability, greater digitisation and AI-enabled cyber threats.
2. **Recognise** cyber security as a strategic organisational risk with direct implications for patient safety, operational continuity and regulatory compliance.
3. **Support** the development of an enhanced Cyber Resilience and Assurance Programme aligned to NHS England requirements.
4. **Support** a programme of strengthened business continuity, disaster recovery and cyber incident exercises.
5. **Support** an annual Board report outlining recovery arrangements for critical systems, including explicit evidence that these plans have been successfully tested.
6. **Support** the development of an options appraisal regarding future cyber capability, expertise and assurance requirements.

Classification: Official

NHS England

To:
- NHS trusts and integrated care boards:
  - chief executive officers
  - chairs

cc.
- NHS trusts and integrated care boards:
  - chief information officers
  - data protection officers and information governance
- Regional communication leads

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

10 June 2026

Dear colleagues,

Board and executive assurance: cyber security risk

The Government's 10 Year Health Plan is transforming how services are delivered through greater digitisation. However, increased use of digital tools also brings new and enhanced risks that need to be managed.

I am writing to ask **boards and executives to assure themselves that cyber security risks are being managed effectively**, with clear, sustained programmes for improvement.

Geopolitical events and technology developments are increasing the cyber security threats we face. As seen in well-documented incidents across the economy, the impact of a cyber attack is felt across the entire organisation, not just its digital function.

Consequently, plans to address cyber security risks need an organisation-wide response; this should receive proper scrutiny and assurance through organisational governance.

Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSPT) is the standard that all frontline NHS organisations are expected to comply with and is aligned to the National Cyber Security Centre's Cyber Assessment Framework (CAF). The next DSPT submissions are due at the end of June 2026.

The DSPT details a range of outcomes, covering the following 5 objectives:

- managing cyber risk
- protecting against cyber-attack and data breaches
- detecting cyber security events

- minimising the impact of incidents
- using and sharing information appropriately

Supporting guidance

Alongside the guidance for Executive and Non –Executive Directors Cyber security guide for executive and non-executive directors - NHS England Digital, we have also identified the 7 foundational outcomes that have the greatest impact on organisational cyber resilience.

These outcomes, set out in Annex A, are relevant for submissions up to 30 June 2026.

New cyber policies from September 2026

From September 2026, we will produce a series of new and updated directive cyber policies to be included in the next DSPT. This will cover issues including multi-factor authentication, high-severity alerts and end-point detection. In addition, the DSPT will be updated to incorporate the next evolution of the CAF, namely 4.0.

We have also provided cyber practitioners with a roadmap for the tightening of requirements for complying with DSPT each year from now until 2030. We therefore expect incremental progress and investment, year on year.

Executive accountability for cyber security

We strongly recommend that each organisation formally appoint a member of the executive team responsible for cyber security to assist the organisation's board of directors in meeting their accountabilities. They should ensure:

- the right cyber security measures are in place
- risks are checked and managed
- improvements are carried out across the organisation

We also recommend that organisations gain assurance of their emergency preparedness, with a particular focus on the operational impact of cyber incidents, which often have effects that last months and years. This should include exercises to assess clinical and operational readiness to cope with such disruptions.

In addition, we recommend that boards should receive an annual report outlining recovery plans for critical systems, including evidence that these plans have been tested.

All current evidence and advice suggest that organisations that put in place the right foundations are more resilient to the consequences of a cyber-attack. I hope this information helps you assure yourselves that the right measures are in place to protect the ongoing provision of services to the public.

Yours sincerely,

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Tom Wechsler

Head of Cyber Security

NHS England | Department of Health and Social Care

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Annex A – Data Security and Protection Toolkit (DSPT): Key expectations and examples of good practice

The overall expectation is for NHS board members and executives to demonstrate grip and appropriate controls, proportionate to the risk and criticality; maintain evidence of compliance; and review and improve controls regularly.

The requirements that boards and executives need to explore for assurance are set out in this Annex.

The detail of what should be submitted before or by the end of June 2026 is contained in this guidance: https://digital.nhs.uk/cyber-and-data-security/guidance-and-resources/dspt-aligned-dcpt-guidance

Asset Management

The organisation must identify, record and manage all assets that support essential functions.
The requirements to meet this expectation are:

- Maintain a complete and up-to-date asset inventory covering hardware, software, cloud services and data.
- Maintain and regularly review an Information Asset Register (IAR).
- Assign an owner for each asset.
- Classify assets based on their importance to essential functions.
- Identify and record dependencies (including supporting infrastructure where relevant).
- Define and enforce lifecycle management (onboarding, change, patching and decommissioning).
- Reconcile inventories against authoritative sources and resolve discrepancies.

Examples of good practice – asset management

- All relevant assets are identified at an appropriate level of detail.
- Assets are prioritised by criticality.
- Ownership and accountability are clear.
- Assets are managed securely throughout their lifecycle.

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Supply Chain

The organisation must understand and manage cyber risks arising from suppliers and third parties.
The requirements to meet this expectation are:

- Maintain a register of all suppliers that support essential functions.
- Assess cyber risk before onboarding and at defined intervals thereafter.
- Apply controls proportionate to supplier criticality.
- Include security requirements in contracts, covering:
    - Minimum security standards
    - Incident notification
    - Audit rights
    - Secure offboarding
- Monitor supplier compliance and track remediation to completion.

Examples of good practice – supply chain

- The organisation understands supply chain risks and dependencies.
- Third-party connections are known and controlled.
- Security and data protection obligations are built into contracts.
- Supply chain incidents are considered in incident response plans.
- Data shared with suppliers is protected.

Identity, Authentication and Access Control

The organisation must control access to systems and data.
The requirements to meet this expectation are:

- Uniquely identify all users and services.
- Verify identity before granting access.
- Enforce multi-factor authentication (MFA) in line with national policy for:
    - Privileged access
    - Remote access
- Apply least privilege access controls.
- Review access rights at least quarterly and on role change.
- Implement secure credential management, including:
    - Strong password policy

Backups

The organisation must ensure data and systems can be restored.
The requirements to meet this expectation are:

- Backup systems and data required for essential functions.
- Align backup scope to recovery objectives (RTO/RPO).
- Protect backups from unauthorised access and tampering.
- Define retention periods and storage locations.
- Maintain segregated or offline copies where appropriate.
- Test backups and restores at planned intervals and after major change.
- Record and remediate restore failures.

Examples of good practice - backups

- Backup arrangements reduce the risk of common failure.
- Backups are secure, automated and regularly reviewed.
- Restore capability is proven through testing.

Security Monitoring

The organisation must detect potential security incidents affecting essential functions.
The requirements to meet this expectation are:

- Define monitoring requirements for critical services.
- Ensure monitoring covers:
  - Identity systems
  - Endpoints and servers
  - Network devices
  - Internet-facing services
  - Cloud environments (where used)
- Collect logs centrally.
- Ensure logs are time-synchronised, protected and retained.
- Regularly validate monitoring coverage.
- Tune alerts to reduce false positives and missed events.

    - Secure storage
    - Timely removal of access

Examples of good practice – identity, authentication and access control

- Shared accounts are not used unless risk-assessed and controlled.
- Joiners, movers and leavers are managed promptly.
- Access is role-based and regularly reviewed.
- Access is removed when no longer required.

Vulnerability Management

The organisation must manage vulnerabilities to reduce risk to essential functions. The requirements to meet this expectation are:

- Operate a documented vulnerability management process consisting of the following activities:
    - Identify
    - Prioritise
    - Remediate or Mitigate
    - Verify
- Scan systems at defined intervals and after significant change.
- Prioritise remediation based on severity and business impact.
- Identify unsupported or end-of-life systems and manage associated risk.
- Define remediation timescales and enforce them.
- Require formal approval for exceptions, with time limits and compensating controls.
- Track all remediation to completion and retain evidence.

Examples of good practice – vulnerability management

- Vulnerabilities are identified from multiple sources.
- Risk-based prioritisation is applied consistently.
- Exceptions are controlled and time bound.
- Evidence of remediation is maintained.

Examples of good practice – security monitoring

- Monitoring detects relevant security events in a timely manner.
- Critical log sources are onboarded and functioning.
- Detection rules are regularly reviewed and improved.

Incident Response

The organisation must be able to respond effectively to cyber incidents.
The requirements to meet this expectation are:

- Maintain an incident response plan based on identified risks.
- Define roles, responsibilities, escalation paths and decision authority.
- Cover the full incident lifecycle consisting of the following stages:
    - Detection
    - Triage
    - Containment
    - Eradication
    - Recovery
    - Post-incident review
- Define internal and external communications, including regulatory reporting.
- Include plans for prolonged outages.
- Test the plan at planned intervals.
- Record lessons learned and update the plan.

Examples of good practice – incident response

- The plan is accessible when needed.
- Responsibilities and decision-making are clear.
- Exercises are carried out regularly.
- Improvements are tracked and implemented.

Humber Teaching NHS Foundation Trust

Agenda Item 23.2

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Ambient Voice Technology (AVT) Medical Device Regulation and AI Policy Compliance
Author/s:	Lee Rickles, Chief Information Officer and Deputy Senior Information Risk Owner
Recommendation:	

To approve		To discuss	
To note	✓	To ratify	
For assurance	✓		

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	The purpose of this paper is to brief the Board on the recent joint NHS England and MHRA guidance regarding medical device regulation for Ambient Voice Technology (AVT).

Key issues:

Positive Assurances to Provide:

- Lexacom AVT has been fully assessed and aligns with the non-medical device category for clinical transcription.
- Appropriate data compliance documentation (DPIA, SLSP) and clinical workflow guardrails are already in place for Lexacom.
- For the majority of clinical staff the changes outlined by NHSE and MRHA likely represent a significant opportunity to support Performance and Productivity and to support wellbeing, burnout risk and turnover intention from greater use of Microsoft CoPilot (following appropriate governance and training).

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- A formal assessment is required for Microsoft Copilot through the Artificial Intelligence and SaMD Oversight Group (AIOG) prior to any clinical deployment or piloting.

Key Risks/Areas of Focus:

- Microsoft Copilot is currently classified under Policy F-034 as an unassessed, non-clinical specific AI tool.

Decisions Made:

The Trust Board are asked to:

- **Note** the updated joint NHS England and MHRA regulatory framework regarding Ambient Voice Technology.

• Using Copilot for clinical documentation without proper medical device and governance assessment presents regulatory, automation bias, and patient safety risks.	• **Confirm** the ongoing compliant status of Lexacom AVT for clinical transcription based on prior completion of Policy F-034 protocols. • **Support** the mandate for the Digital and Clinical Safety teams to proceed with a formal, comprehensive clinical safety and information governance assessment of Microsoft Copilot for AVT use, with findings to be presented back to the Digital Delivery Group (DDG) with approval via BeDigital and EMT.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	
Analogue to Digital	Yes
Sickness to Prevention	

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	29/09/26
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		AI oversight Group	07/08/26

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	√
Enhancing prevention, wellbeing and recovery	
Fostering integration, partnership and alliances	
Developing an effective and empowered workforce	√
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	Y

Public Exemption:

Is the report exempt from public disclosure	No

1. Introduction and Purpose

This purpose of this paper is to brief the Trust Board on the joint letter issued by NHS England and the Medicines and Healthcare products Regulatory Agency (MHRA) on 29 July 2026 regarding medical device regulation for Ambient Voice Technology (AVT) products (Attached at appendix A).

This paper outlines the regulatory landscape changes and requests approval to initiate a formal safety and information governance assessment for Microsoft Copilot before any clinical piloting or deployment can occur.

2. Trust Policy

Ambient Voice Technology is defined in the Trust Policy on *Artificial Intelligence and Software as a Medical Device Policy (F-034)* as '*systems that can listen to and process spoken language in the background during routine interactions, such as clinical consultations. These tools can generate clinical documentation or reports based upon conversations between clinicians and patients. Final responsibility for reviewing and validating outputs rests with the clinician who remains liable for documentation of their activity*. '

The use or otherwise of AVT would be subject to a comprehensive governance assessment to ensure any approved use complies with policy F-034.

The Policy was approved at EMT (October 2025) and ratified at Trust Board (January 2026), and is subject to review in October 2028 (*or sooner depending on how the landscape evolves*)

3. Background: National Regulatory Clarity on AVT

The MHRA has published updated guidance establishing a risk-proportionate regulatory framework for AVT deployment in the NHS. The guidance explicitly divides AVT functionalities into two categories:

- **Non-Medical Device Status:** AVT products solely intended to transcribe and summarise clinical conversations, draft correspondence, or suggest clinical codes for clinician review **are not** regulated as medical devices under the Medical Devices Regulations 2002 (MDR 2002).

- **Medical Device Status:** AVT products intended to support diagnosis, treatment, or automated clinical actions (such as generating discharge summaries, ordering medicines, or diagnostic tests) **remain strictly regulated** as medical devices.

Regardless of regulatory classification, the national directive mandates that all deployed AVT products must interface natively or integrate fully into the Trust's Electronic Patient Record (EPR) system.

4. Current Position & Trust Policy Alignment

4.1 Lexacom AVT (Assessed)

The Trust's current deployment of Lexacom AVT aligns with the non-medical device category for clinical transcription and documentation support. An assessment has already been completed against Trust Policy F-034, confirming that:

- Appropriate data compliance documentation (DPIA, SLSP) is established.
- Clinical workflows maintain the mandatory "human oversight" model, ensuring clinicians review, validate, and approve all outputs before entry into the patient record.

4.2 Microsoft Copilot (Unassessed)

There is potential to leverage Microsoft Copilot (including Teams Copilot) to support clinical workflows. However, under **Section 9 of Trust Policy F-034**, Copilot is explicitly classified as an *Open Source/Non-Clinical Specific AI Product*.

- **Current Restriction:** Staff are strictly prohibited from using Copilot to summarise or draft clinical notes, as it processes data outside of specifically ratified clinical guardrails.
- **Requirement:** To transition Copilot into an approved clinical AVT solution, it must undergo the exact same robust governance pipeline as standalone clinical applications to mitigate risks such as automation bias and data hallucinations. This also releases other opportunities for "purely administrative" clinical functions (as defined by Medical Device Regulations 2002); for example rewriting of clinical documentation or reformulation of clinical documentation when using clinical notes to create alternative letters or assessments.

5. Governance Requirements for Copilot Assessment

Before Microsoft Copilot can be authorized for clinical use, the following technical and clinical assurance steps must be completed via the **Artificial Intelligence and SaMD Oversight Group (AIOG)**:

Clinical Safety & Risk Management

- **DCB0160 Safety Case:** The Clinical Safety Officer (CSO) must compile a complete hazard log assessing the risk of clinical bias, inaccuracies, and hallucinations.
- **Equality Impact:** A formal Equality and Health Inequalities Impact Assessment (EHIIA) must evaluate potential biases affecting underrepresented groups or staff/patients with diverse digital literacy or language needs.

Information Governance & Cyber Security

- **DPIA and SLSP Completion:** The Information Asset Owner (IAO), supported by the Information Governance Officer, must complete a Data Protection Impact Assessment to map data flows and confirm that data processing complies fully with UK GDPR.
- **Supplier Assurance:** Verification that data used during Copilot processing is not utilized to train public AI models and stays within secure UK jurisdictions.

Technical Interoperability

- **EPR Integration:** The Digital/Biomedical Team must evaluate the technical architecture to ensure Copilot can securely interface with the Trust's EPR system to meet national scaling expectations.

6. Recommendations

The Trust Board are asked to:

1. **Note** the updated joint NHS England and MHRA regulatory framework regarding Ambient Voice Technology.
2. **Confirm** the ongoing compliant status of Lexacom AVT for clinical transcription based on prior completion of Policy F-034 protocols.
3. **Support** the mandate for the Digital and Clinical Safety teams to proceed with a formal, comprehensive clinical safety and information governance assessment of Microsoft Copilot for AVT use, with findings to be presented back to the Digital Delivery Group (DDG) , with approval then via BeDigital and EMT.

Humber Teaching NHS Foundation Trust

Agenda Item 24

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Finance Report Month 5 (August 2026)
Author/s:	Peter Beckwith, Director of Finance Iain Omand, Deputy Director of Finance
Recommendation:	

To approve		To discuss	✓
To note	✓	To ratify	
For assurance			

.

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	This report is being presented to the Trust Board and provides the financial position for the Trust as at the 31 August 2026 (Month 5). The report provides assurance regarding financial performance, key financial targets, and objectives

Key issues:

Positive Assurances to Provide: • The Trust recorded a breakeven position which is in line with the Regional NHSE planning target • The cash balance at the end of Month 5 was £29.802m although this has been affected by a timing issue and a position of £20.839m is more reflective of the actual position • The Better Payment Practice Code figures show achievement of 98.4%.	**Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):** • Monthly reports on the finance position continue to be reported to EMT and ODG • Mid-year finance review to be presented to EMT and Finance Committee alongside a review of grip and control checklists/
Key Risks/Areas of Focus: • Nothing to escalate	**Decisions Made:** • The Trust Board are asked to note the Finance report for the year to date 31 August 2026/27

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)

Hospital to Community	n/a
Analogue to Digital	n/a
Sickness to Prevention	n/a

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee	***Qtrly***	Executive Management Team	***Mthly***
Mental Health Legislation Committee		Operational Delivery Group	***Mthly***
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	✓
Enhancing prevention, wellbeing and recovery	✓
Fostering integration, partnership and alliances	✓
Developing an effective and empowered workforce	✓
Maximising an efficient and sustainable organisation	✓
Promoting people, communities and social values	✓

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	✓

Public Exemption:

Is the report exempt from public disclosure	No

FINANCE REPORT – August 2026

1. Executive Summary

This report presents to the Trust Board the financial position for the Trust as at the 31 August 2026 (Month 5). The report provides assurance regarding financial performance, key financial targets, and objectives.

The Trust Board are asked to note the financial position for the Trust and raise any queries, concerns, or points of clarification.

The Trust returned a breakeven position for the period to August 2026 and there are no particular issues to highlight as risks at this stage in the financial year.

2. Trust Position as at August 2026

The Trust's NHSE target for 2026/27 is a requirement to achieve a break-even budget for the year with a profile that is set at breakeven on a monthly basis.

Table 1 on the following page shows for the period to Month 5 the Trust recorded a breakeven for the year to date and is forecasting breakeven at outturn.

The donated assets depreciation and Capital Grant Donation do not count against the Trust's financial control target, the Month 5 net variance to budget for these items is £0.016m resulting in a ledger position of £0.016m deficit.

Table 1: 2026/27
Income and Expenditure and Forecast

	26/27 Net Annual Budget £000s	Year to Date			Full Year		
		Budget £000s	Actual £000s	Variance £000s	Budget (£000)	Forecast (£000)	Variance £000s
Income							
Block Income	**194,348**	**81,003**	**81,112**	**108**	**194,348**	**194,348**	**-**
YHCR	5,180	2,158	2,836	678	5,180	5,351	171
Total Income	**199,529**	**83,162**	**83,948**	**786**	**199,529**	**199,700**	**171**
Clinical Services							
Children's & Learning Disability	47,810	19,799	19,656	143	47,810	47,725	85
Community and Addictions	22,173	9,247	9,540	(293)	22,173	22,173	0
Mental Health	62,410	25,952	26,291	(340)	62,410	62,677	(268)
Forensic Services	14,728	6,136	6,008	128	14,728	14,647	82
	147,121	**61,133**	**61,495**	**(362)**	**147,121**	**147,222**	**(101)**
Corporate Services	**44,686**	**19,241**	**18,411**	**831**	**44,686**	**43,134**	**1,553**
Total Expenditure	**191,807**	**80,375**	**79,906**	**469**	**191,807**	**190,356**	**1,451**
EBITDA	**7,722**	**2,787**	**4,042**	**1,255**	**7,722**	**9,344**	**1,622**
Depreciation	5,591	2,330	2,350	(21)	5,591	5,644	(53)
YHCR Amortisation	1,157	482	659	(177)	1,157	1,157	0
Interest	(1,136)	(474)	(498)	24	(1,136)	(1,126)	(10)
IFRS 16	1,788	745	771	(26)	1,788	1,847	(59)
PDC Dividends Payable	1,822	759	759	(0)	1,822	1,822	-
Operating Total	**(1,500)**	**(1,055)**	**(0)**	**1,055**	**(1,500)**	**0**	**1,500**
BRS	(1,500)	(1,055)	-	(1,055)	(1,500)	-	(1,500)
Profit on Assets Held for Sale	-	-	-	-	-	-	-
Non Recurrent Income				-	-	-	-
Operating Total	**0**	**(0)**	**(0)**	**(0)**	**0**	**0**	**0**
Excluded from Control Total							
Donated Depreciation	39	16	16	(0)	39	39	(0)
	(39)	**(16)**	**(16)**	**(0)**	**(39)**	**(39)**	**0**
Ledger Position	**(39)**	**(16)**	**(16)**	**(0)**	**(39)**	**(39)**	**(0)**
EBITDA %	**3.9%**	**3.4%**	**4.8%**		**3.9%**	**4.7%**	
Surplus %	**-0.8%**	**-1.3%**	**0.0%**		**-0.8%**	**0.0%**	

2.1 Income

The Income position shows an overachievement of £0.786m as at August which is related to the YHCR invoices which have been forwarded to Partners.

2.2 Divisional Net Expenditure

The overall Divisional net expenditure position is showing a forecast overspend of £0.101m.

2.2.1 Children's and Learning Disability (£0.085m Forecast underspend)

Children's services are forecast to be £0.296m underspent. The biggest underspends are forecast in the 0-19 teams due to vacancies. In the East Riding there have been a number of posts on hold to make savings and offset the agenda for change pay pressure as it is not being supported by the Council. There are also savings in the Universal Children's Services department from the North East Lincs Child Health Information Service contract with underspends on both pay and non pay.

For Early Intervention Services the forecast assumes that the funding flows to the Trust MHST Wave 15 and that the final 6 months of funding is released for the Wave 11 EMHPs. Vacancy savings are anticipated as we are holding posts until the ICB confirms the income for 26-27, this is to ensure we don't have a financial pressure if the funding is less than forecast.

The Neuro position is currently overspent because of non-recurrent investment to support waiting list pressures.

Learning disability services are currently £0.202m overspent and forecast to end the year with a £0.084m overspend. There is a timing difference on income for Granville and a pay pressure on Townend Court due to the amount of bank staff used. With the decline in patient numbers at Townend the clinical model is being reviewed, and savings are expected, bringing the service back in line with budget for the 2nd half of the financial year.

New investment in Mental Health Support Teams and the Inspire Day Service means income and pay variances will be forecast until the new budgets are set up**.**

2.2.2 Community and Addictions (breakeven)

The Division is currently forecasting to break even to the annual budget.

Within the overall divisional position, Addictions Services are reporting a favourable variance of £0.148m, primarily driven by planned staffing vacancies being held temporarily while existing staff complete the required qualifications to progress into these roles. Income levels have also exceeded the planned budget.

Pay-related pressures across several services, including the Scarborough and Ryedale Core Teams, Diabetes, Malton Ward & Community Management, continue to be offset by underspends within UCR, Whitby Core and the Stroke Service. Safer staffing reviews undertaken across the core nursing teams have identified opportunities to realign workforce resources, contributing to a reduction in pay variances within Scarborough and Whitby services.

Following the temporary reduction in bed capacity on Malton Ward as a result of the fire, staff have been redeployed to support pressures in other services, maximising the use of substantive workforce capacity and reducing reliance on bank staffing.

The Division continues to progress its agreed BRS through established governance arrangements, maintaining a focus on financial recovery while ensuring safer staffing and the long-term sustainability of services. Although the overall financial position remains broadly balanced, risks remain in relation to workforce pressures, with the Division currently carrying 39 substantive vacancies.

A review of non-pay variances by the finance team has resulted in attaining a £0.051m BRS saving, as well as funding some pressures internally.

The Division has robust governance and oversight arrangements in place and remains confident in its ability to manage these pressures, sustain high-quality service delivery and achieve its BRS target.

2.2.3 Mental Health (£0.268m overspend)

The Mental Health Division is currently forecasting an overspend of £0.268m, primarily driven by cost pressures within Older People's Unplanned Mental Health Services.

Inpatient services continue to experience increased staffing costs associated with maintaining safe patient care, including enhanced therapeutic observations and support for patients with more complex needs. A proportion of this pressure is linked to delays in patient discharge where suitable social care placements are not immediately available, resulting in extended lengths of stay.

The Division is also managing a financial pressure within the Care Home Liaison Service following the withdrawal of Better Care Fund funding from East Riding of Yorkshire Council, which had supported the service since 2023/24.

In response, the Division has commenced a comprehensive review of Older People's Unplanned Mental Health Services to ensure resources are aligned to demand and service requirements. This work is being undertaken alongside ongoing discussions and due diligence regarding the potential transfer of Older People Out of Area funding from the ICB, which may provide a degree of financial mitigation in future periods.

Whilst these pressures remain a risk to the forecast position, they are currently being partially offset through vacancy savings across planned mental health services and continued budgetary oversight. The Division will continue to monitor expenditure closely and identify further opportunities to reduce the forecast variance as the year progresses.

2.2.4 Forensic (£0.082m underspend)

Year to date the Forensic Division is £0.128m underspent, this is driven by pay savings from vacancies, predominately in community teams. To date pay is underspent by £0.106m.

Vacancy savings in the community teams are forecast to continue and offset pressures in inpatient services due to high patient acuity. The current run rate on pay is not expected to

continue as the forecast reflects the recent recruitment in admin across the division and the appointment of additional newly qualified nurses. There is also an allowance for winter pressures, which along with the recent recruitment results in a forecast pay underspend of £0.015m.

Non pay is forecast to have the biggest favourable variance (£0.046m) due to expected savings on travel, training and security.

Medium Secure Inpatient Medics have previously been highlighted as an area of pressure due to the use of agency and the cost of additional PAs. The successful appointment of the agency medic into a Trust locum position will help bring the costs for this staff group back in line with budget.

2.2.5 Corporate Services (£1.553m underspend)

Corporate Services (including Finance Technical Items) is showing a forecast underspend of £1.553m, the main factor being items held centrally to offset pressures.

3. Cash

As at the end of Month 5 the Trust held the following cash balances:

Table 2: Cash Balance

Cash Balances	£000s
Cash with GBS	29,752
Nat West Commercial Account	28
Petty cash	22
Total	**29,802**

There is a timing issue in terms of the ledger stating the position at £29.802m as this doesn't reflect the month 4 Salaries of £8.500m and Payment run of £0.463m being deducted from the actual cash position. This would bring the amount to £20.839m.

The cash balance is held in the Government Banking Service account earning interest of 3.64% and avoiding a PDC dividend charge for each day it remains in the account.

4. Better Payment Practice Code BPPC

The BPPC figures are shown at Table 3. The current position is 98.9% for non-NHS and 90.0% for NHS with an overall total of 98.4%. Work is constantly ongoing to maintain this position with targeted support to managers.

Table 3: Better Payment Practice Code

Better Payment Practice Code	YTD Number	YTD £
NON NHS		
Total bills paid	11,166	36,366
Total bills paid within target	11,047	35,211
Percentage of bills paid within target	98.9%	96.8%
NHS		
Total bills paid	728	12,944
Total bills paid within target	655	12,804
Percentage of bills paid within target	90.0%	98.9%
TOTAL		
Total bills paid	11,894	49,310
Total bills paid within target	11,702	48,015
Percentage of bills paid within target	98.4%	97.4%

5. The Trust Board are asked to note the Finance report for the year to date Month 5 position and comment accordingly.

Humber Teaching NHS Foundation Trust

Agenda Item 25

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Performance Report August 2026
Author/s:	Peter Beckwith, Executive Director of Finance, Resources Estates and Digital
Recommendation:	

To approve		To discuss	✓
To note	✓	To ratify	
For assurance			

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	This purpose of this report is to inform the Trust Board on the current levels of performance as at the end of August 2026.

Key issues:

Positive Assurances to Provide:

- Care Programme Approach (CPA) achieved 95.7% against 95% targets
- Mental Health Urgent Response (F2F) within 24hours performance has continued to achieve compliance against 80% target.
- Safer staffing reviews confirm that staffing levels continue to meet required safe staffing establishments across inpatient services.
- No areas are flagging as red for Care Hours Per Patient Day on the safer staffing dashboard.

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- More detailed commentary has been provided within the body of the report for Quality Operational, Workforce and Finance Sections.
- Continued implementation of the Working Towards a Healthier Workforce Plan and Rapid Response Sickness Absence Model to address sickness hotspots, improve attendance and support workforce wellbeing.
- Talking Therapies improvement proposal shared with Quality Committee September.
- 104ww recovery meetings take place on a bi-weekly basis with the position being closely monitored. Additional resource expected to support further improvement

Key Risks/Areas of Focus:

- Sickness absence remains at 5.9%, above the Trust target, continuing to impact workforce capacity, service resilience and productivity across a number of inpatient and community services
- Talking Therapies 18week wait compliance was not achieved in August. This continues to be caused by an increase in complexity and changes to acceptance criteria.
- Children and Young People 4week wait Stopped Clocks, saw a slight deterioration

Decisions Made:

- Trust Board are asked to note the current performance as at the end of August.

in August. The focus remains on eradicating 104week waits	

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	Indicators Reported as enablers for the shift - Virtual Ward, Urgent Care Response, Delayed Transfer of Care, 72-hour follow-up, Community Mental Health Team access, Liaison, crisis response, out-of-area placements
Analogue to Digital	Virtual Ward supports digitally enabled monitoring and remote care
Sickness to Prevention	Indicators Reported as enablers for the Shift - MHST, EIP, Talking Therapies, CYP access, perinatal, IPS, 4-week waits

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		**Date**
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee	***Qtrly***	Executive Management Team	***Mthly***
Mental Health Legislation Committee		Operational Delivery Group	***Mthly***
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	✓
Enhancing prevention, wellbeing and recovery	✓
Fostering integration, partnership and alliances	✓
Developing an effective and empowered workforce	✓
Maximising an efficient and sustainable organisation	✓
Promoting people, communities and social values	✓

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	✓

Public Exemption:

Is the report exempt from public disclosure	No

1 Introduction and Purpose

This purpose of this report is to inform the Trust Board on the current levels of performance as at the end of August.

2 Trust Performance Report

The August 2026 version of the Trust Performance report is attached at appendix A.

The report continues to use statistical process charts (SPC) for a select number of indicators with upper and lower control limits resented in graphical format.

All indicators are aligned to the Trusts Strategic Goals, indictors have been grouped under either committee or operational delivery group (*noting performance is reported to EMT monthly*) with more detailed narrative for each section of the report.

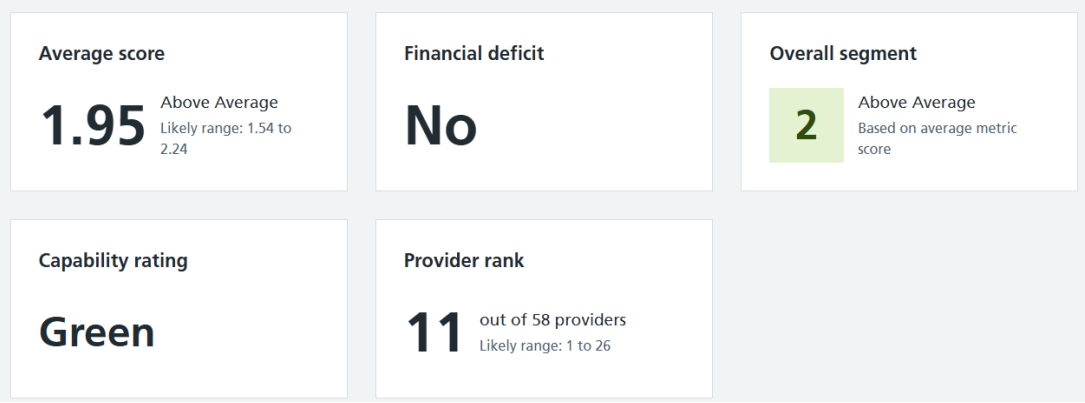
3 National Oversight Framework

Scores by domain for each quarter of the 2025/26 National Oversight Framework are summarised in the table below:

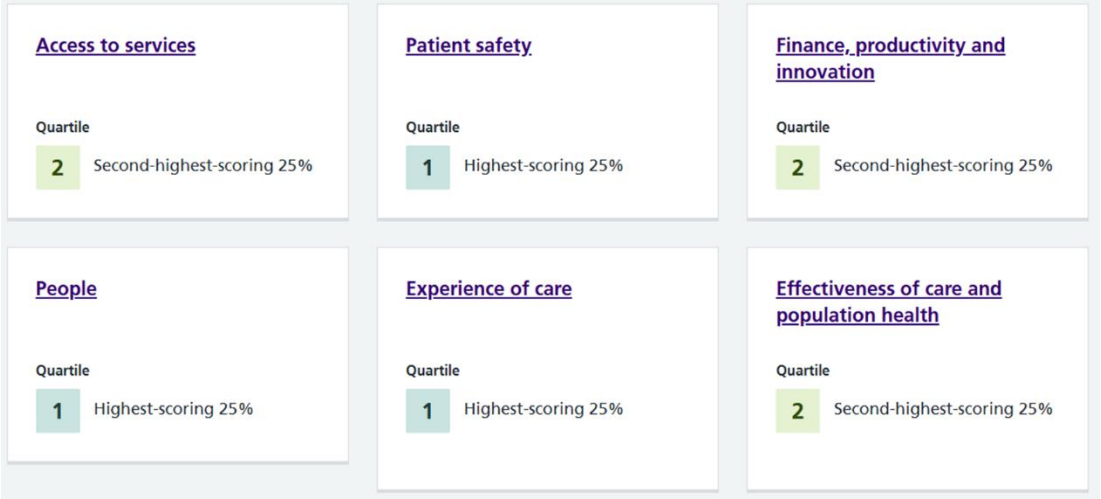
Domain	Q1	Q2	Q3	Q4
Access to Services	3.27	2.83	1.49	1.00
Effectiveness and Experience	1.39	1.35	1.35	1.35
Patient Safety	2.23	2.10	1.90	1.38
People and Workforce	2.35	2.47	2.33	2.28
Productivity and Value for Money	2.25	2.77	2.77	2.76
Overall Score	**2.22**	**2.21**	**1.91**	**1.79**
Segmentation	**2**	**2**	**1**	**1**
Rank	**22nd**	**19th**	**7th**	**4th**

The NHS Oversight Framework 2026/27 results for Q1 have now been published, the Trust has moved into segment 2 missing the threshold for segment 1 by 0.01, the Trusts rank in the League Table of 58 Mental Health and Community Trusts is 11th which means the Trust remains in the upper quartile.

For 2026/27, NHS England has changed how organisations are placed into segments. Instead of the previous approach to segments based on quartiles, segmentation is now based on fixed national thresholds. This means our change in segmentation reflects the new methodology for segmentation applies, had the previous methodology continued the Trust would have remained in segment 1.



A summary of the domains scores for Q1 appears in the table below:



4 Recommendation

Trust Board are asked to note the current performance as at the end of August and that work is taking place via Executive Management Team to further refine the performance report which comes to Trust Board.

Financial Year
2026-27

Humber Teaching
NHS Foundation Trust

TRUST PERFORMANCE REPORT

This report provides a high-level overview of the NHS Trust's current performance levels, drawing on key indicators from the Integrated Quality and Performance Tracker.

The purpose of the report is to present the Board with a thematic review of performance across a selected set of indicators over the past 24 months. The analysis includes Statistical Process Control (SPC) charts, illustrating trends and variation in performance against established upper and lower control limits.

Reporting Month:
Aug-26

Chief Executive: Michele Moran
Prepared by: Business Intelligence Team

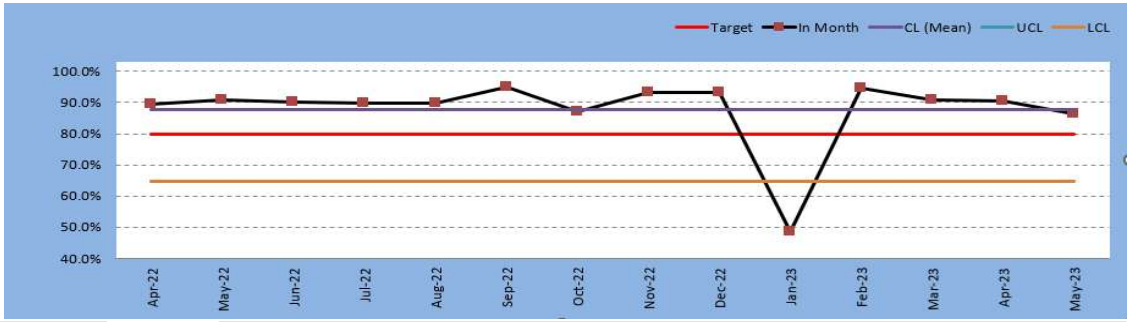
Caring, Learning
& Growing Together

Humber Teaching NHS Foundation Trust

Trust Performance Report

For the period ending:	August 2026

Purpose	This paper provides a summary on the progress being made against a basket of NHS performance indicators together with executive summary and underpin the Trust's Strategy 2017-2022. A sample of the strategic goals are represented in this report. Particular attention is drawn to the use of Statistical Process Control Charts (SPC).
What are SPCs?	SPCs contain upper and lower control limits which are in the most part based on 2 standard deviation points above and below the average. SPC averages are best plotted over a minimum of 12 data points. The majority of charts, if not all, within the TPR are based over 24 data points and include targets where these have been set. The charts can help us understand the scale of any problem, gather information and identify possible causes when used in conjunction with other investigative tools such as process mapping. SPC tells us about the variation that exists in the systems that we are looking to improve. SPCs should be used to help to set baselines and evaluate how we are currently operating within these thresholds. They can also help us to assess whether service changes have made a sustainable difference. They give an indication as to whether there is relatively stable variation over time or whether there are special causes creating exceptional variance. This is done by analysing the chart looking at how the values fall around the average and between or outside the Upper Control Limit (UCL) and the Lower Control Limit (LCL). These lines fall either side of the mean/average. They do not indicate whether the indicator is achieving the target that has been set, but they allow us to better understand how stable the performance is and whether or not it is changing. Attention would be specifically drawn to peaks and troughs outside of the control limits and initiate further investigation as to what the causes of these may be. SPCs are not always useful with low numbers, short periods of time or where data would normally be expected to be more erratic or seasonal unless this is plotted over a substantial amount of time. An example of an SPC chart with an exception is below:
Example SPC Chart	S – statistical, because we use some statistical concepts to help us understand processes. P – process, because we deliver our work through processes ie how we do things. C – control, by this we mean predictable.



Strategic Goal 1	Innovating Quality and Patient Safety	**Strategic Goal 4**	Developing an effective and empowered workforce
Strategic Goal 2	Enhancing prevention, wellbeing and recovery	**Strategic Goal 5**	Maximising an efficient and sustainable organisation
Strategic Goal 3	Fostering integration, partnership and alliances	**Strategic Goal 6**	Promoting people, communities and social values

Key Indicators	The following is a list of indicators highlighted within this report and the Goal to which they are set against. Other than the Safer Staffing dashboard, each indicator uses SPC charts

Humber Teaching NHS Foundation Trust

Trust Performance Report

Humber Teaching NHS Foundation Trust

For the period ending: **August 2026**

Dashboard	Safer Staffing	A dashboard to provide overview on a number of clinical indicators for the Trust's inpatient units across all services	Quality
Dashboard	Mortality	Learning from Patient Deaths as required under the Patient Safety Incident Response Framework	Quality
Goal 1	Incidents per 10,000 Contacts	Number of Incidents per 10,000 Contacts (based on contacts and occupied bed days)	Quality
Goal 2	72 hour follow ups	Percentage of patients who had a follow up within 72 hours (3 days) of discharge from Inpatient hospitals	ODG
Goal 2	CPA - Reviews	Percentage of patients who are on CPA and have had a review in the last 12 months	ODG
Goal 2	52 Week Waits	Number of patients who have yet to be seen for treatment and have been waiting more than 52 weeks. (Excludes ASD & ADHD Services for both Adult and Paediatrics)	ODG
Goal 2	52 Week Waits - Adult (18+) ASD/ADHD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service and ADHD for Adults (18+) and have been waiting more than 52 weeks	ODG
Goal 2	52 Week Waits - Paediatric ASD/ADHD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service and ADHD for Children and have been waiting more than 52 weeks	ODG
Goal 2	MH Urgent Response	New Urgent Referrals to Crisis Care teams in the reporting period with first face to face contact within 24 hours of referral	ODG
Goal 2	CYP_4WW_StoppedClocks	CYPMH - Proportion of Children and Young people referral-spells that have had a full meaningful help clock stop within four weeks.	ODG
Goal 2	ADULT_4WW_StoppedClocks	Adult CMH - Proportion of Adult referral-spells that have had a full meaningful help clock stop within four weeks.	ODG
Goal 2	CYP MH 104WW	CYP MH - number of referral-spells that are waiting a full meaningful help clock stop	ODG
Goal 2	Community Waiting list over 52 weeks	Community Services (Adult and CYP) - Number of patients who have yet to be seen for care and have been waiting more than 52 weeks.	ODG
Goal 2	Early Intervention in Psychosis	Percentage of patients who were seen within two weeks of referral	ODG
Goal 2	NHSER Talking Therapies - 6 and 18 week waits	Percentage of patients who were seen within 6 weeks and 18 weeks of referral	ODG
Goal 2	NHSER Talking Therapies - Moving to Recovery	Recovery Rates for patients who were at caseness at start of therapeutic intervention	ODG
Goal 2	CMHT Access	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services for adults and older adults with severe mental illness. Rolling 12 months.	ODG
Goal 2	CYP MH Access	Number of CYP aged under 18 accessing support by NHS funded community services and school or college based Mental Health Support Teams (receiving at least one contact). Rolling 12 months. *Includes Neuro Services, no team types are excluded.*	ODG
Goal 2	Perinatal Access	Number of women with at least one attended contact (F2F or video) with a specialist community perinatal mental health service in the last 12 months.	ODG
Goal 2	IPS Access	Number of referrals that accessed Individual Placement Support (IPS) - rolling 12 months	ODG
Goal 2	MHST Access	Number of referrals that accessed MHST - rolling 12 months	ODG

Humber Teaching NHS Foundation Trust

Trust Performance Report

For the period ending: **August 2026**

Goal 2	Liaison 1 hour response	New referrals to liaison psychiatry teams from A&E in the reporting period with first face to face contact within 1 hour	ODG
Goal 2	UCR 2 hr response	The percentage of 2-hour Urgent Crisis Response (UCR) referrals that achieved the 2-hour standard in the reporting month	ODG
Goal 2	Virtual Ward	Virtual Ward Bed Occupancy Rate	ODG
Goal 3	Out of Area Placements	Number of days that Trust patients were placed in out of area wards including split across Adult, Older Adult and PICU	ODG
Goal 4	Delayed Transfers of Care	Results for the percentage of Mental Health delayed transfers of care	ODG
Goal 1	Mandatory Training	A percentage compliance based on an overall target of 85% for all mandatory and statutory courses	People & OD
Goal 1	Vacancies (WTE)	Proportion of posts vacant when compared to the budgeted establishment. This information is taken from the Trust financial ledger.	People & OD
Goal 1	Clinical Supervision	Percentage of staff with appropriate clinical supervision taken place within the last 4-6 weeks	People & OD
Goal 4	Sickness Absence	Percentage of staff sickness across the Trust (not including bank staff)	People & OD
Goal 4	Staff Turnover	Percentage of leavers against staff in post (excluding employee transfers)	People & OD
Goal 5	Cash in Bank	The level of cash and cash equivalents held by the organisation at a given point in time, reflecting its short-term financial liquidity and ability to meet operational and contractual obligations.	Finance
Goal 5	BPPC (Value)	The percentage of total invoice value (£) that is paid within the agreed payment timeframe.	Finance
Goal 5	Bank/Agency Spend	The total expenditure incurred on internal temporary staff (bank & agency workers) over a defined reporting period, measured in pounds (£)	Finance

Quality Committee

Positive Assurances to Provide:

- Safer staffing – No areas flagging red for CHPPD
- Continued progress in reducing agency fill and a positive picture across most areas, bank fill monitored through Safer Staffing Gorup
- No community areas with 5 red flags
- 17 out of 18 wards with less than 5 red flags with the exception of TEC however their position regarding training has improved
- 12 out of 18 wards above target for sickness and work to address continues.
- 10/20 community areas are flagging for sickness
- Clinical supervision compliance remains stable, however Mill View Court and Mill View Lodge are under the compliance threshold, as well as Townend Court and Granville Court. However August data showing Granvill Court above threshold at 88%, Townend Court 100% and Mill View Lodge is 89% and Mill View Court have not submitted data these areas will be picked up through the safer staffing group.
- 99.5% of incident report resulted in harm free care
- 0 never events
- 0.3% of incidents resulted in severe harm or death in August, which is similar to other months (0.2% July, 0.3% June).
- Statutory and Mandatory training is at 94.7%

Matters of Concern or Key Risks to Escalate:

- Challenges remain regarding sickness levels in 12 inpatient areas over 5% threshold and 10 community areas.
- Improving position re ILS and BLS compliance as rapid improvement plan in place.

Key Actions Commissioned/Work Underway:

- Of the nurses who were in final placement with the trust 23/28 have secured employment to commence September 2026.
- Mock Inspection activity continues and in August PICU underwent a Mock Inspection, the results of this will be reported to EMT.

Decisions Made:

- Trust Board are asked to note the current performance as at the end of August and that work is taking place via Executive Management Team to further refine the performance report which comes to Trust Board

PI RETURN FORM 2026-27

Safer Staffing Inpatient Dashboard

For the period ending: July 2026

NHS Humber Teaching NHS Foundation Trust

Units						Bank / Agency Hours		Average Safer Staffing Fill Rates				High Level Indicators																Indicator	
								Day		Night		Current Month				YTD													
	Ward	Speciality	WTE	OBDs (Inc Leave)	CHPPD Hours (Registered)	Bank % Filled	Agency % Filled	Registered	Unregistered	Registered	Unregistered	Staffing Incidents (Poor Staffing Levels)	Incidents of Physical Violence / Agression	Complaints (Upheld / Partly upheld)	Failed S17 Leave	Staffing Incidents (Poor Staffing Levels)	Incidents of Physical Violence / Agression	Complaints (Upheld / Partly upheld)	Failed S17 Leave	Clinical Supervision	Mandatory Training (ALL)	Mandatory Training (ILS)	Mandatory Training (BLS)	Sickness Levels (Clinical)	WTE Vacancies (RN Only)	Jun-26	Jul-26
Adult MH	Avondale	Adult MH Assessment	29.0	✗ 77%	✓ 10.7	18.8%	1.3%	✓ 101%	✓ 99%	✓ 96%	✓ 103%	0	9	2	0	2	30	4	0	✓ 100.0%	✓ 92.9%	✓ 100.0%	! 82.4%	✗ 6.9%	3.0	! 2	! 2
	New Bridges	Adult MH Treatment (M)	37.6	✗ 97%	! 7.3	16.5%	0.3%	✓ 92%	✓ 97%	✓ 91%	✓ 105%	0	2	0	2	0	15	0	24	✓ 88.1%	✓ 94.4%	! 82.4%	✓ 95.7%	✗ 9.4%	1.6	✓ 1	! 2
	Westlands	Adult MH Treatment (F)	37.4	✗ 93%	! 7.6	28.6%	1.4%	! 84%	! 81%	✓ 95%	✓ 102%	0	11	0	0	0	58	1	3	✓ 90.9%	✓ 92.1%	✓ 92.9%	✗ 72.7%	✗ 9.0%	0.0	✓ 1	! 3
	Mill View Court	Adult MH Treatment	31.0	✗ 95%	! 7.5	16.3%	0.4%	✓ 92%	✓ 98%	✓ 99%	✓ 102%	0	0	0	1	0	10	3	1	! 78.1%	✓ 95.1%	✓ 93.3%	✓ 93.8%	! 5.1%	0.8	! 2	✓ 1
	PICU	Adult MH Acute Intensive	38.3	! 80%	✓ 27.2	24.4%	0.5%	✓ 101%	✓ 103%	✓ 97%	✓ 113%	0	8	0	0	0	69	0	1	✓ 95.0%	✓ 96.0%	✓ 100.0%	✓ 91.3%	✓ 2.1%	1.6	✓ 1	✓ 0
OPMH	Maister Lodge	Older People Dementia Treatment	33.3	✗ 98%	✓ 14.4	46.2%	3.0%	✓ 101%	✓ 117%	✓ 185%	✓ 131%	2	13	1	0	2	32	1	0	✓ 86.1%	✓ 89.1%	✓ 91.7%	✗ 66.7%	✗ 20.0%	1.2	! 4	! 3
	Mill View Lodge	Older People Treatment	32.5	✗ 99%	✓ 13.6	22.3%	0.5%	! 89%	! 89%	✓ 101%	✓ 116%	0	0	0	0	0	2	1	0	! 83.3%	✓ 96.4%	! 80.0%	✓ 94.7%	✗ 11.6%	0.0	! 2	! 2
	Maister Court	Older People Treatment	22.6	✗ 99%	✓ 17.7	40.2%	1.7%	! 76%	! 79%	✓ 106%	✓ 92%	0	0	0	0	0	0	0	0	✓ 95.2%	✓ 93.1%	✗ 55.6%	✓ 90.0%	✗ 13.9%	-2.4	! 2	! 3
Forensic	Pine View	Forensic Low Secure	32.1	✗ 96%	✓ 8.3	13.1%	0.0%	✓ 100%	! 89%	! 77%	✓ 116%	0	0	0	0	0	0	0	0	✓ 100.0%	✓ 95.7%	✓ 90.9%	✓ 90.5%	✗ 11.1%	1.1	✓ 1	! 2
	Derwent	Forensic Medium Secure	28.8	✗ 90%	✓ 12.6	8.7%	0.0%	! 88%	! 76%	✓ 123%	✓ 97%	0	0	0	0	0	2	0	0	✓ 100.0%	✓ 95.8%	✓ 100.0%	✓ 95.0%	! 4.7%	-0.4	✓ 1	✓ 1
	Ouse	Forensic Medium Secure	23.5	! 88%	✓ 11.5	32.4%	0.0%	✓ 93%	✓ 157%	✓ 112%	✓ 210%	0	1	0	0	1	5	2	4	✓ 100.0%	✓ 96.5%	✓ 87.5%	! 81.3%	! 5.0%	2.1	! 2	✓ 0
	Swale	Personality Disorder Medium Secure	27.3	✗ 60%	✓ 13.5	30.9%	0.0%	✓ 96%	! 88%	✓ 100%	✓ 97%	0	0	0	0	0	0	0	0	✓ 100.0%	✓ 99.8%	✓ 100.0%	✓ 100.0%	✓ 2.1%	1.0	✓ 1	✓ 1
	Ullswater	Learning Disability Medium Secure	27.4	✗ 75%	✓ 18.4	22.5%	0.0%	! 90%	✓ 126%	✓ 117%	✓ 127%	0	6	0	1	0	21	0	1	✓ 92.9%	✓ 94.2%	✓ 100.0%	✗ 62.5%	✗ 6.1%	-1.9	! 3	! 3
Child & LD	Townend Court	Learning Disability	42.1	✗ 18%	✓ 74.4	14.9%	0.0%	✓ 94%	✗ 69%	✓ 100%	✗ 65%	0	5	0	0	0	37	0	0	! 80.6%	✓ 93.4%	✗ 73.3%	✓ 91.7%	✗ 6.1%	0.0	✗ 5	✗ 5
	Inspire	CAMHS	9.8	! 82%	✓ 21.2	14.5%	0.0%	✓ 126%	✗ 75%	✓ 97%	✓ 118%	0	0	0	0	0	0	1	0	✓ 85.0%	✓ 94.3%	✓ 89.5%	✓ 85.2%	✗ 9.0%	0.4	! 2	! 2
	Granville Court	Learning Disability Nursing Care	48.3	✗ 63%	✓ 21.2	20.9%	0.0%	✓ 108%	! 87%	✓ 109%	✓ 107%	0	0	0	0	0	0	0	0	! 84.1%	✓ 97.3%	! 81.8%	✓ 100.0%	✗ 9.2%	0.7	! 2	! 2
CH	Whitby Hospital	Physical Health Community Hospital	29.9	✗ 91%	! 7.1	5.7%	2.1%	✓ 106%	✗ 69%	✓ 99%	✓ 102%	0	0	0	0	0	0	0	0	✓ 100.0%	✓ 92.1%	✓ 93.3%	✓ 88.9%	✓ 3.2%	1.3	! 3	! 2
	Malton Hospital	Physical Health Community Hospital	31.7	✗ 76%	✓ 10.3	5.3%	0.0%	! 76%	! 82%	✓ 145%	✗ 48%	0	0	0	0	2	1	2	0	✓ 100.0%	✓ 93.5%	✓ 100.0%	! 82.4%	✗ 5.6%	0.9	! 2	! 3

KEY					
	✓	Target met	!	Within 5% of target	✗ Target not met

PI RETURN FORM 2026-27

Safer Staffing Inpatient Dashboard

For the period ending: July 2026

Humber Teaching NHS Foundation Trust

Exception Reporting and Operational Commentary

Safer Staffing Dashboard Narrative : July

Twelve units were below the Trust target for sickness absence in July, similar to June from May (n=13) and consistent with previous months.

Units reporting sickness above 10% remains unchanged to the previous month (n=4). Maister Lodge remains at 20%. Maister Court remains high at 13.9%. Mill View Lodge and Pine View are also reporting sickness levels above 10%.

Whitby inpatient ward and PICU have sustained sickness level below the Trust target. Derwent and Ouse have improved and are at Trust target for July. Ullswater, TEC, Inspire and Malton have showed improvement however they are still above the Trust target of 5%.

Immediate Life Support (ILS) training remains relatively stable with 13 units at 85% or above. 6 units have now achieved 100%. Basic Life Support (BLS) compliance has improved from 9 units over 85% in June to 12 in July, with 10 over 90% compliance.

Overall Statutory and Mandatory Training compliance has remained consistently above the Trust target of 85% across all wards.

Care Hours Per Patient Day (CHPPD) performance remains strong across the majority of inpatient wards, with no red flags reported in July.

Clinical supervision compliance remains stable, with 14 units achieving compliance above 85% in July and no nil returns noted. Maister Lodge has recovered their position above the 85% target threshold.

There was one unit with 5 red flags in June and July (TEC) due to continued low bed occupancies, HCA fill rates, ILS training below target, and sickness at 6.1%. No other units with more than 3 red flags.

The CHPPD RAG ratings are following discussions with and agreed by EMT in Nov 2022. Breakdowns are as follows:

Red RAG falls below the lowest rating, Green RAG is greater than the highest rating. Amber RAG falls between

Red Rag	Green Rag	Units Applied
<=5.3	>=6.3	Pine view, Ouse
<=7	>=8	New Bridges, Westlands, Mill View Court, Swale, Whitby, Malton
<=8	>=9	Avondale
<=9.3	>=10.3	Maister Lodge, Maister Court, Derwent, Inspire, Granville
<=10.5	>=11.5	Mill View Lodge
<=11.0	>=12.0	Ullswater
<=15.6	>=16.6	PICU
<=27.0	>=28.0	Townend Court

Slips/Trips and Falls (Rolling 3 Months)			
	May-26	Jun-26	Jul-26
Maister Lodge	4	5	14
Millview Lodge	1	8	5
Malton IPU	1	2	1
Whitby IPU	0	3	2

Registered Nurse Vacancy Rates (Rolling 12 months)											
Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
10.0%	11.2%	11.8%	4.1%	4.3%	4.3%	4.0%	4.5%	5.1%	3.7%	4.0%	5.0%

PI RETURN FORM 2026-27

Safer Staffing Community Dashboard

For the period ending: July 2026

NHS Humber Teaching NHS Foundation Trust

			Workforce Indicators					Quality Indicators						Trend	
	Team	Speciality	WTE in post	Vacancies (WTE)	Sickness	Bank Spend £	Agency Spend £	Mandatory Training	Clinical Supervision	Friends & Family Responses	Friends & Family %	Serious Incidents	Complaints (Upheld / Partly upheld)	Jun-26	Jul-26
Adult MH Services	Mental Health Crisis Intervention	Adult Crisis	56.4	15.4%	✗ 5.2%	£42,704	£0	✓ 95.1%	✓ 96.3%	4	✓ 100.0%	0	0	✓ 1	✓ 1
	Hull Mental Health Team	Hull Adult MHT	26.3	29.1%	✗ 11.8%	£7,173	£0	✓ 87.3%	✗ 40.0%	1	✗ 0.0%	0	2	! 2	! 3
	Beverley Mental Health Team	ER Adult MHT	6.7	1.0%	✗ 6.2%	£0	£0	✓ 95.7%	✓ 100.0%	0	✗ NS	0	0	✓ 1	✓ 1
	Goole Mental Health Team	ER Adult MHT	9.6	-3.7%	✓ 0.6%	£111	£0	✓ 97.4%	✓ 100.0%	1	✓ 100.0%	0	0	✓ 1	✓ 0
	Haltemprice Mental Health Team	ER Adult MHT	9.5	3.9%	✓ 3.6%	£994	£0	✓ 95.7%	✗ 75.0%	0	✗ NS	0	1	✓ 1	✓ 1
	Holderness Mental Health Team	ER Adult MHT	11.4	1.2%	✓ 1.4%	£171	£0	✓ 96.6%	✓ 100.0%	0	✗ NS	0	0	✓ 0	✓ 0
	Bridlington & Driffield MHT	ER Adult MHT	13.0	18.0%	✓ 2.3%	£141	£0	✓ 98.8%	✓ 100.0%	2	✓ 100.0%	0	0	✓ 0	✓ 0
	STaRS Community	Rehab &LTC	20.4	15.2%	✗ 10.4%	£1,387	£0	✓ 93.5%	✓ 90.9%	0	✗ NS	0	1	! 2	✓ 1
Older People MH Services	Crisis Intervention Team for Older People (CITOP)	OP Crisis	27.6	8.2%	✗ 10.8%	£4,311	£0	✓ 90.1%	! 83.3%	5	✓ 100.0%	0	0	✓ 1	✓ 1
	Hull Intensive Care Team for Older People (HICTOP)	Hull OP CMHT	21.3	12.5%	✓ 3.8%	£0	£0	✓ 98.2%	✓ 100.0%	11	✓ 100.0%	0	0	✓ 1	✓ 0
	Beverley and Haltemprice OP CMHT	ER OP CMHT	7.9	8.7%	! 4.6%	£0	£0	✓ 97.3%	✓ 100.0%	0	✗ NS	0	0	✓ 0	✓ 0
	Bridlington & Driffield OP CMHT	ER OP CMHT	6.2	29.0%	✓ 0.0%	£2,579	£0	✓ 92.8%	✓ 100.0%	5	✓ 100.0%	0	0	✓ 0	✓ 0
	Goole & Pocklington OP CMHT	ER OP CMHT	5.0	25.5%	✓ 0.5%	£0	£0	✓ 99.1%	✓ 100.0%	0	✗ NS	0	0	✓ 0	✓ 0
	Holderness OP Community Team	ER OP CMHT	4.0	25.0%	✗ 5.6%	£0	£0	✓ 100.0%	✓ 100.0%	5	✓ 100.0%	0	0	✓ 0	✓ 1
Universal	Early Intervention in Psychosis	14-65 MHT	27.2	1.7%	✗ 5.7%	£0	£0	✓ 95.6%	✓ 85.2%	2	✓ 100.0%	0	0	✓ 1	✓ 1
	Hospital Mental Health Team	Liaison Services	34.9	14.0%	! 4.6%	£8,402	£33,661	✓ 95.4%	✓ 87.9%	12	! 83.3%	0	1	! 2	✓ 0
Community Services	Ryedale Team	Comm Services	19.8	3.7%	✗ 6.4%	£928	£0	! 81.0%	✓ 93.3%	0	✗ NS	0	0	✓ 1	✓ 1
	Scarborough Hub	Comm Services	62.4	13.2%	✗ 9.1%	£24,016	£0	✓ 88.4%	✗ N/R	0	✗ NS	0	0	✓ 1	✓ 1
	Whitby Community Nurses	Comm Services	24.2	27.2%	✗ 9.9%	£1,596	£0	✓ 89.8%	✓ 100.0%	0	✗ NS	0	0	✓ 1	✓ 1
	Pocklington Nurses	Comm Services	17.4	10.8%	✓ 0.2%	£1,411	£0	✓ 89.6%	✓ 100.0%	0	✗ NS	0	0	✓ 0	✓ 0

Points of Note :

Complaints - Zero figures indicate at least one complaint was made but not upheld. Figures above zero indicate these complaints were either Upheld or Partly Upheld. These incur a Red flag.

No returns for clinical supervision will incur a Red Flag

FFT % results based on the number of responses received with a satisfactory outcome

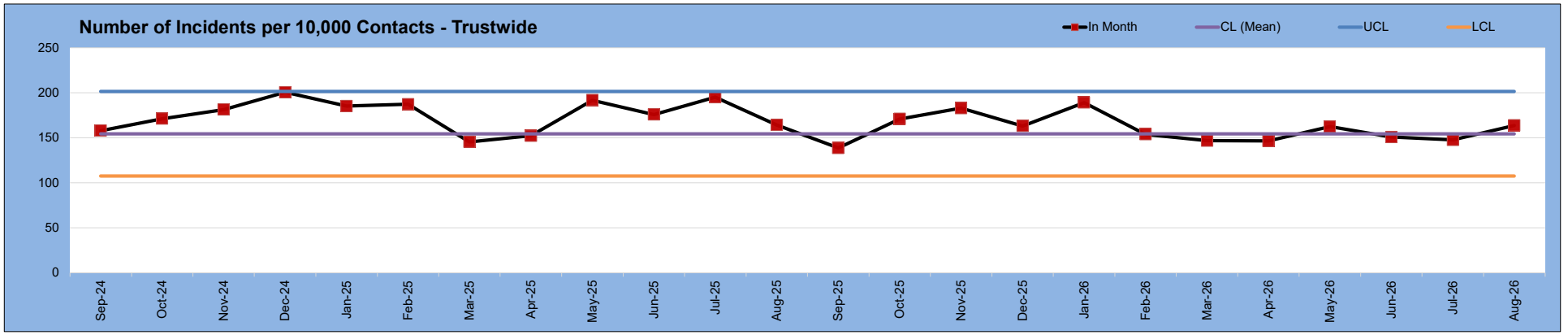
PI RETURN FORM 2026-27

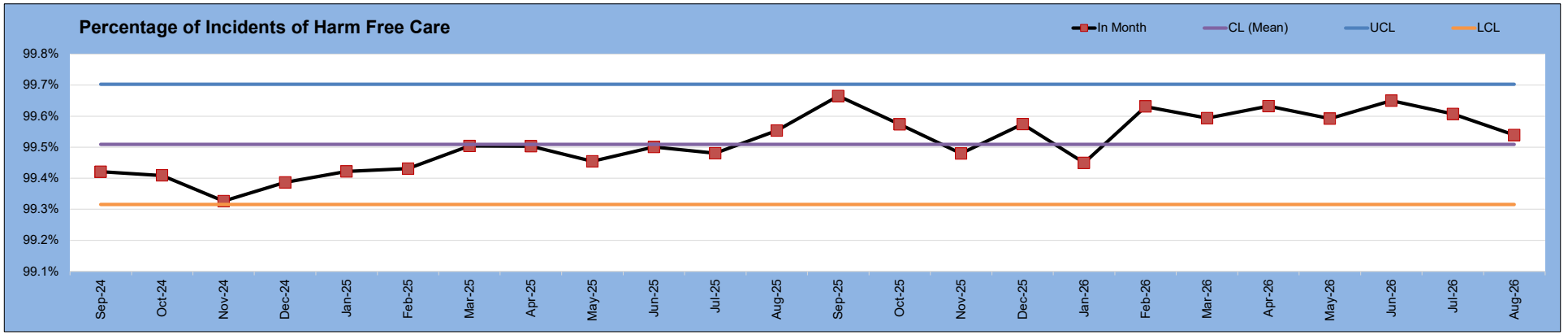
	Number of Incidents	% Harm Free Care
Current month:	164	99.5%

Goal 1: Innovating Quality and Patient Safety

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Incidents per 10,000 Contacts	Number of Incidents per 10,000 Contacts (based on contacts and occupied bed days)	**Executive Lead: Sarah Smyth**





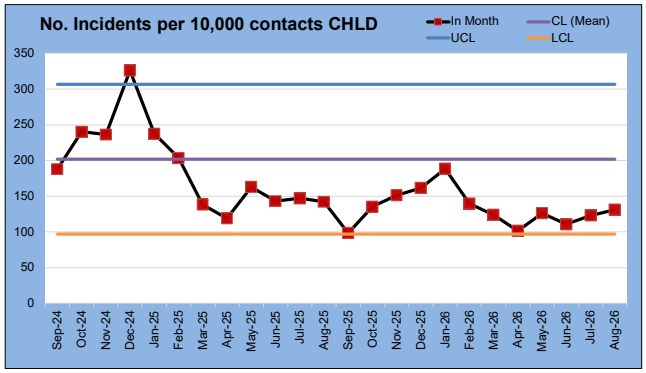
PI RETURN FORM 2026-27

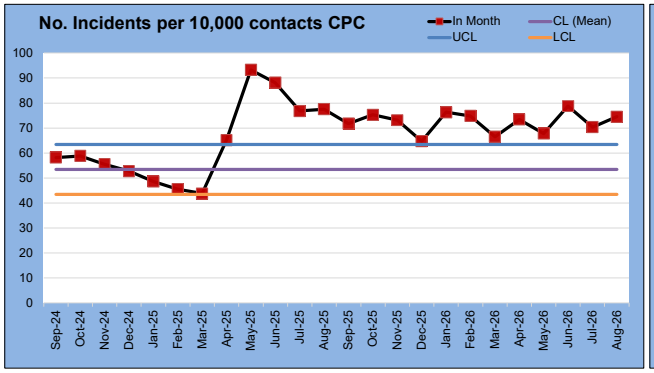
Trustwide current month:
164

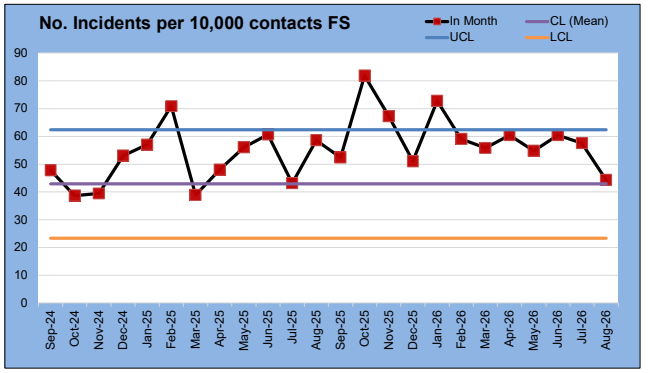
Goal 1: Innovating Quality and Patient Safety

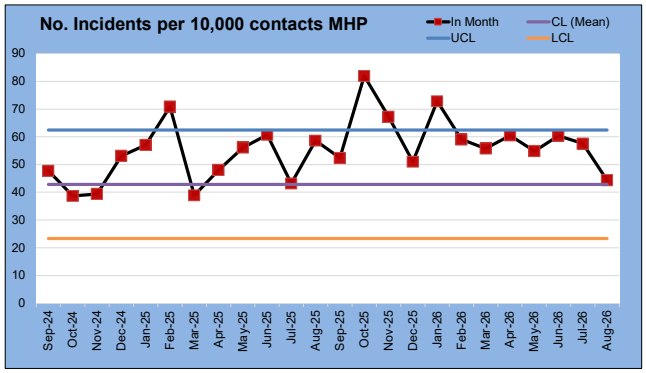
For the period ending: **August 2026**

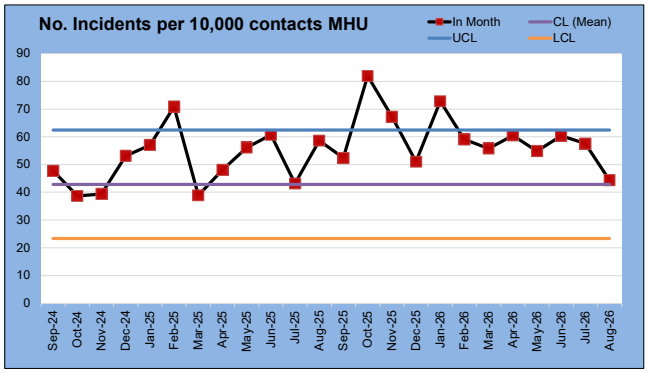
Indicator Title	Description/Rationale	
Incidents by Division	Number of Incidents per 10,000 Contacts (based on contacts and occupied bed days)	**Executive Lead: Sarah Smyth**











Current Month per Division

Children & Learning Disability (CHLD)	131
Community & Primary Care (CPC)	75
Forensic Services (FS)	682
Mental Health Planned (MHP)	44
Mental Health Unplanned (MHU)	508

Incident Analysis	Jul-26	Aug-26
Never Events	0	0
% of Harm Free Care	99.6%	99.5%
% Incidents reported in Severe Harm or Death	0.2%	0.3%

Operational Delivery Group Committee

Positive Assurances to Provide:

- Follow ups completed within 72hours of discharge achieved 94.9% against an 80% target
- Care Programme Approach (CPA) achieved 95.7% against a 95% target. Close monitoring remains in place
- Plans to mobilise adult ADHD provision are underway. Indicative Activity Plan has been developed.
- Mental Health Urgent Response Face to Face within 24hours continues to achieve compliance against the 80% target. Close monitoring continues to further improve the position
- Adult 4ww clock stop achieved 34.7% in August, an increase from previous month.
- CYP 104week waits Stopped Clocks – the current focus remains on embedding outcome measures to stop the clock. 104week waits recovery is the key focus currently, significant progress has been made towards trajectory
- Physical Health Community Waiting List maintains a 0 >52week wait position
- EIP – seen within 14days achieved 62.5% against a 60% target. Reporting indicators have been updated to align with national measures.
- Talking Therapies 6ww target achieved 75.7% against a 75% target.
- Children & Young People (CYP) Mental Health Access has achieved above target.
- Community Mental Health Team Access has achieved above target.
- Individual Placement Support (IPS) Access has achieved above target.
- Mental Health Support Teams (MHST) referrals have achieved above target.
- Liaison 1hour Response achieved 85.7% which is above the 80% target.
- Urgent Crisis Response (UCR) 2-hour Response achieved 95.8%
- Virtual Ward Occupancy has achieved 80% against an 80% target.
- The additional social worker support provided by East Riding Local Authority to support older adult discharges is beginning to impact of discharge delays. The impact of the discharge delays has impacted on out of area placements.
- Delayed Transfer of Care for Community Hospitals improved in August. The Trust continues to work closely with North Yorkshire Local Authority on this through discharge meetings.

Matters of Concern or Key Risks to Escalate:

- Close focus on 52ww to ensure data quality issues are managed, small number of cases in Memory Assessment service. Service presented recovery plan at the last performance and productivity meeting.
- >52week waits for Adult Autism has increased – predominantly as a result of children's transitions. Additional capacity is being sourced through an Independent Provider. Overall waiting list position continues to decrease.
- >52week waits position for children's Autism and ADHD continues to increase, Right to Choose funding has been confirmed. Plans being developed to agree the impact on neurodiversity waiting times
- Children and Young People 4week wait Stopped Clocks, saw a slight deterioration in August. The focus remains initially on eradicating 104week waits.
- CYP 104week waits Stopped Clocks – the current focus remains on embedding outcome measures to stop the clock. 104week waits recovery is the key focus currently, significant progress has been made towards trajectory
- Talking Therapies 18week wait compliance was not achieved in August. This continues to be caused by an increase in complexity and changes to acceptance criteria. The service have developed a recovery proposal which will be shared with Quality Committee in September.
- Talking Therapies Moving to Recovery did not achieve 50% in August (49.8% achieved). This is under investigation as this sudden deterioration was not expected.
- Perinatal Access has not achieved against the target. Progress is being made to promote the service to support with achievement.
- Work continues with the ICB regarding 117 Team capacity to enable efficient discharge of patients. This is impacting on the Older complex pathways (25 in August – increase)

Key Actions Commissioned/Work Underway:

- Funding has been confirmed to support Neurodiversity improvements. Work is underway to agree the activity plan and mobilise the service changes
- Further exploration of efficiency opportunities to support with Memory Assessment Service waiting times recovery.
- 104ww recovery meetings take place on a bi-weekly basis with the position being closely monitored. Additional resource expected to support further improvement.
- Talking Therapies improvement proposal shared with Quality Committee September.
- Gateway review completed and recommendation awaited to support Perinatal Service with improvement plans - ongoing
- Phase 1 of a scheme of works is due for completion to develop Townend Court which will include female High Dependency Unit for adult mental health and will improve out of area placements for PICU – ongoing
- Development proposal has been accepted for a 4 bedded step up facility for older adults, this development will support admission avoidance and reduce out of area placements
- CMHT Rapid Improvement Group continues to meet to identify opportunities to further improve

Decisions Made:

- None commented

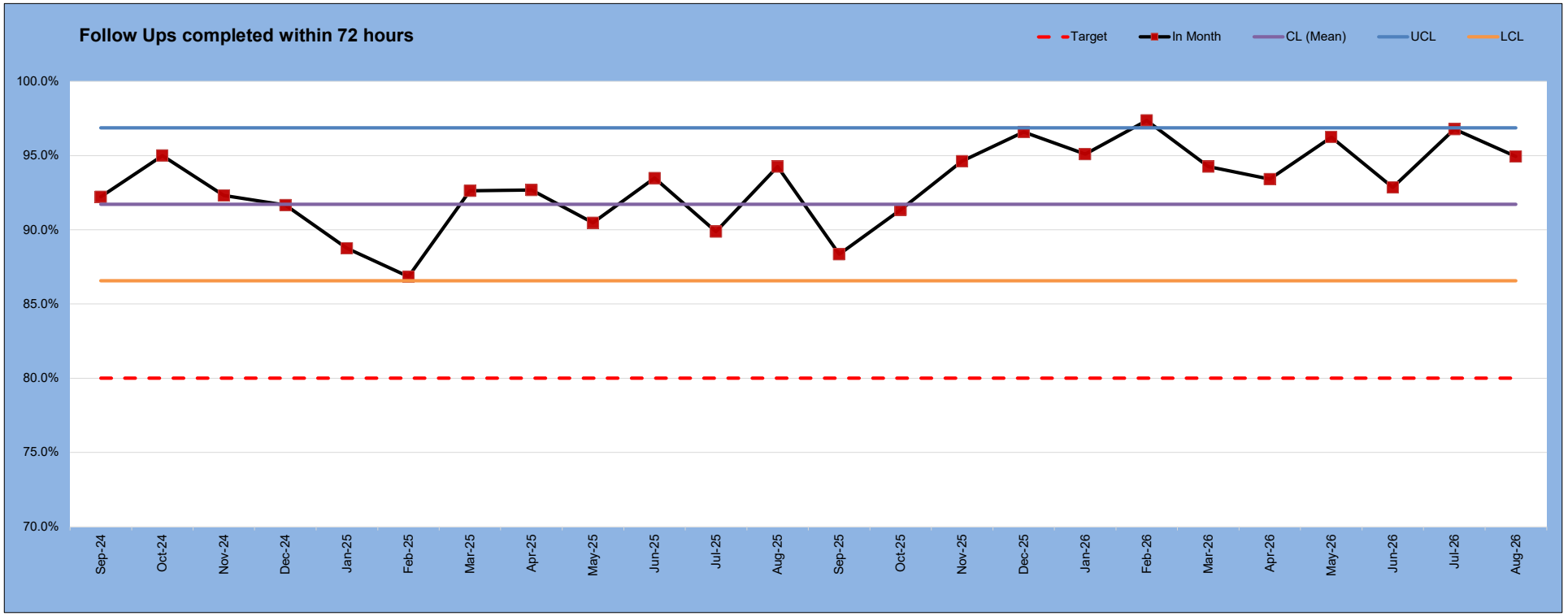
PI RETURN FORM 2026-27

Current month stands at:
94.9%

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
72 hour follow ups	Percentage of patients who had a follow up within 72 hours (3 days) of discharge from Inpatient hospitals	**Executive Lead: Lynn Parkinson**



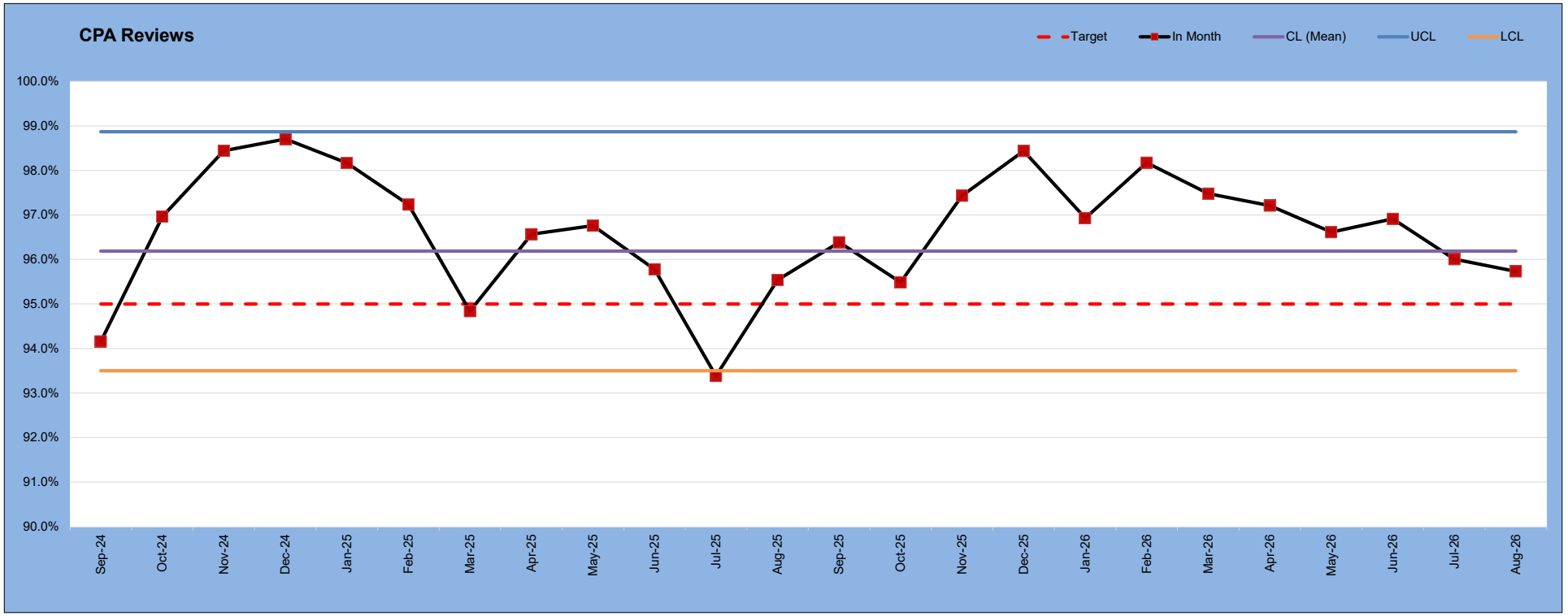
PI RETURN FORM 2026-27

Current month stands at:
95.7%

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
CPA - Reviews	Percentage of patients who are on CPA and have had a review in the last 12 months	**Executive Lead: Lynn Parkinson**



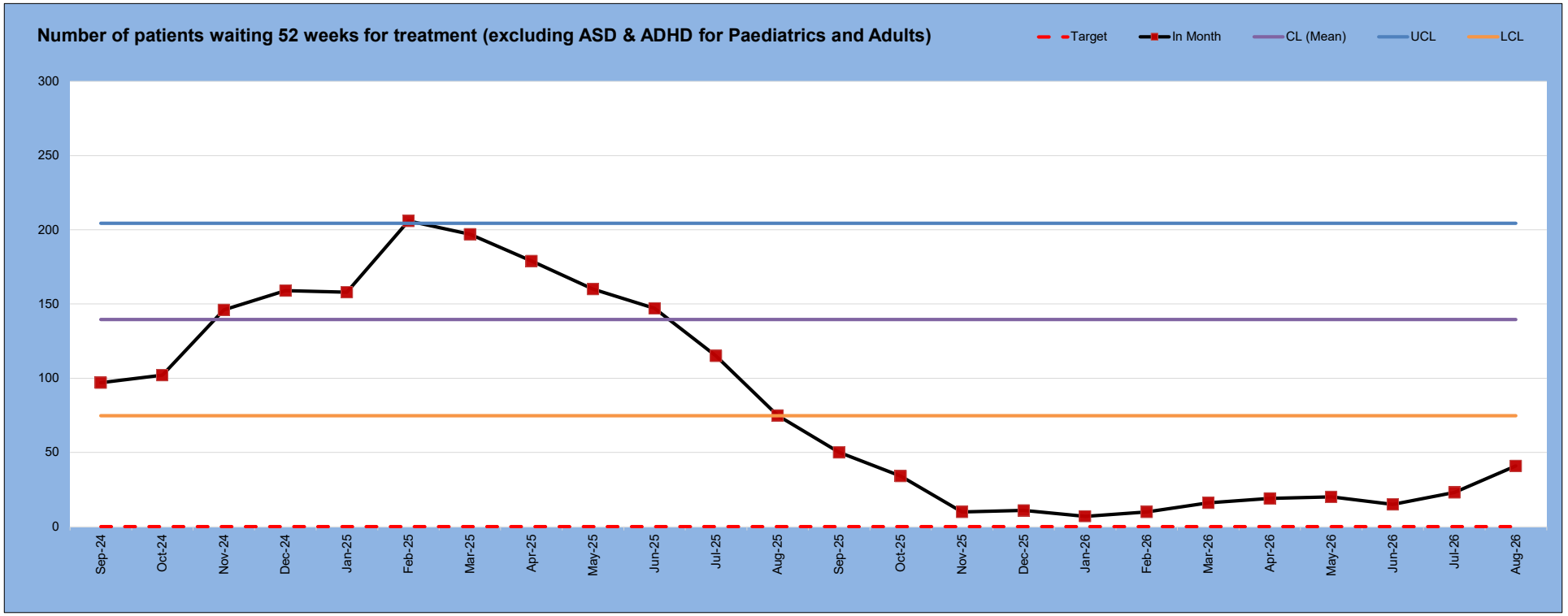
PI RETURN FORM 2026-27

Current month stands at: 41

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
52 Week Waits	Number of patients who have yet to be seen for treatment and have been waiting more than 52 weeks. (Excludes ASD & ADHD Services for both Adult and Paediatrics)	**Executive Lead: Lynn Parkinson**



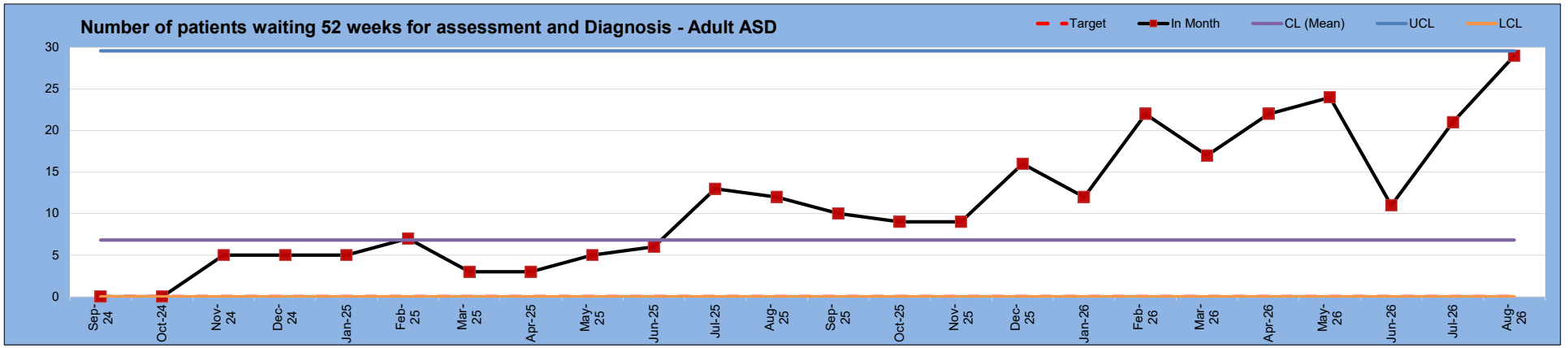
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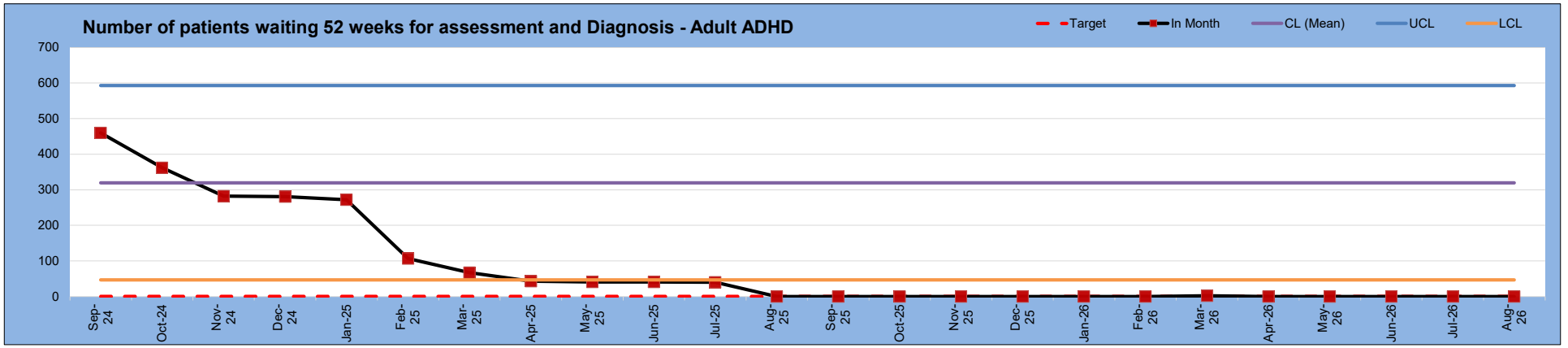
	Adult ASD	Adult ADHD
Current month:	29	0

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
52 Week Waits - Adult (18+) ASD/ADHD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service and ADHD for Adults (18+) and have been waiting more than 52 weeks	**Executive Lead: Lynn Parkinson**





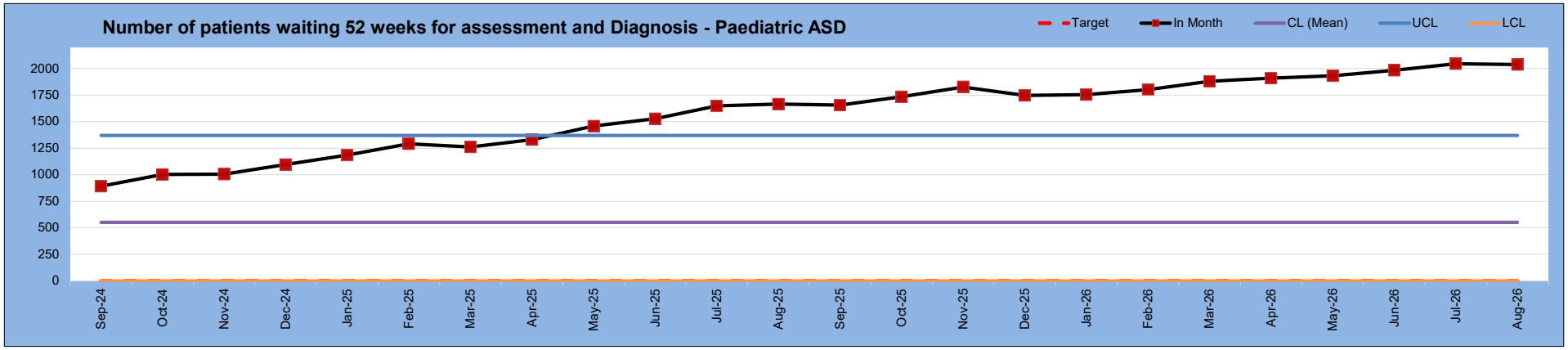
PI RETURN FORM 2026-27

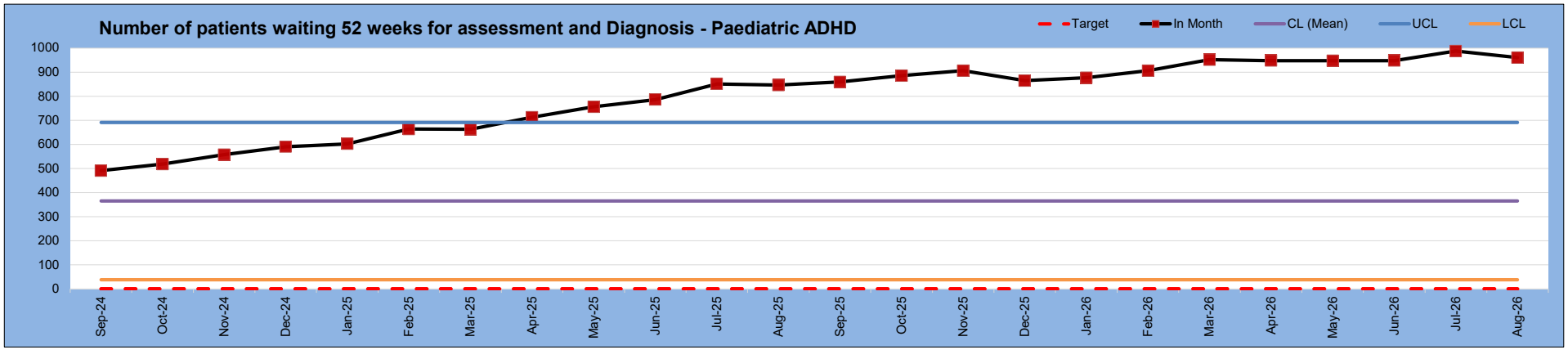
	Paediatric ASD	Paediatric ADHD
Current month:	2039	960

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
52 Week Waits - Paediatric ASD/ADHD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service and ADHD for Children and have been waiting more than 52 weeks	**Executive Lead: Lynn Parkinson**





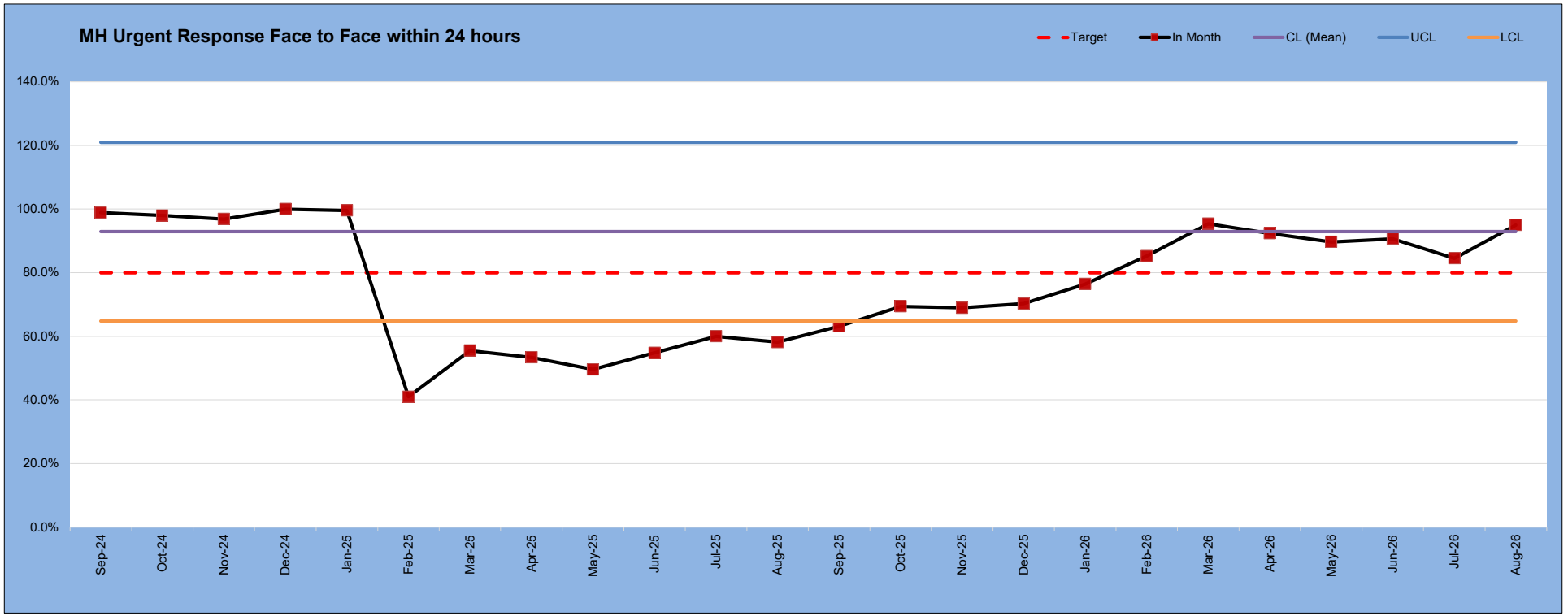
PI RETURN FORM 2026-27

Current month stands at:
95.0%

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
MH Urgent Response	New Urgent Referrals to Crisis Care teams in the reporting period with first face to face contact within 24 hours of referral	**Executive Lead: Lynn Parkinson**



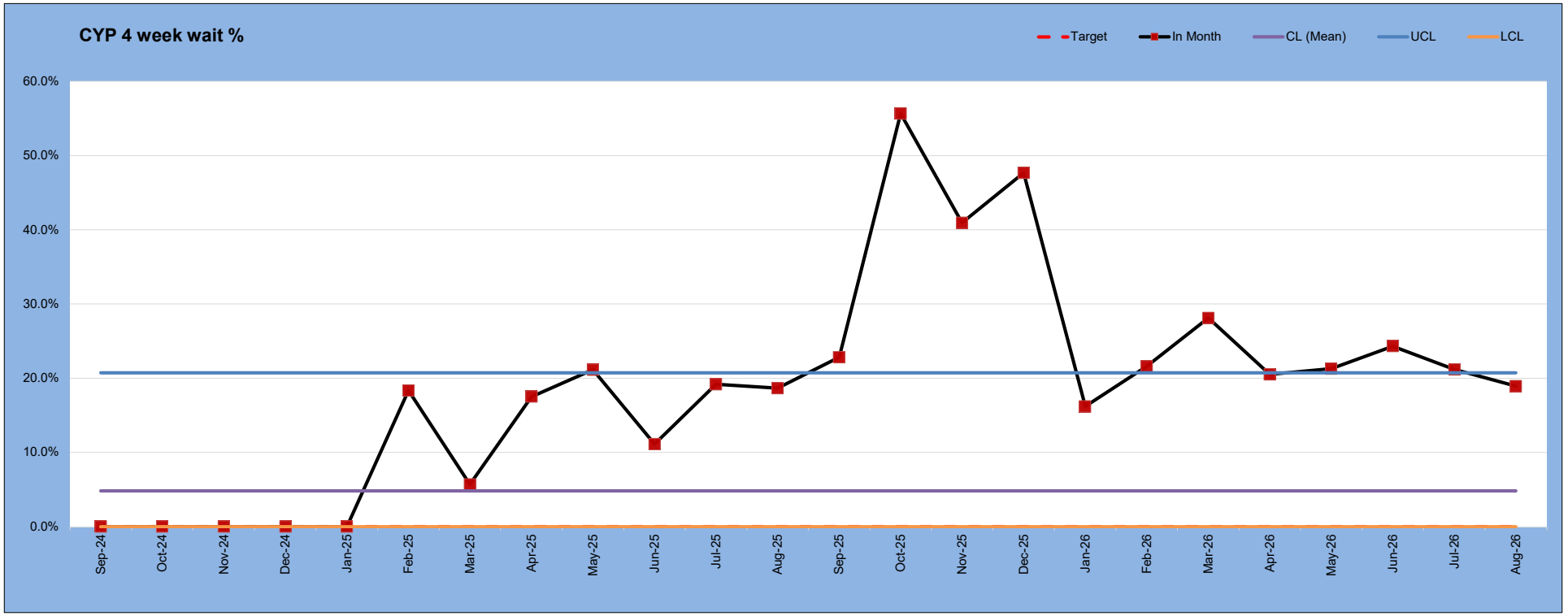
PI RETURN FORM 2026-27

Current month stands at:
18.9%

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
CYP_4WW_StoppedClocks	CYPMH - Proportion of Children and Young people referral-spells that have had a full meaningful help clock stop within four weeks.	**Executive Lead: Lynn Parkinson**



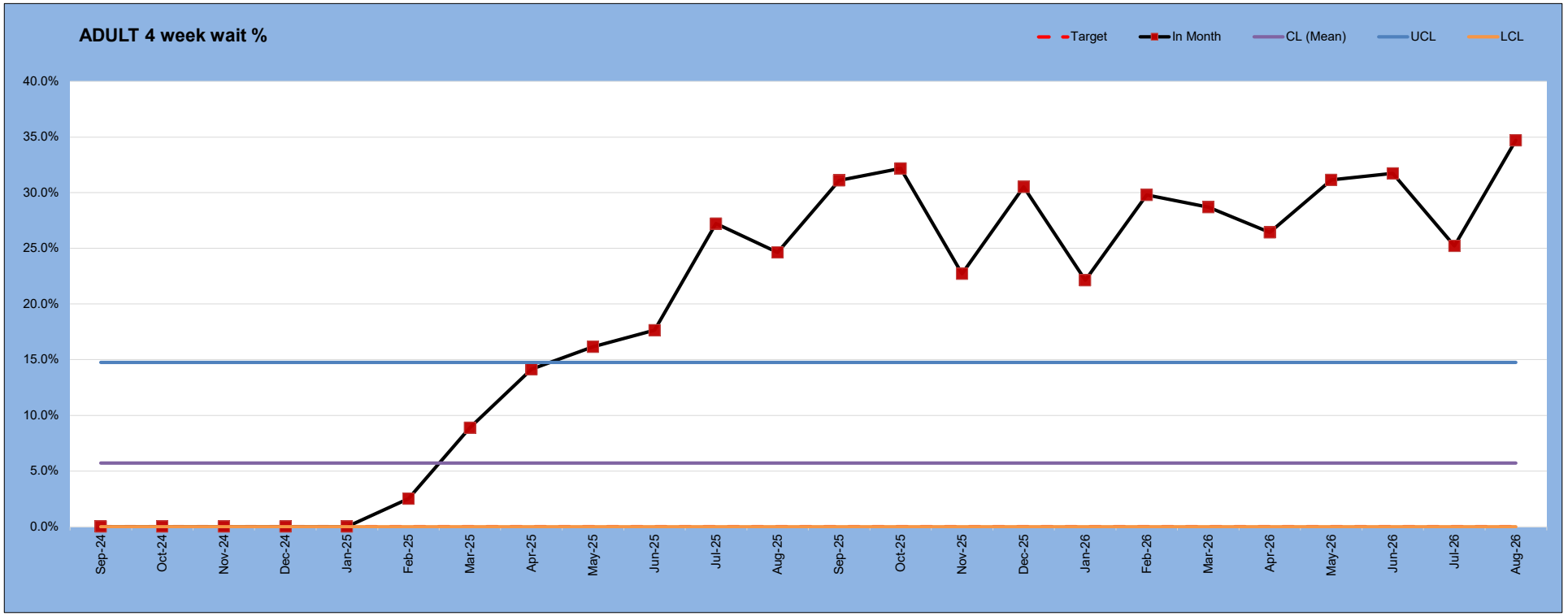
PI RETURN FORM 2026-27

Current month stands at:
34.7%

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
ADULT_4WW_StoppedClocks	Adult CMH - Proportion of Adult referral-spells that have had a full meaningful help clock stop within four weeks.	**Executive Lead: Lynn Parkinson**



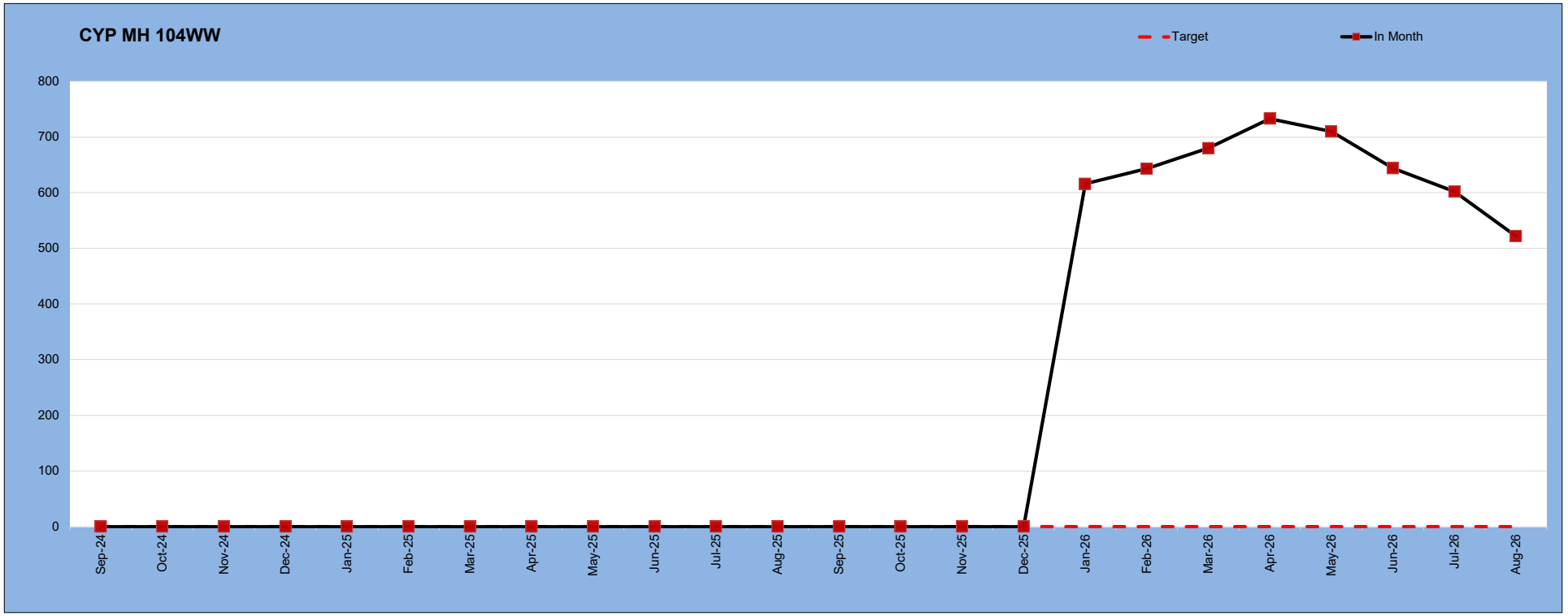
PI RETURN FORM 2026-27

Current month stands at: 522

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
CYP MH 104WW	CYP MH - number of referral-spells that are waiting a full meaningful help clock stop	**Executive Lead: Lynn Parkinson**



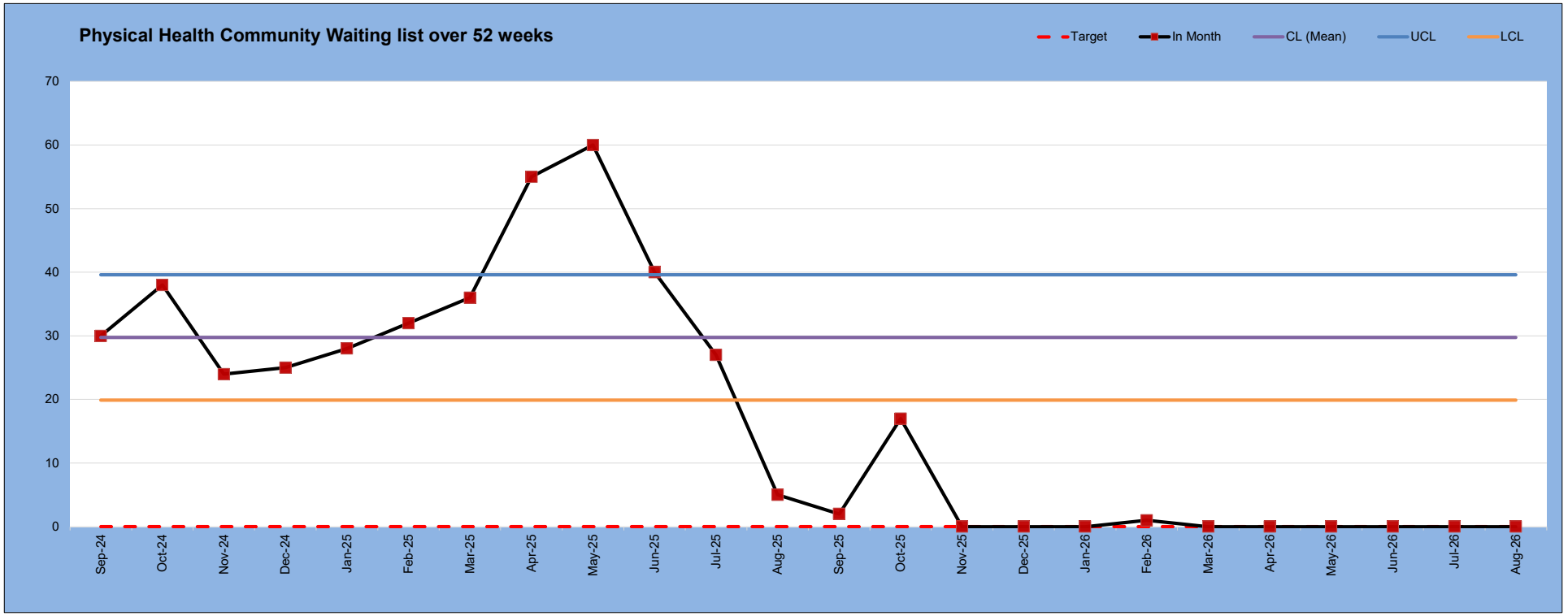
PI RETURN FORM 2026-27

Current month stands at:
0

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Community Waiting list over 52 weeks	Community Services (Adult and CYP) - Number of patients who have yet to be seen for care and have been waiting more than 52 weeks.	**Executive Lead: Lynn Parkinson**



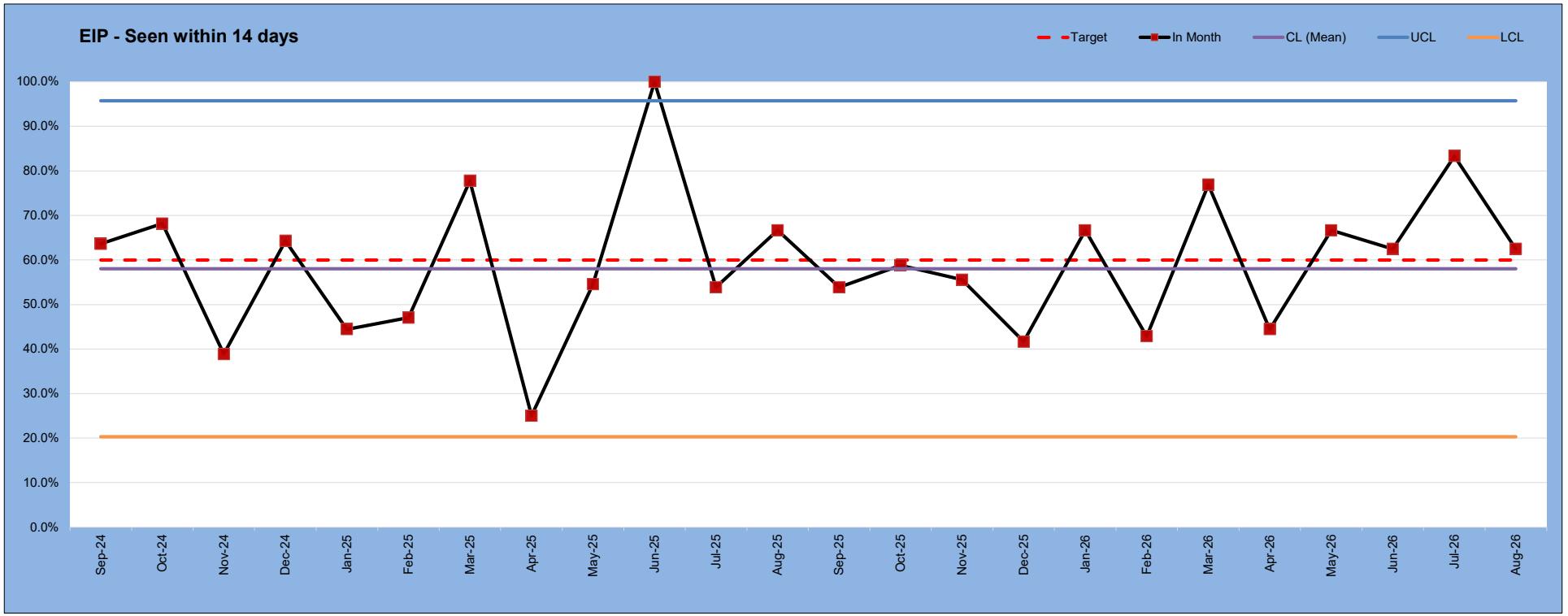
PI RETURN FORM 2026-27

Current month stands at:
62.5%

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Early Intervention in Psychosis	Percentage of patients who were seen within two weeks of referral	**Executive Lead: Lynn Parkinson**



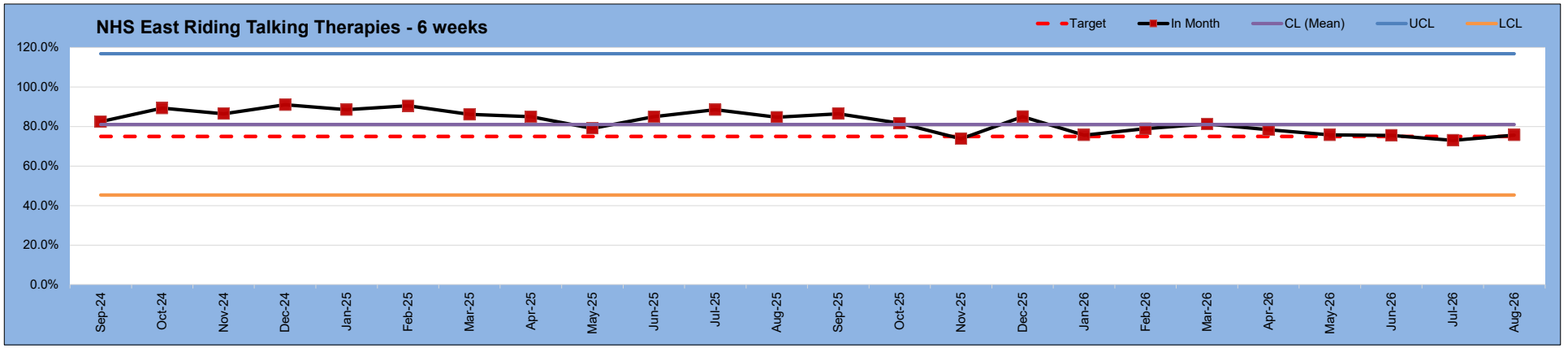
PI RETURN FORM 2026-27

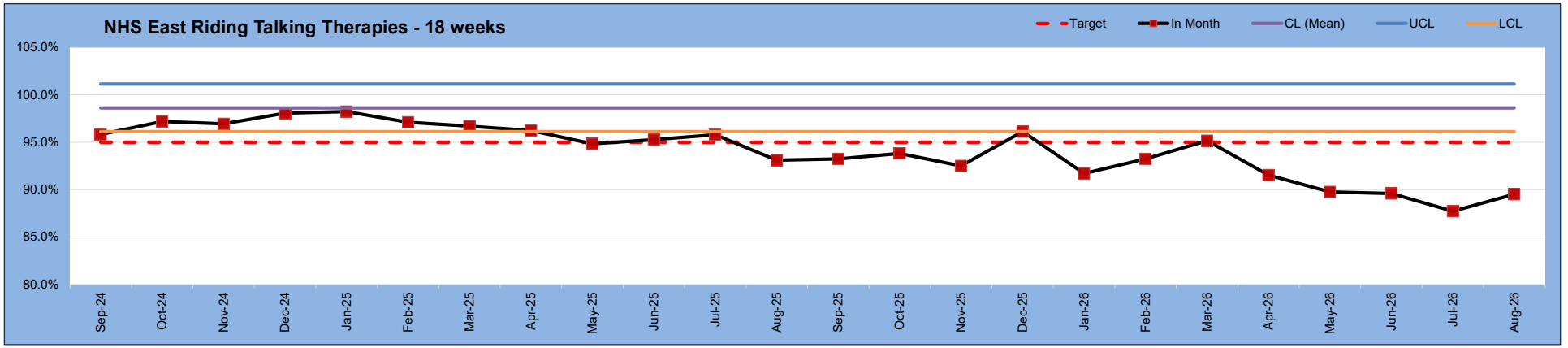
	6 week waits	18 week waits
Current month:	75.7%	89.5%

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
NHSER Talking Therapies - 6 and 18 week waits	Percentage of patients who were seen within 6 weeks and 18 weeks of referral	**Executive Lead: Lynn Parkinson**





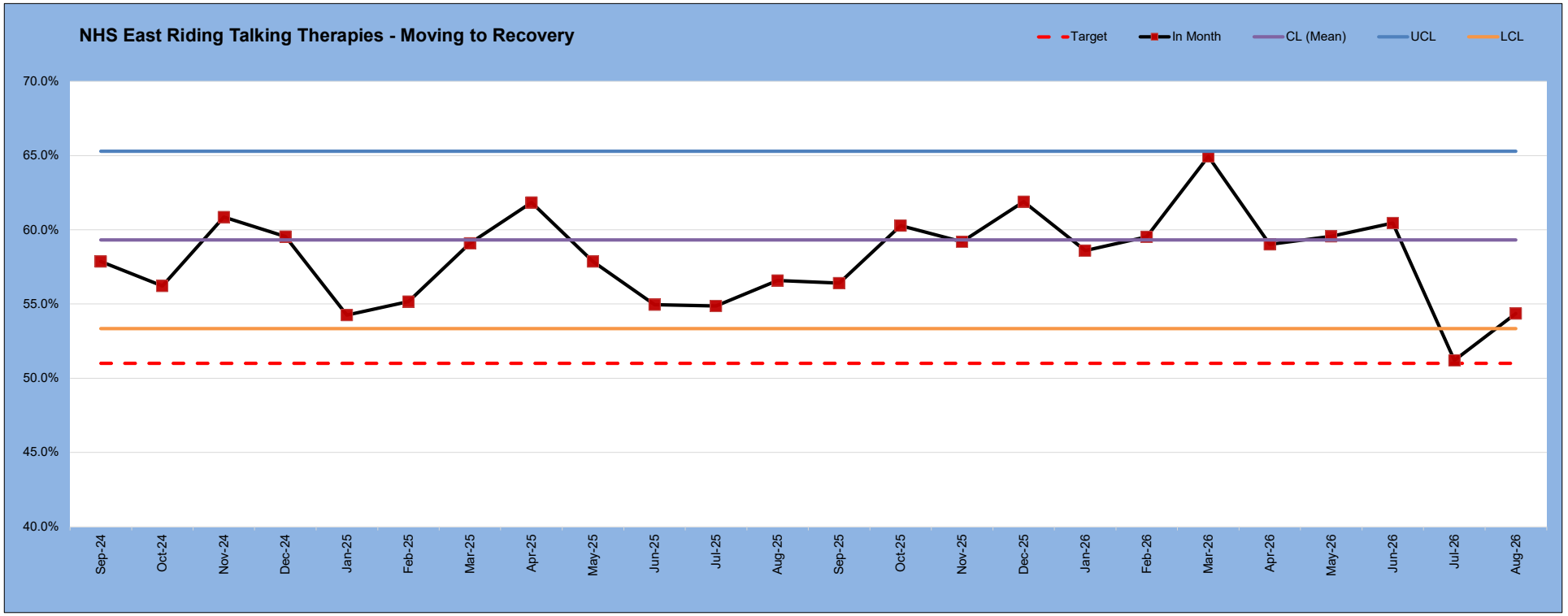
PI RETURN FORM 2026-27

Current month stands at:
54.3%

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
NHSER Talking Therapies - Moving to Recovery	Recovery Rates for patients who were at caseness at start of therapeutic intervention	**Executive Lead: Lynn Parkinson**



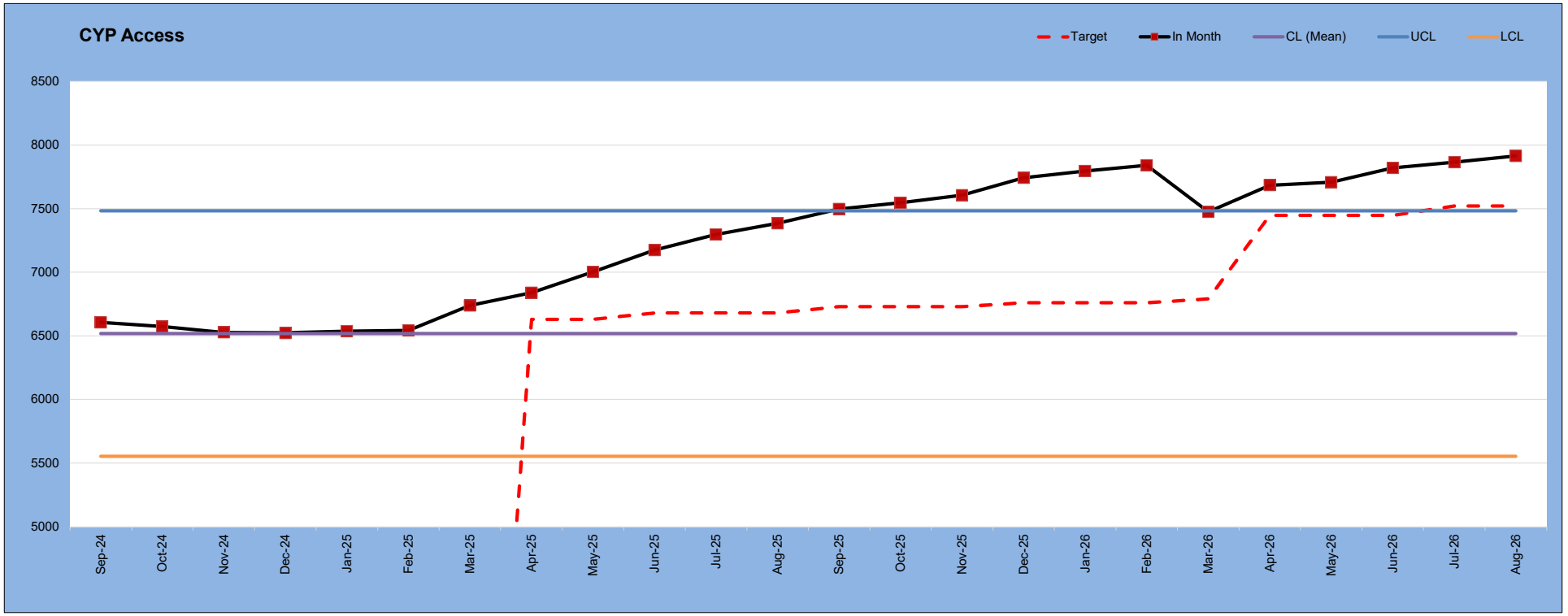
PI RETURN FORM 2026-27

Current month stands at:
7915

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
CYP MH Access	Number of CYP aged under 18 accessing support by NHS funded community services and school or college based Mental Health Support Teams (receiving at least one contact). Rolling 12 months. Includes Neuro Services, no team types are excluded.	**Executive Lead: Lynn Parkinson**



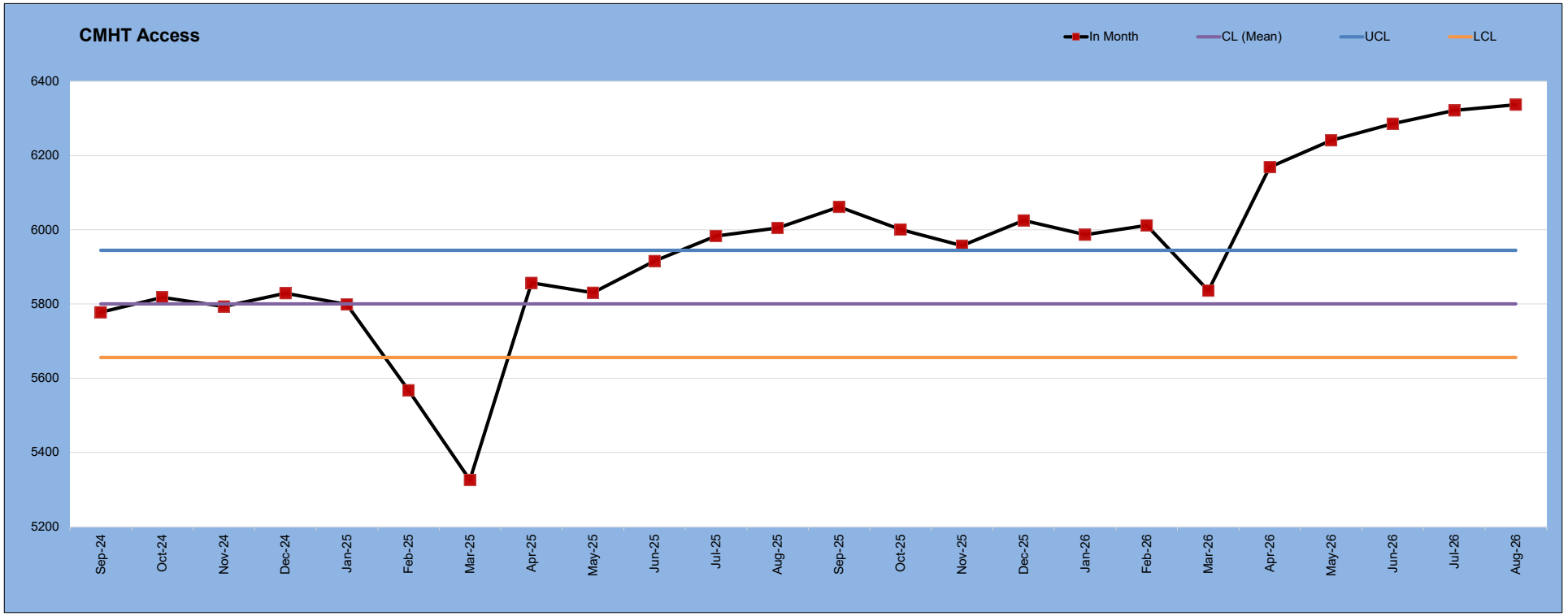
PI RETURN FORM 2026-27

Current month stands at:
6337

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
CMHT Access	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services for adults and older adults with severe mental illness. Rolling 12 months.	**Executive Lead: Lynn Parkinson**



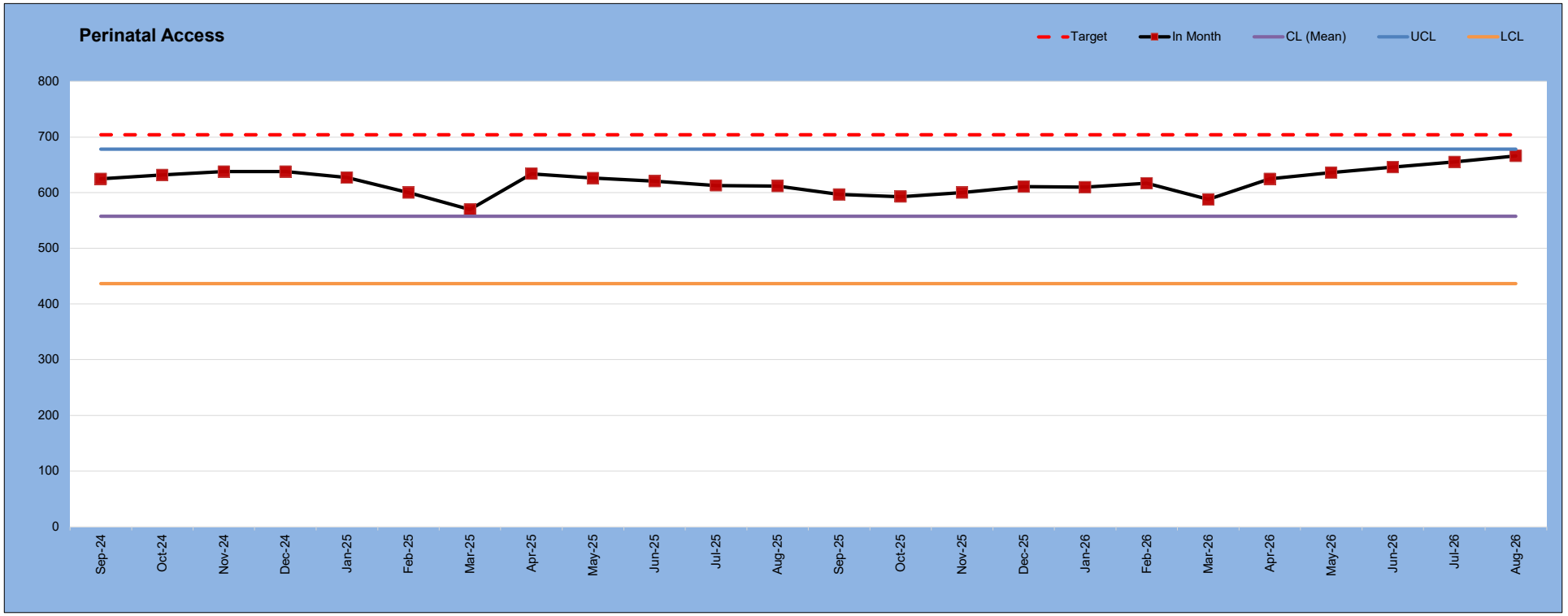
PI RETURN FORM 2026-27

Current month stands at:
666

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Perinatal Access	Number of women with at least one attended contact (F2F or video) with a specialist community perinatal mental health service in the last 12 months.	**Executive Lead: Lynn Parkinson**



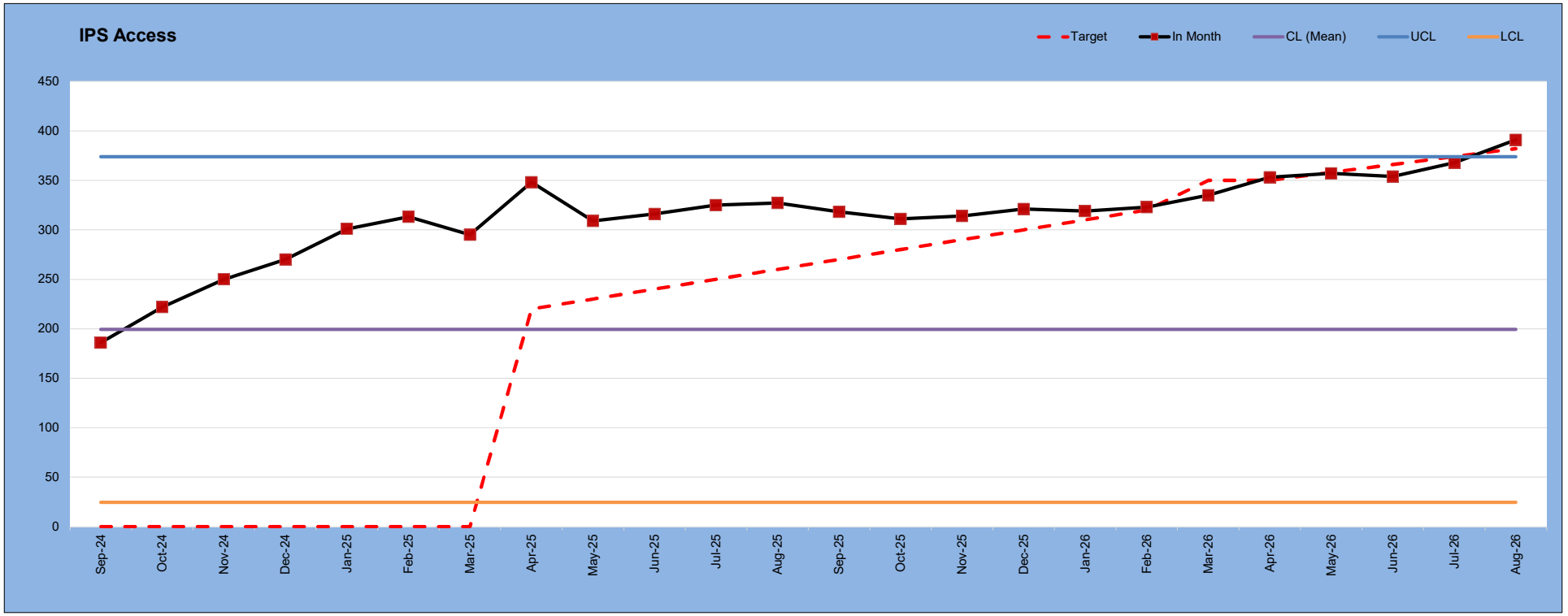
PI RETURN FORM 2026-27

Current month stands at:
391

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
IPS Access	Number of referrals that accessed Individual Placement Support (IPS) - rolling 12 months	**Executive Lead: Lynn Parkinson**



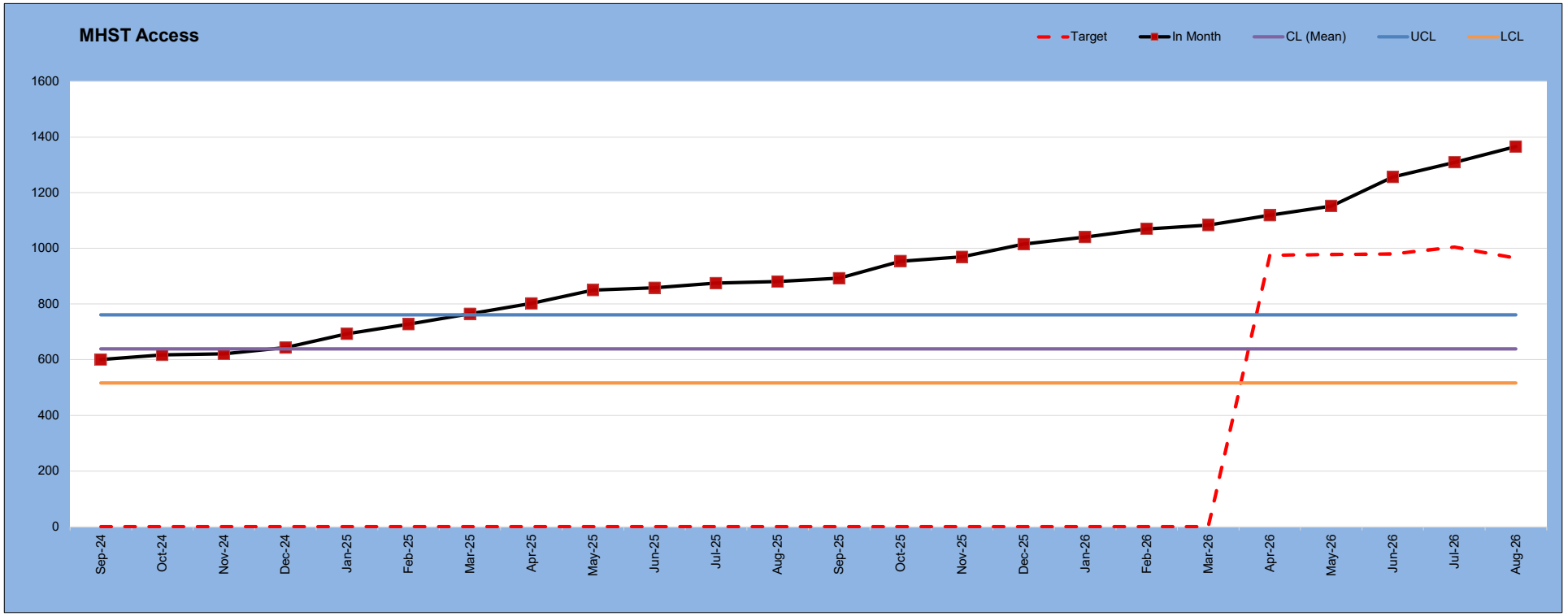
PI RETURN FORM 2026-27

Current month stands at:
1366

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
MHST Access	Number of referrals that accessed MHST - rolling 12 months	**Executive Lead: Lynn Parkinson**



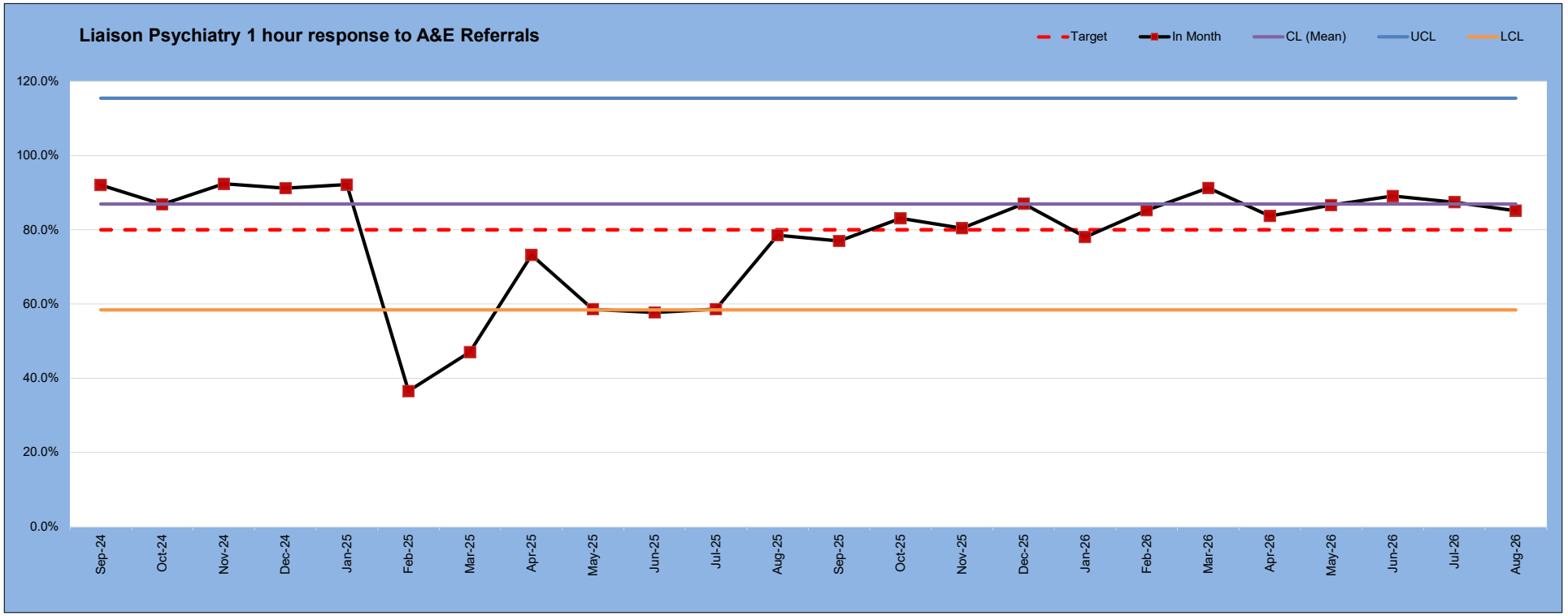
PI RETURN FORM 2026-27

Current month stands at:
85.1%

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Liaison 1 hour response	New referrals to liaison psychiatry teams from A&E in the reporting period with first face to face contact within 1 hour	**Executive Lead: Lynn Parkinson**



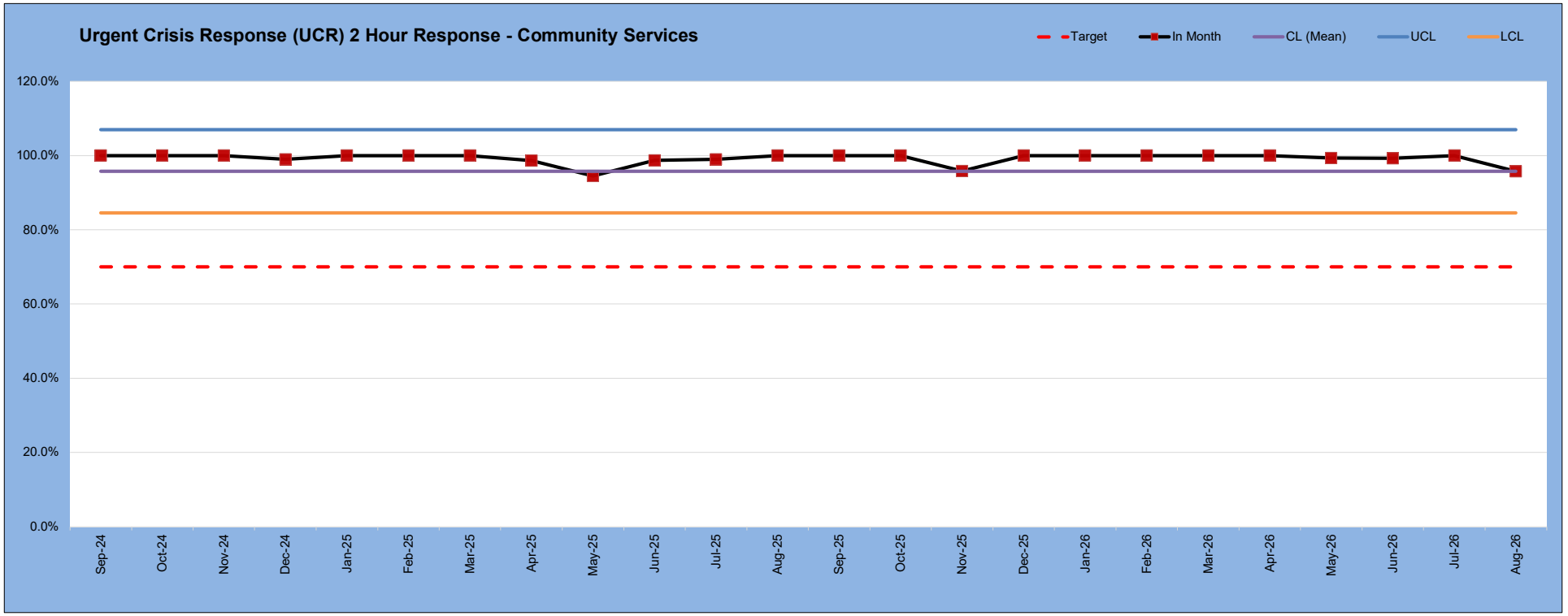
PI RETURN FORM 2026-27

Current month stands at:
95.8%

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
UCR 2 hr response	The percentage of 2-hour Urgent Crisis Response (UCR) referrals that achieved the 2-hour standard in the reporting month	**Executive Lead: Lynn Parkinson**



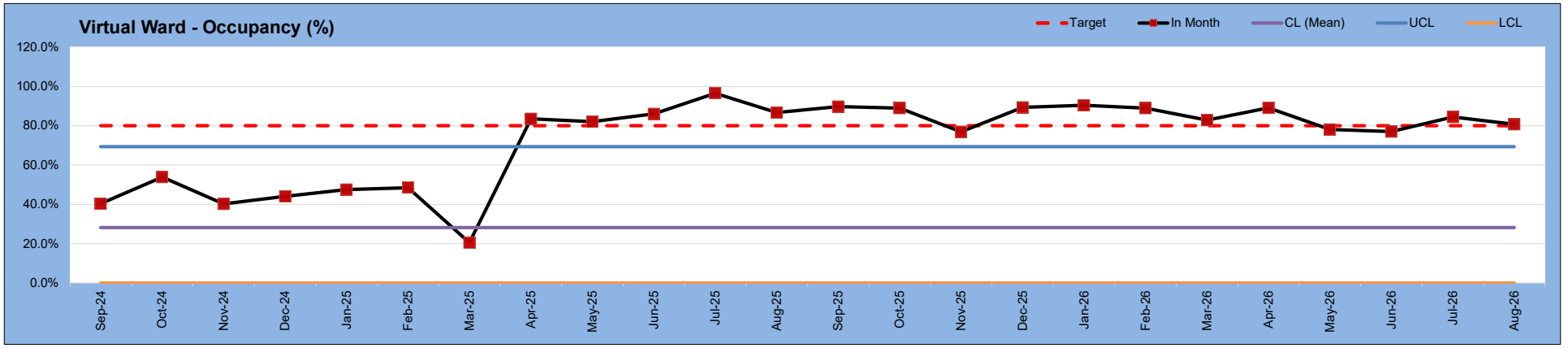
PI RETURN FORM 2026-27

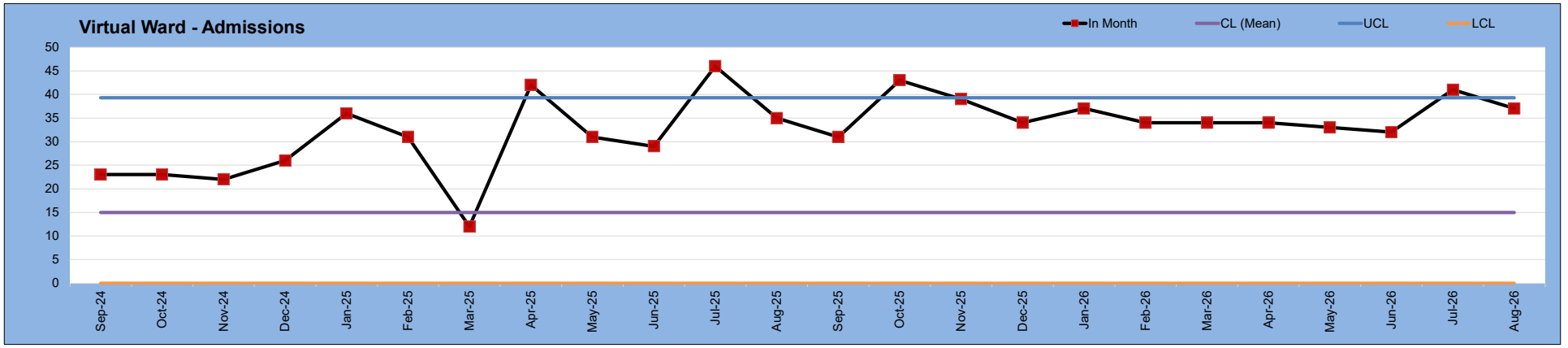
Current month stands at:
80.6%

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Virtual Ward	Virtual Ward Bed Occupancy Rate	**Executive Lead: Lynn Parkinson**





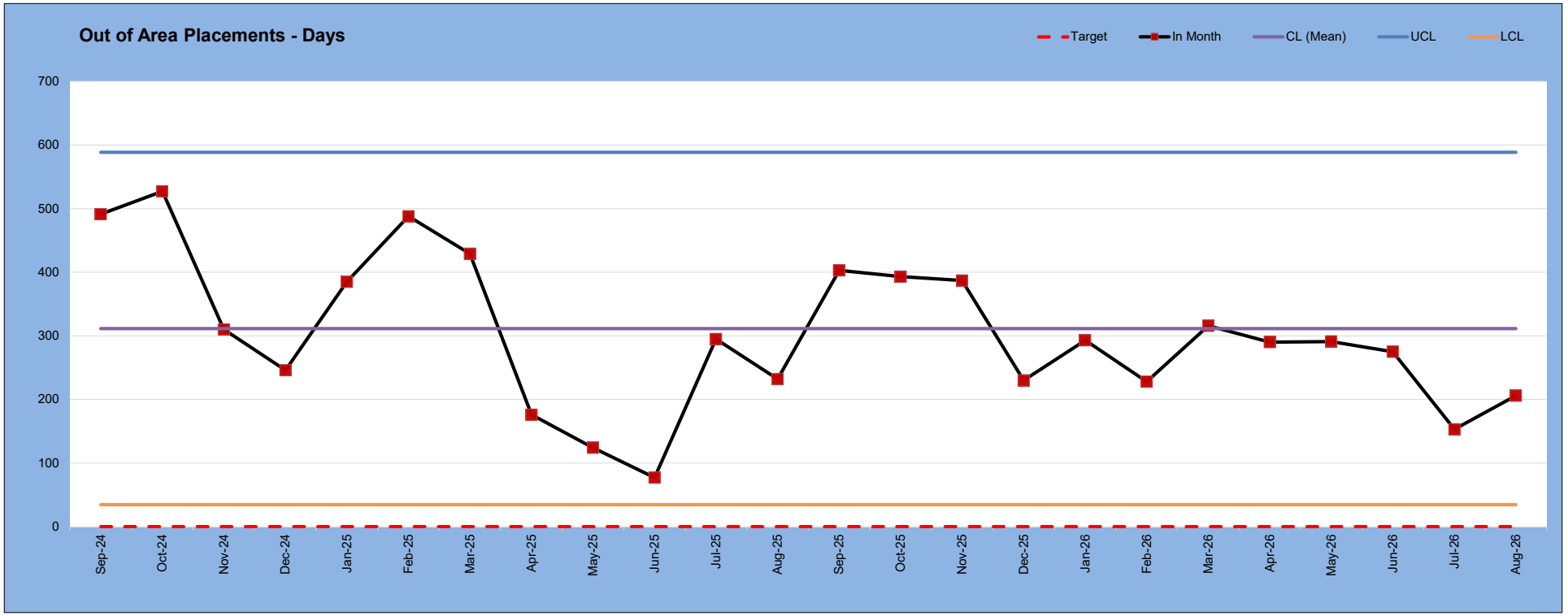
PI RETURN FORM 2026-27

Patients OoA within Month
20

Goal 3: Fostering integration, partnership and alliances

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Out of Area Placements	Number of days that Trust patients were placed in out of area wards including split across Adult, Older Adult and PICU	**Executive Lead: Lynn Parkinson**

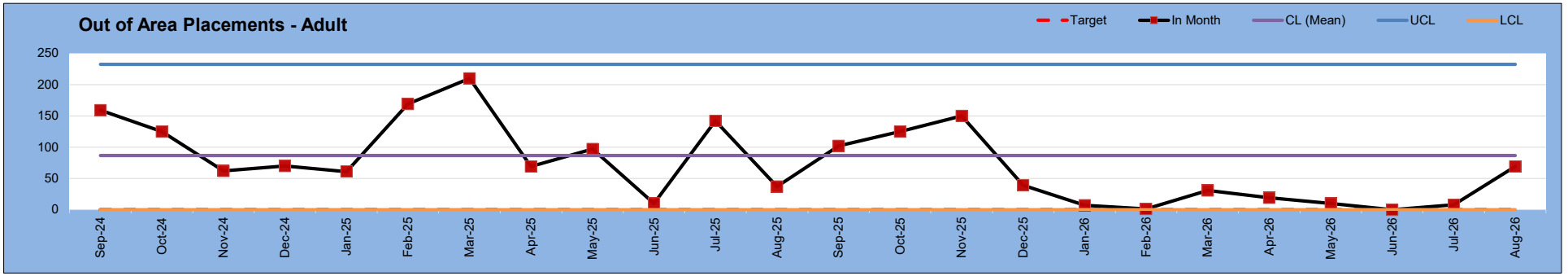


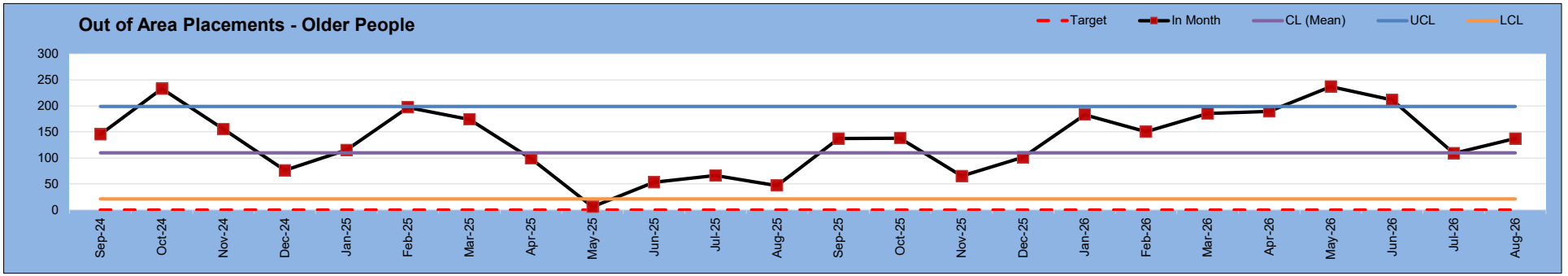
PI RETURN FORM 2026-27

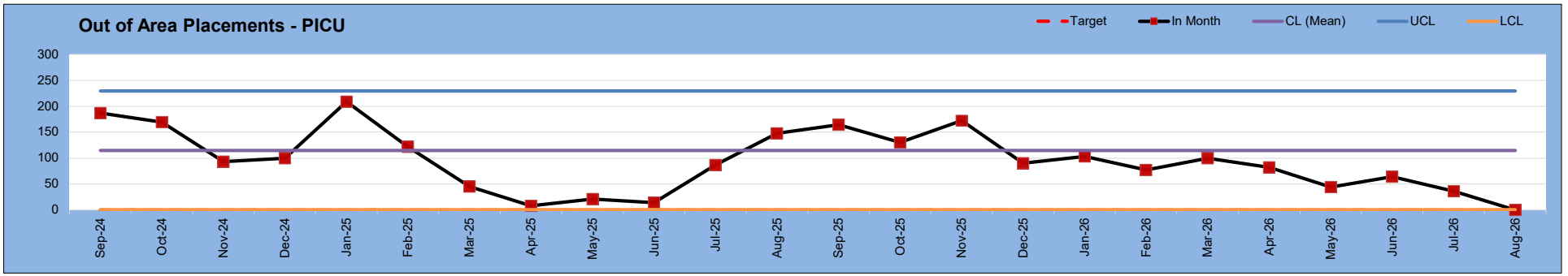
Goal 3: Fostering integration, partnership and alliances

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Out of Area Placements	Number of days that Trust patients were placed in out of area wards - split across Adult, Older Adult and PICU	**Executive Lead: Lynn Parkinson**







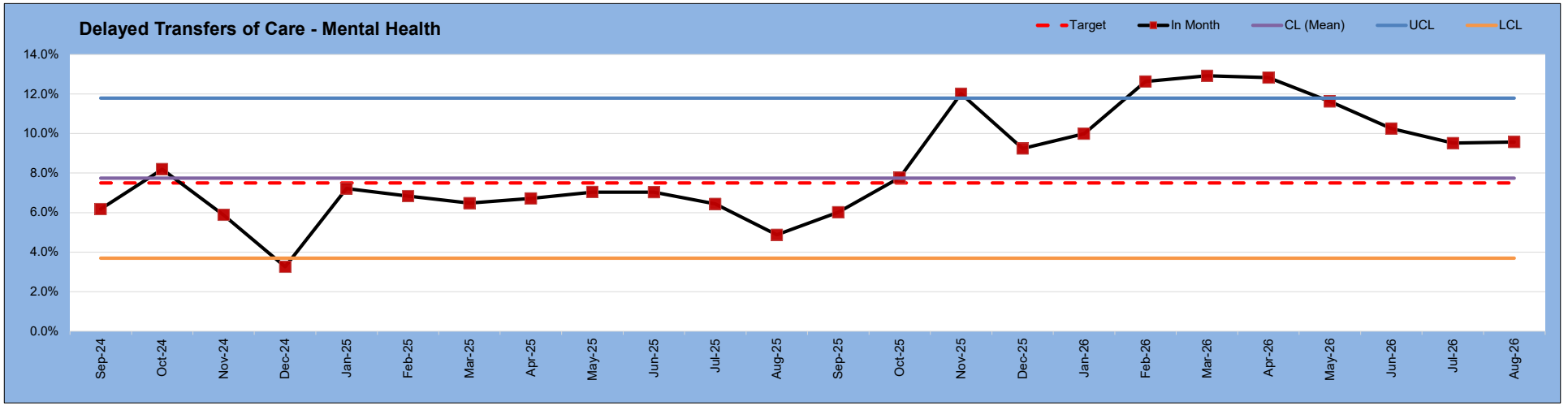
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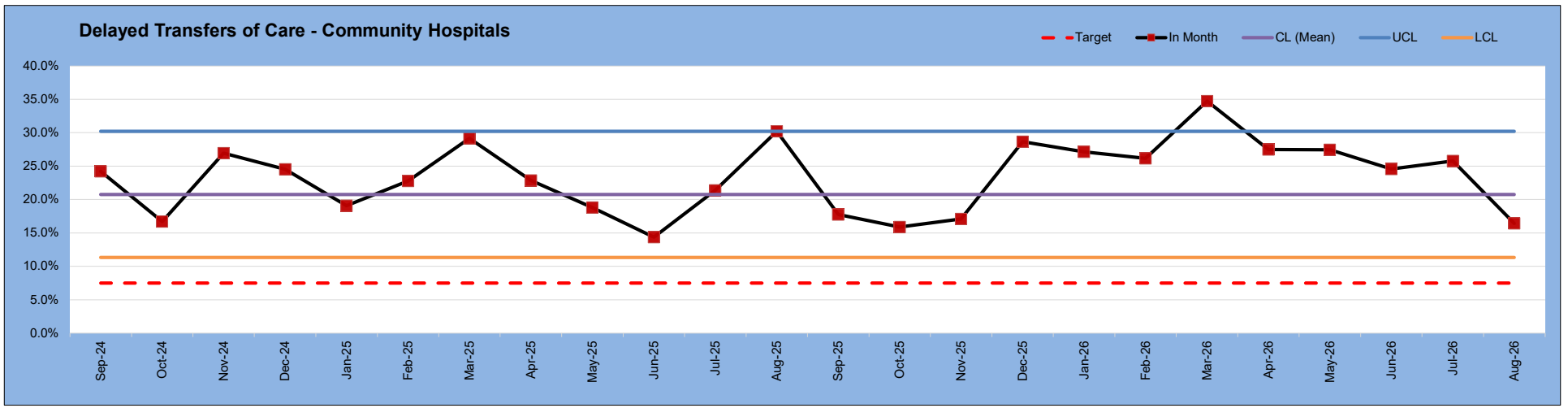
	MH DToC %	CH DToC %
Current month:	9.6%	16.4%

Goal 4: Fostering integration, partnership and alliances

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Delayed Transfers of Care	Results for the percentage of Mental Health delayed transfers of care	**Executive Lead: Lynn Parkinson**





People & Organisational Development Committee

Positive Assurances to Provide:

- Clinical supervision compliance remains strong at 92.5%, providing assurance that staff continue to receive appropriate professional support, reflective practice and clinical oversight to maintain high standards of care.
- Overall vacancy levels have improved further, reducing to 6.7%, reflecting the impact of sustained recruitment activity and workforce planning initiatives, supporting greater workforce stability across the Trust.
- Staff turnover remains low at 0.7%, continuing to demonstrate good retention and organisational stability.
- Mandatory training compliance remains high at 94.7%, significantly exceeding the Trust target and providing assurance that staff maintain the knowledge and skills required to deliver safe and effective care.
- Workforce indicators remain broadly stable, demonstrating continued strengths in recruitment, retention, learning and development, and workforce governance.

Matters of Concern or Key Risks to Escalate:

- Sickness absence remains at 5.9%, above the Trust target, continuing to impact workforce capacity, service resilience and productivity across a number of inpatient and community services.
- Whilst overall vacancies have reduced, consultant vacancies remain elevated in some specialties, creating recruitment challenges and potential risks to service sustainability and medical workforce resilience.

Key Actions Commissioned/Work Underway:

- Continued implementation of the Working Towards a Healthier Workforce Plan and Rapid Response Sickness Absence Model to address sickness hotspots, improve attendance and support workforce wellbeing.
- Ongoing implementation of the revised Sickness Absence Policy, alongside enhanced management capability and support arrangements to promote earlier intervention and consistent application.
- Continued recruitment and retention initiatives, including delivery of the Medical Workforce Plan and targeted actions to reduce vacancies in hard-to-recruit professions and specialties.
- Sustained focus on leadership, wellbeing, culture and staff experience through delivery of the People Strategy, Being Humber, NHS Staff Standards and NHS People Promise commitments.

Decisions Made:

- Workforce performance remains stable, with continued improvements in vacancy levels and sustained strong compliance in mandatory training and clinical supervision. Workforce metrics routinely reviewed in ODG, EMT and People & OD Committee, with focus in Divisional Accountability Reviews
- Continued organisational focus on reducing sickness absence, addressing consultant vacancies and maintaining recruitment momentum to support delivery of Trust priorities and workforce sustainability.

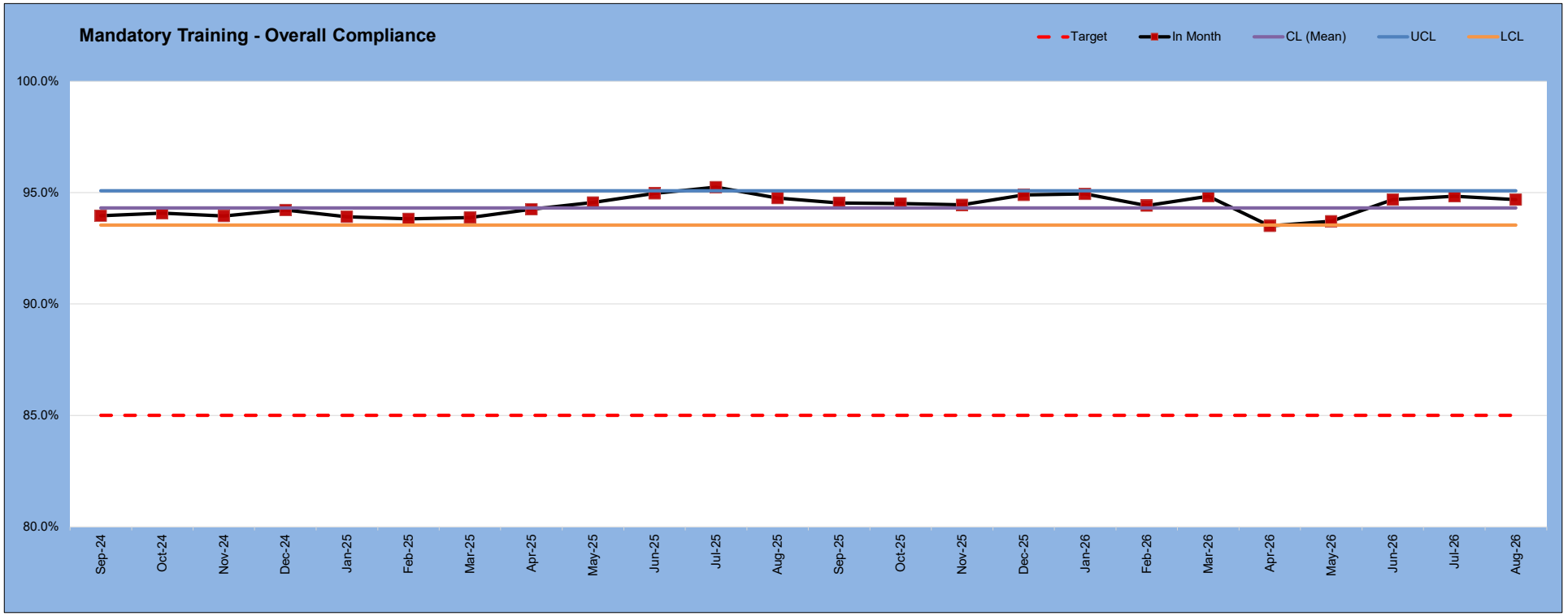
PI RETURN FORM 2026-27

Current month stands at:
94.7%

Goal 1: Innovating Quality and Patient Safety

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Mandatory Training	A percentage compliance based on an overall target of 85% for all mandatory and statutory courses	**Executive Lead: Karen Phillips**



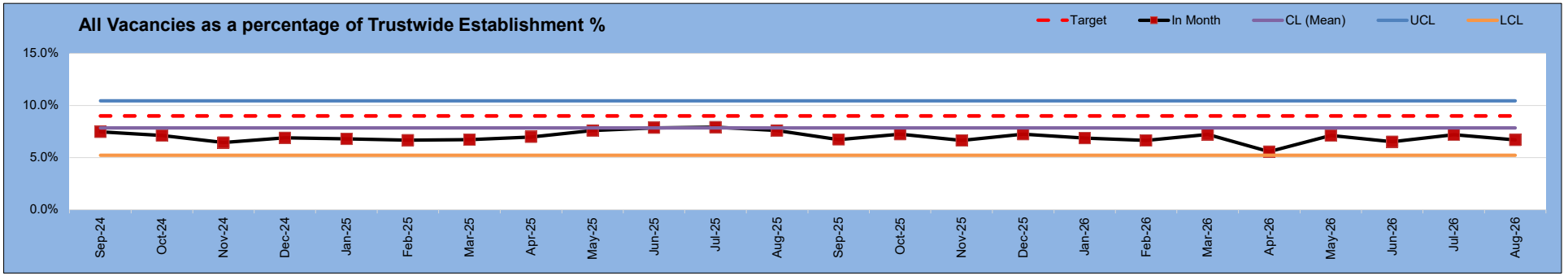
PI RETURN FORM 2026-27

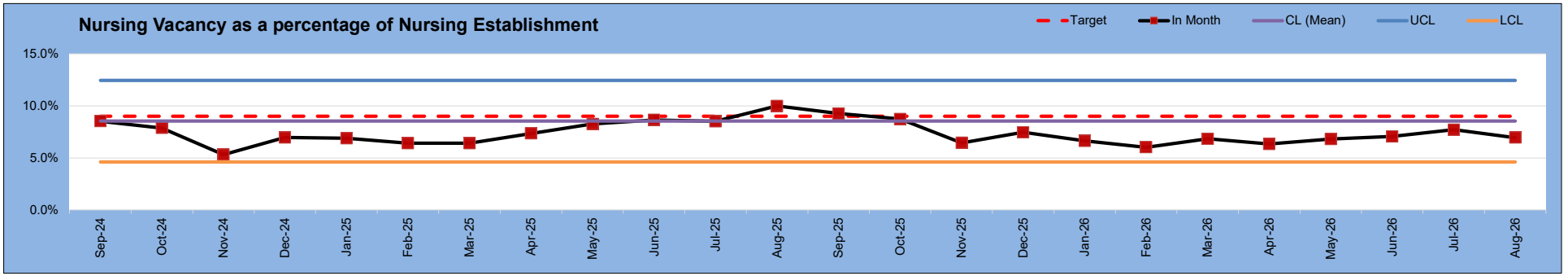
Current month stands at:
6.7%

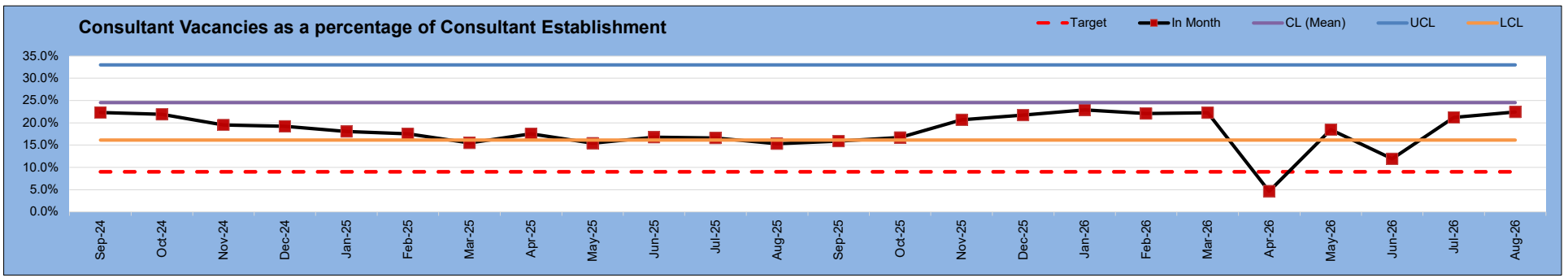
Goal 1: Innovating Quality and Patient Safety

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Vacancies (WTE)	Proportion of posts vacant when compared to the budgeted establishment. This information is taken from the Trust financial ledger.	**Executive Lead: Karen Phillips**







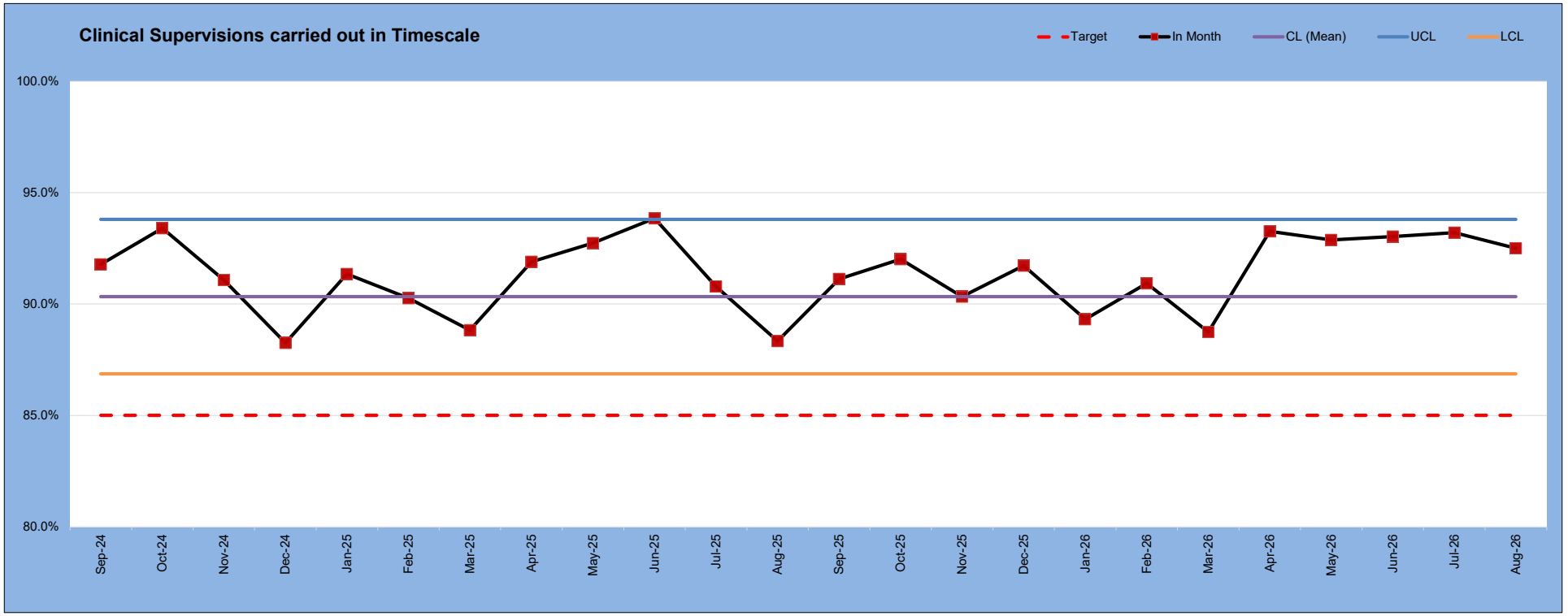
PI RETURN FORM 2026-27

Current month stands at:
92.5%

Goal 1: Innovating Quality and Patient Safety

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Clinical Supervision	Percentage of staff with appropriate clinical supervision taken place within the last 4-6 weeks	**Executive Lead: Sarah Smyth**



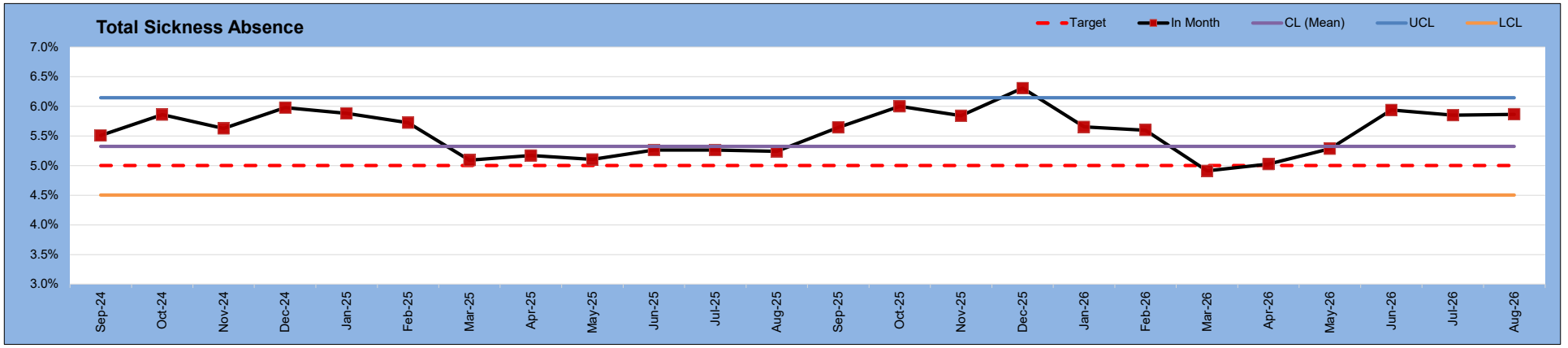
PI RETURN FORM 2026-27

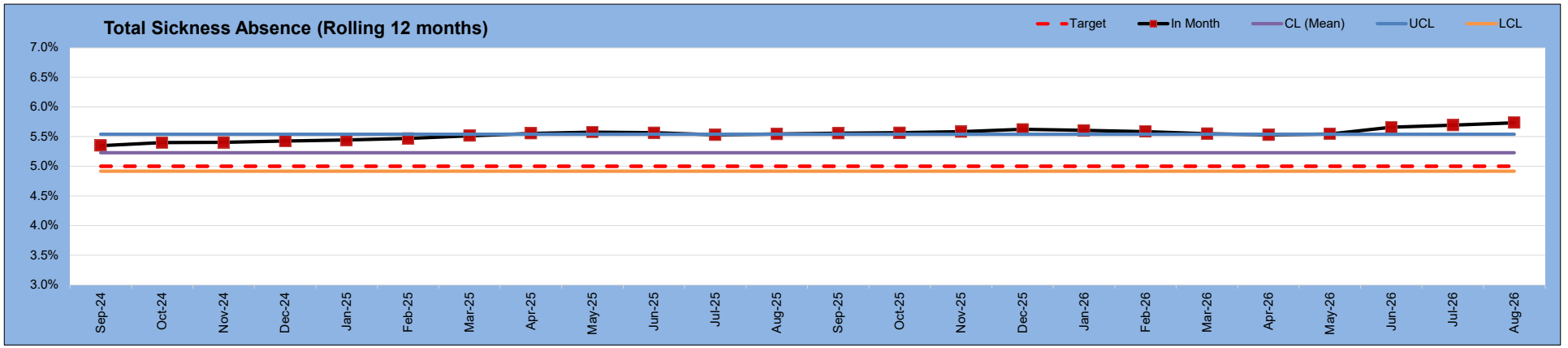
Current month stands at: 5.9%

Goal 4: Developing an effective and empowered workforce

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Sickness Absence	Percentage of staff sickness across the Trust (not including bank staff)	**Executive Lead: Karen Phillips**





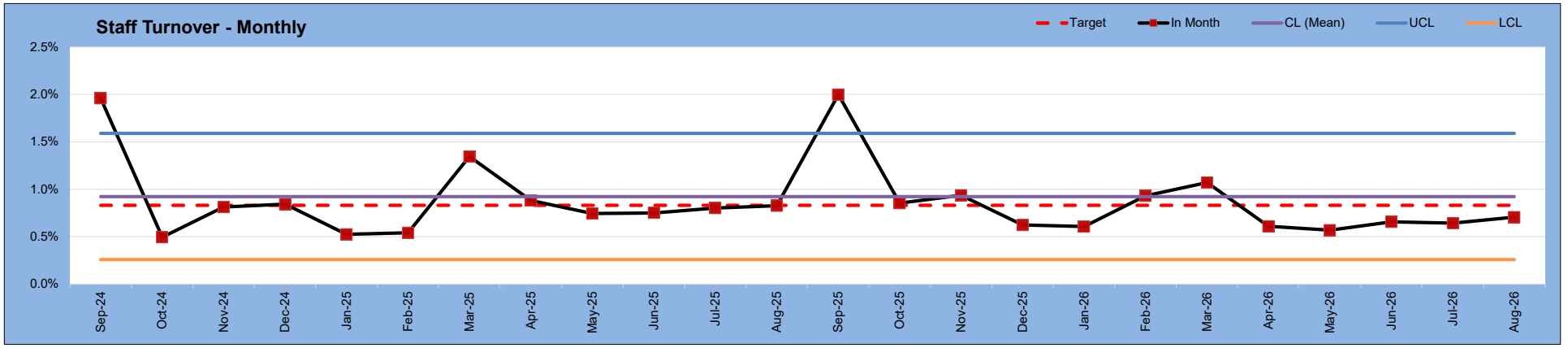
PI RETURN FORM 2026-27

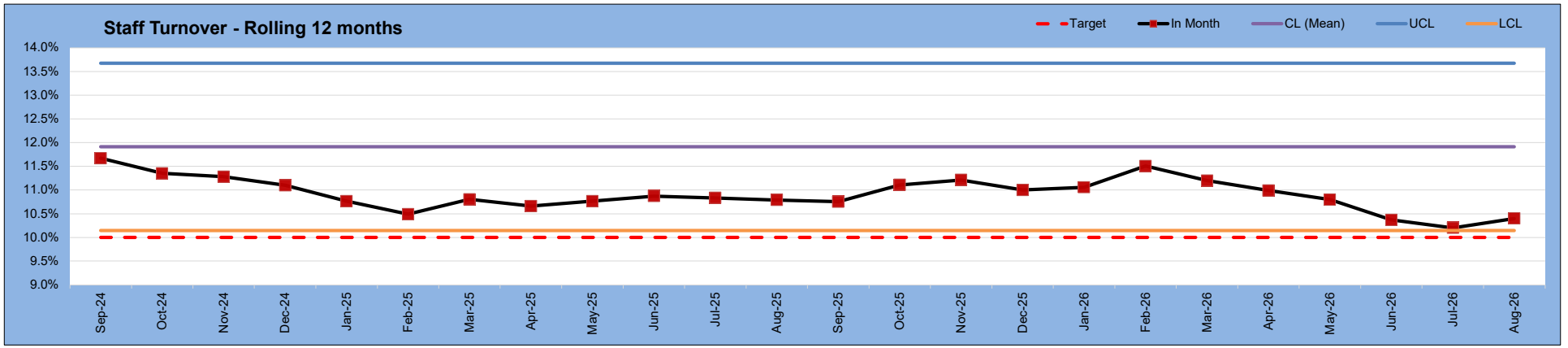
Current month stands at:
0.7%

Goal 4: Developing an effective and empowered workforce

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Staff Turnover	Percentage of leavers against staff in post (excluding employee transfers)	**Executive Lead: Karen Phillips**





Finance Committee

Positive Assurances to Provide:

- Strong performance on Better Payment Practice Code (Value) for both NHS (99.2%) and Non NHS (98.7%) in August 2026.

Matters of Concern or Key Risks to Escalate:

- Nothing to escalate

Key Actions Commissioned/Work Underway:

- Separate Finance Report appears elsewhere on the Board Agenda

Decisions Made:

- None

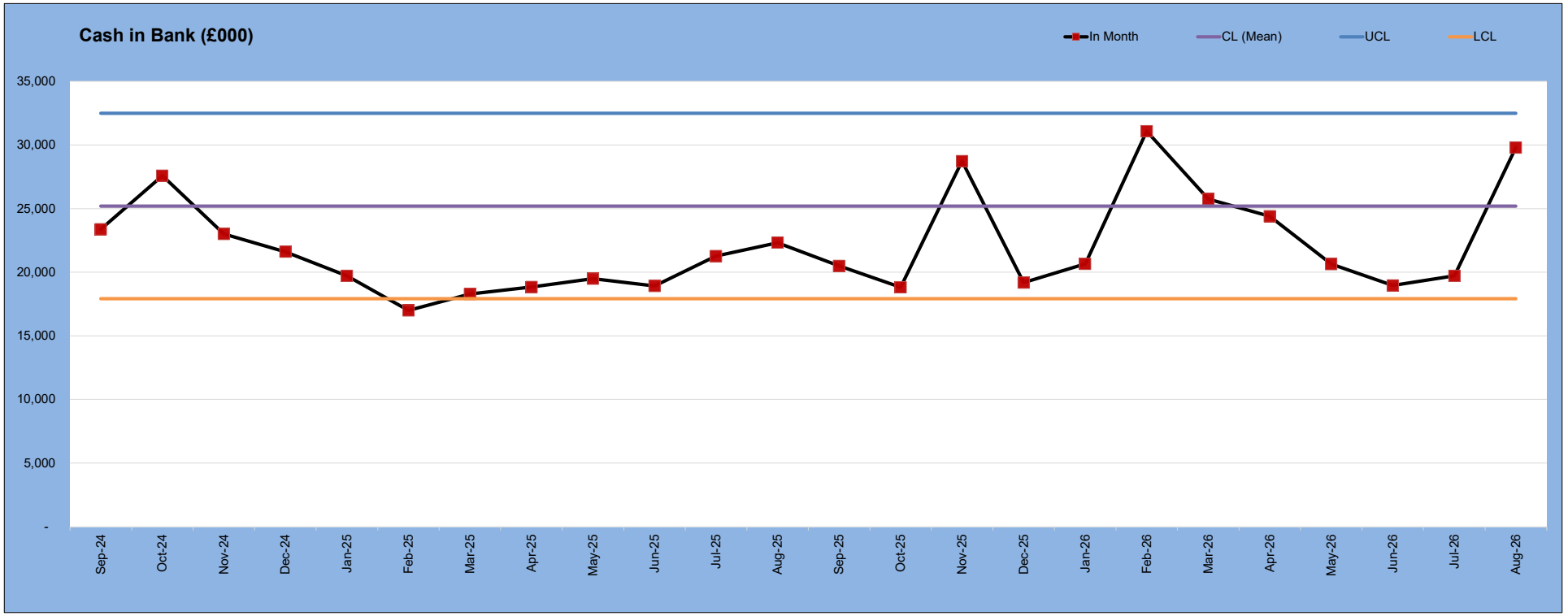
PI RETURN FORM 2026-27

Current month stands at:
29,802

Goal 5: Maximising an efficient and sustainable organisation

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Cash in Bank	The level of cash and cash equivalents held by the organisation at a given point in time, reflecting its short-term financial liquidity and ability to meet operational and contractual obligations.	**Executive Lead: Peter Beckwith**



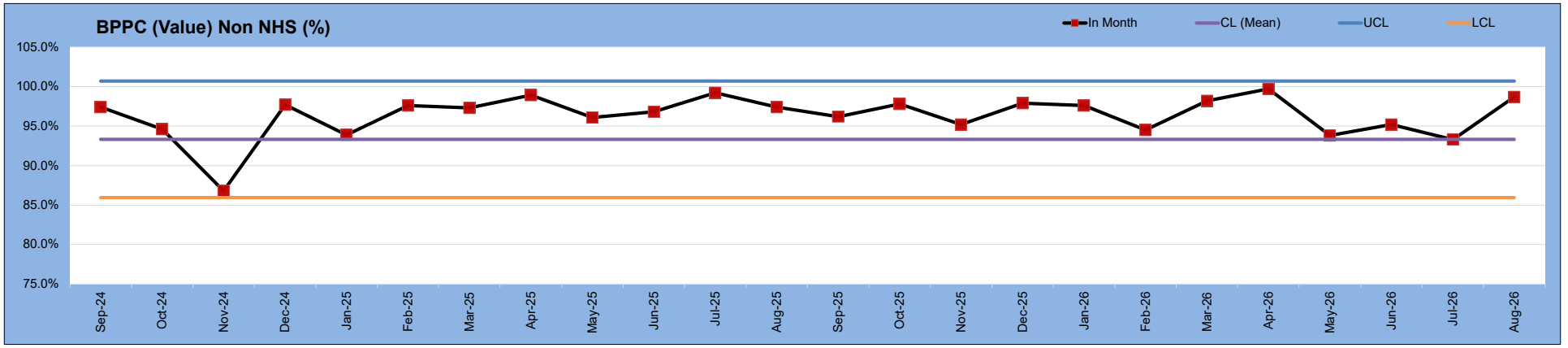
PI RETURN FORM 2026-27

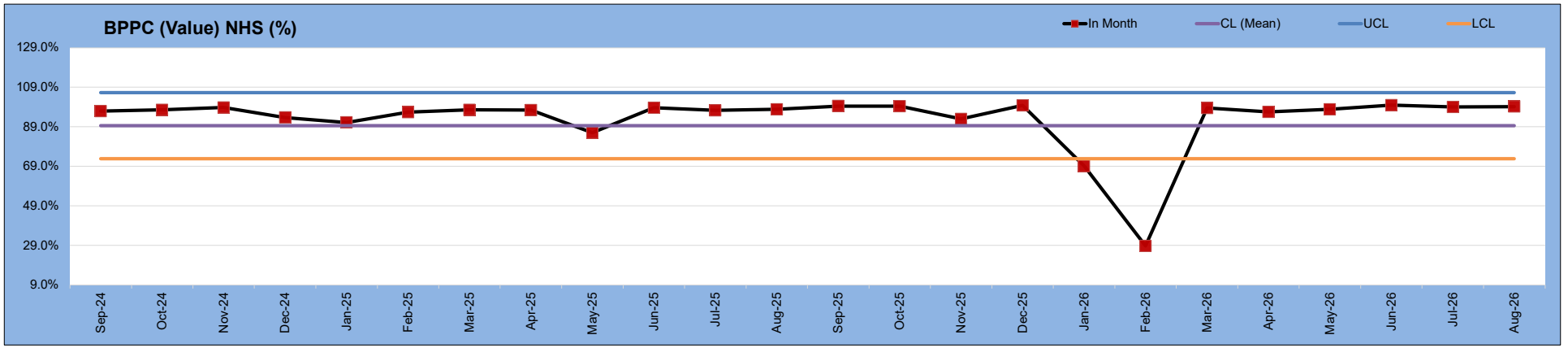
Goal 5: Maximising an efficient and sustainable organisation

	BPPC Non NHS	BPPC NHS
Current month:	98.7%	99.2%

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
BPPC (Value)	The percentage of total invoice value (£) that is paid within the agreed payment timeframe.	**Executive Lead: Peter Beckwith**





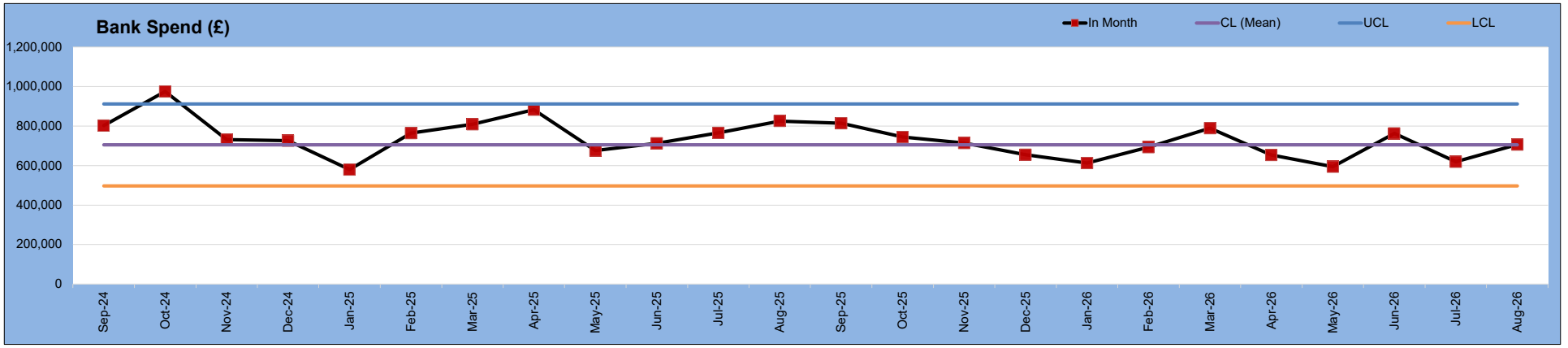
PI RETURN FORM 2026-27

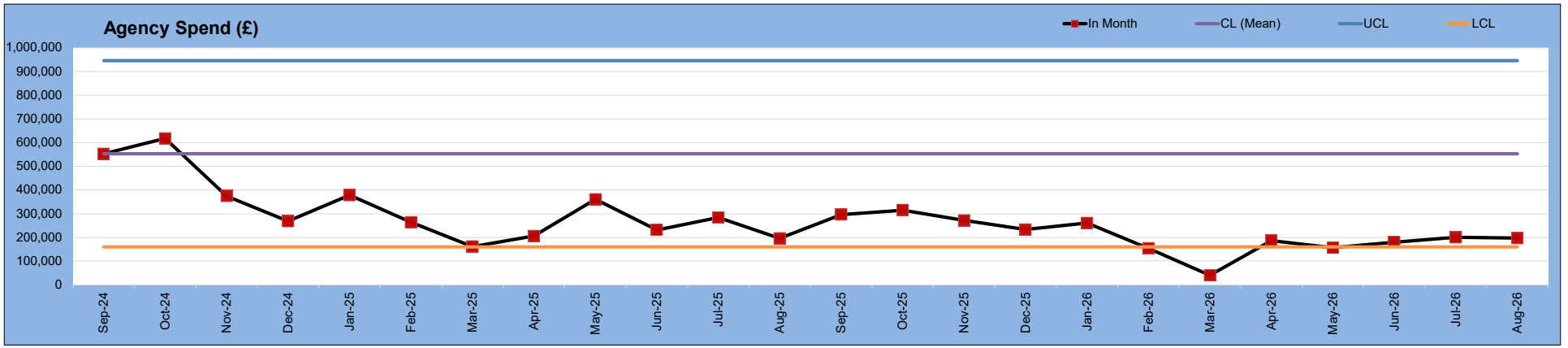
Goal 5: Maximising an efficient and sustainable organisation

	Bank Spend	Agency Spend
Current month:	706,028	197,119

For the period ending: **August 2026**

Indicator Title	Description/Rationale	
Bank/Agency Spend	The total expenditure incurred on internal temporary staff (bank & agency workers) over a defined reporting period, measured in pounds (£)	**Executive Lead: Peter Beckwith**





Humber Teaching NHS Foundation Trust

Trust Performance Report

GLOSSARY

A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
BI	Business Intelligence
BLS	Basic Life Support
CAMHS	Child and Adolescent Mental Health Services
CHPPD	Care Hours per Patient Day
CL	Central Line
CMH	Community Mental Health
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CYP	Children and Young People
CYP MH	Children and Young People's Mental Health
DToC	Delayed Transfer of Care
EIP	Early Intervention in Psychosis
F2F	Face to Face
FFT	Friends and Family Test
ILS	Immediate Life Support
IPS	Individual Placement Support
IPU	Inpatient Unit
LCL	Lower Control Limit
LD	Learning Disability
MH	Mental Health
MHST	Mental Health Support Teams
NHSER	NHS East Riding
OBD	Occupied Bed Days
OBDs	Occupied Bed Days (plural)
ODG	Operational Delivery Group
PICU	Psychiatric Intensive Care Unit
RN	Registered Nurse
RTT	Referral to Treatment
SPC	Statistical Process Control
TPR	Trust Performance Report
UCL	Upper Control Limit
UCR	Urgent Crisis Response
WTE	Whole Time Equivalent
YTD	Year to Date

NHS
Humber Teaching
NHS Foundation Trust

Executive Team:

Chief Executive: Michele Moran
Chair: Caroline Flint
Chief Operating Officer: Lynn Parkinson
Director of Finance: Peter Beckwith
Associate Director of People and Organisational Development: Karen Phillips
Medical Director: Kwame Fofie
Director of Nursing: Sarah Smyth

Caring, Learning
& Growing Together

Issue Date: 23/09/2026

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 26

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Risk Register Update
Author/s:	Sarah Smyth, Executive Director of Nursing, Quality and Professions Oliver Sims Risk and Incident Lead Manager
Recommendation:	

To approve		To discuss	
To note	√	To ratify	
For assurance			

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	The report provides the Board with an update on the Trust-wide risk register (15+ risks) including the detail of any additional or closed risks since last reported to Trust Board in May 2026.

Key issues:

Positive Assurances to Provide:

- The Trust-wide risk register details the risks facing the organisation scored at a current rating of 15 or higher (significant risks).

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Please see the risk register extract supporting this report for details of the actions being undertaken for each of the risks highlighted.

Key Risks/Areas of Focus:

- All 15+ risks which are detailed in the report
- OPS41 is a new risk
- Risk MH187 is a new revised risk and has direct executive oversight

MH187 – There is a risk that pressures within the Hull Community Mental Health Team relating to caseload management, patient allocation processes, leadership capacity, waiting list management, workforce availability, patient safety oversight and team culture could result in patients not receiving timely, effective and safe care. Failure to effectively manage demand and capacity may lead to increasing waiting times, difficulties in maintaining "waiting well" arrangements, inequitable caseload distribution, reduced staff well-being and diminished assurance regarding patient safety and quality of care.

Decisions Made:

Trust-wide Risk Register (15+ significant risks only)

- The Trust-wide risk register extract contains **6 risks** currently rated at 15+:

Risk Description	Current Rating
OPS31 – Failure to effectively address waiting times within the Trust's Children's Neurodiversity services which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain	16
FII223 – Risk to longer-term financial sustainability if block contract values are insufficient to cover the Trust Cost base.	16
WF57 – Persistent and elevated sickness absence rates across Trust staff groups -currently averaging 5.6% (Dec 25) pose a significant risk to workforce capacity, operational delivery, and the ability of the organisations to meet performance expectations under the 2025/26 NHS Oversight Framework as well as	16

	reduced staffing levels compromising patient safety, increase waiting times, and hinder service recovery.	
	FII247 – As a result of difficulties within the ICS to meet challenging financial targets for 2026/27, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery.	**15**
	MH187 – There is a risk that pressures within the Hull Community Mental Health Team relating to caseload management, patient allocation processes, leadership capacity, waiting list management, workforce availability, patient safety oversight and team culture could result in patients not receiving timely, effective and safe care. Failure to effectively manage demand and capacity may lead to increasing waiting times, difficulties in maintaining "waiting well" arrangements, inequitable caseload distribution, reduced staff well-being and diminished assurance regarding patient safety and quality of care.	**16**
	OPS41 – T Increased discharge delays resulting from constraints within social care and care home placements. Lack of Local Authority support for the Care Home Inreach Service, which aims to prevent deterioration of care home residents and avoid escalation into secondary care. Plans to disaggregate Local Authority social workers from integrated community teams, reducing multidisciplinary working and impacting coordination of patient care and discharge planning. If these issues continue, there is a risk of increased length of stay, poorer patient outcomes and experience, increased admissions and readmissions, greater pressure on inpatient capacity, failure to achieve national discharge standards, and deterioration in relationships across the health and care system.	**16**

Alignment with the Three Shifts in the Long-Term Plan (*If not applicable please state*)	
Hospital to Community	Supports discussion relating to prevention, recovery, place-based partnerships, neighbourhood working and integrated models of care.
Analogue to Digital	Supports consideration of digital transformation, data, technology and AI-enabled service improvement within agreed risk appetite parameters.
Sickness to Prevention	Directly supports the strategic objective of enhancing prevention, wellbeing and recovery, including reducing health inequalities and improving population health outcomes.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	

	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	01/09/2026
	Mental Health Legislation Committee		Operational Delivery Group	24/08/2026
	Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*	
√ *Tick those that apply*	
Innovating Quality and Patient Safety	√
Enhancing prevention, wellbeing and recovery	√
Fostering integration, partnership and alliances	
Developing an effective and empowered workforce	
Maximising an efficient and sustainable organisation	
Promoting people, communities and social values	√

Areas to include within the report:	
Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	√
Public Exemption:	
Is the report exempt from public disclosure	No

Risk Register Update September 2026

1. Trust-wide Risk Register – Existing Risks

The report provides the Board with an update on the Trust-wide risk register (15+ risks) including the detail of any additional or closed risks since last reported to Trust Board in May 2026.

There are currently **6 risks** in total reflected on the Trust-wide risk register which records all risks currently scored at a rating of 15 or above.

Table 1 below reflects the four existing 15+ risks previously reported to Trust Board, with the new / escalated risks included since last review in May 2026 detailed in ***Table 2*** later in the report.

Table 1 - Trust-wide Risk Register – Existing Risks (current risk rating 15+)

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score	Movement from prev. quarter
OPS31	Failure to effectively address waiting times within the Trust's Children's Neurodiversity services which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain	20	16	8	⟷
FII239	As a result of difficulties within the ICS to meet challenging financial targets for 2025/26, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery.	20	15	5	⟷
WF57	Persistent and elevated sickness absence rates across Trust staff groups—currently averaging 5.54% (Sep 25) pose a significant risk to workforce capacity, operational delivery, and the ability of the organisations to meet performance expectations under the 2025/26 NHS Oversight Framework as well as reduced staffing levels compromising patient safety, increase waiting times, and hinder service recovery.	20	16	8	⟷
FII223	As a result of difficulties within the ICS to meet challenging financial targets for 2026/27, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery.	20	16	8	⟷

2. New / Escalated Trust-wide Risks

There are **two risks** to highlight which have been added to the Trust-wide risk register since last reported to the Trust Board in May 2026.

Table 2 - Trust-wide Risk Register – New / Escalated Risks

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score
MH187	There is a risk that pressures within the Hull Community Mental Health Team relating to caseload management, patient allocation processes, leadership capacity, waiting list management, workforce availability, patient safety oversight and team culture could result in patients not receiving timely,	20	16	8

	effective and safe care. Failure to effectively manage demand and capacity may lead to increasing waiting times, difficulties in maintaining "waiting well" arrangements, inequitable caseload distribution, reduced staff well-being and diminished assurance regarding patient safety and quality of care. Causes: • High and increasing demand for Community Mental Health Team (CMHT) services. • Workforce vacancies, recruitment challenges and sickness absence. • Inconsistent or ineffective caseload management and allocation processes. • Limited leadership capacity to provide operational oversight and support. • Growth in waiting lists and challenges in maintaining robust waiting well arrangements. • Variation in risk management, supervision and patient review processes. • Pressures impacting staff morale, engagement and team culture. • Increasing complexity and acuity of patients being managed within community settings.			
OPS41	Due to ongoing financial challenges within East Riding (ER) Local Authority, there is a risk that reduced social care capacity and service investments will adversely affect patient flow, discharge processes and integrated care pathways for older adults. This includes: Increased discharge delays resulting from constraints within social care and care home placements. Lack of Local Authority support for the Care Home Inreach Service, which aims to prevent deterioration of care home residents and avoid escalation into secondary care. Plans to disaggregate Local Authority social workers from integrated community teams, reducing multidisciplinary working and impacting coordination of patient care and discharge planning. If these issues continue, there is a risk of increased length of stay, poorer patient outcomes and experience, increased admissions and readmissions, greater pressure on inpatient capacity, failure to achieve national discharge standards, and deterioration in relationships across the health and care system.	20	16	8

3. Closed/ De-escalated Trust-wide Risks

There are **no risks** to highlight that was previously held on the Trust-wide risk register and has been closed / de-escalated since last reported to the Trust Board in May 2026.

4. Recommendations

The Trust Board is asked to discuss and note the update

Trust-wide Risk Register 15+

Row	Risk ID	Description of Risk	Impact/ Consequence Type	Likelihood (Initial)	Impact (initial)	Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls	Gaps in Assurance	Likelihood (Current)	Impact (Current)	Current Risk Score	Current risk	What additional actions need to be completed?	Date Reviewed	Lead Manager	Lead Director	Risk Monitoring Group	Risk Oversight Group	Likelihood (Target)	Impact (Target)	Target risk score	Target risk
1	OPS31	Failure to effectively address waiting times within the Trust's Children's Neurodiversity services which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain	Objectives	Almost Certain	Severe	20	Significant	1. Targeted meetings with Division and service areas to address areas of challenge 2. Local Targets and KPIs. 3. Close contact being maintained with individual service users affected by ongoing issues. 4. Waiting Times Procedure in place 5. Waiting times review is key element of Divisional performance and accountability reviews. 6. Review completed of all services with high levels of waiting times and service-level recovery plans developed. 7. Capacity and Demand review includes a focus on productivity and development of plans detailing Recovery requirements 8. Planning round and discussions taking into acute waiting times position 9. Devised process for skill mixing / pathway review to use existing funding to address patient that require treatment that stay in system 10. ICB continuing to review how we can address neurodiversity services challenges and national taskforce implemented to consider these demands.	1. Reports to demonstrate waiting list performance to Trust Board, Quality Committee and Operational Delivery Group. 2. Quality impact on key identified areas monitored via Quality Committee. 3. Weekly divisional meetings with Performance & Access Mgr around waiting list performance. 4. Introduction of Monthly Performance & Productivity Group chaired by COO. 5. Capacity and Demand planning has either taken place or is scheduled to take place in all long waiting areas and improvement trajectories developed or proposals developed for improvement.	1. Opportunities to revise pathways to increase productivity or reduce demand into services. 2. insufficient funding available to support demand / service provision 3. Outcome of option review for ASD/ADHD	1. Children's Autism number of patient waiting >52 weeks - March 2026 1880 - June 2026 1946 2. Children's ADHD number of patient waiting assessment >52 weeks - March 2026 952 - June 2026 920 3. Operational planning guidance does not provide instructions in relation to neuro services. 4. Limited over 52-week progress	Likely	Severe	16	Significant	1. A Mobilisation and Activity Planning exercise is being completed to demonstrate how an all age service for Neurodiversity will be developed using Right to Choose funding 2. Funding confirmed from ICB as £2.4million in phase 1 (this will create an all age service and assist with current waiting list pressures)	18/08/2026	Claire Jenkinson	Lynn Parkinson	ODG / EMT	Trust Board	Unlikely	Severe	8	High
2	FI223	Risk to longer-term financial sustainability if block contract values are insufficient to cover the Trust Cost base.	Objectives	Almost Certain	Severe	20	Significant	1. Draft Financial Plan in progress. 2. BRS 2025/26 developed 3. Monthly reporting, monitoring and discussion with budget holders. 4. Small contingency / risk cover provided in plan. 5. MTFP in development to inform plans. 6. Service and Operational plans. 7. Regular reviews with NHSE/I and relevant Commissioners 8. Non-recurrent savings identified 9. Performance & Productivity Group oversight and Model Hospital productivity benchmarking.	1. Monthly reporting to EMT. 2. Bi monthly reporting to Board 3. Quarterly Reporting to Finance Committee 4. Monthly reporting to NHSE/I and feedback 5. ODG monitoring progress of Financial Position and BRS plans. 6. Budget Reduction Strategy policy and procedure agreed by Finance and Investment Committee and Trust Board. 7. External / Internal Audit on financial controls/systems. 8. Regular input through Humber and North Yorkshire ICS 9. Cash Position for the Trust is strong 10. Month 4 financial performance reporting and cash forecast review - Trust delivered breakeven at Month 4; cash balance £19.708m; Better Payment Practice Code 98.3%.	1. Current underlying position of the Trust is a risk of £1.500m - met by Non recurrent Efficiencies 2. The 2026/27 Pay Award funding is £0.300m less than budget 3. Uncertainty regarding the outcome of the Deconstructing the Block Exercise and its effect on the Planning round for 2027/28	1. Medium term Financial Planning provided by NHSE with proposed minimum uplifts of 0.3% and 0.0% for 2027/28 and 28/29	Likely	Severe	16	Significant	Medium Term Financial Plan to be developed with the ICB and NHSE (31/03/2027)	15/07/2026	Iain Omand	Peter Beckwith	Directorate Business Meeting/ Executive Management Team	Board	Unlikely	Severe	8	High
3	WF57	Persistent and elevated sickness absence rates across Trust staff groups -currently averaging 5.6% (Dec 25) pose a significant risk to workforce capacity, operational delivery, and the ability of the organisations to meet performance expectations under the 2025/26 NHS Oversight Framework as well as reduced staffing levels compromising patient safety, increase waiting times, and hinder service recovery.	Objectives	Almost Certain	Severe	20	Significant	1.Over 700 staff have access HWB MOTs 2. Launch of HWB Plus to support ongoing workplace wellness 3. Internal OH team delivering against management referrals and pre-employment screening 4.People Strategy with focus on Wellbeing and associated metrics 5. Implementation of rapid response model to target and assess teams presenting with 8%+ sickness absence rates	1. People and OD Committee (insight reports). 2. Divisional Business Meetings. 3. EMT 4. Trust Board 5. ODG 6. Accountability Reviews 7. The Trust is currently in segment 1 of the NOF	1. Inpatient areas continue to report high levels of absence	1. 5.58% rolling sickness absence rate (June 2026) above the 5% Trust target. 2. All divisions with the exception of C&LD report absence above the Trust target	Likely	Severe	16	Significant	3. Embed Plus schemes in the organisation (31.03.2027) 4. Continue to deliver HWB MOTS to the workforce (31.03.2027)	31/07/2026	Vickie Murray	Karen Phillips	Directorate Business Meeting / Executive Management Team	Trust Board	Unlikely	Severe	8	High

Trust-wide Risk Register 15+

Row	Risk ID	Description of Risk	Impact/ Consequence Type	Likelihood (Initial)	Impact (initial)	Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls	Gaps in Assurance	Likelihood (Current)	Impact (Current)	Current Risk Score	Current risk	What additional actions need to be completed?	Date Reviewed	Lead Manager	Lead Director	Risk Monitoring Group	Risk Oversight Group	Likelihood (Target)	Impact (Target)	Target risk score	Target risk
4	FII247	As a result of difficulties within the ICS to meet challenging financial targets for 2026/27, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery .	Objectives	Likely	Catastrophic	20	Significant	1. Regular contractual discussions with commissioners and Trust taking all necessary action to ensure receipt of appropriate funding. 2. Budget Reduction Strategy in place up to 2028-29 and small amount of contingency/risk cover provided for in plan.	1. Monthly reporting to EMT 2. Quarterly Reporting to Finance Committee monitoring of performance against plans. 3. Monthly reports and Quarterly Accounts Returns to NHS I with quarterly feedback. 4. ODG and Divisional ODG reports monitoring financial position and performance against plans. 5. Accountability Review monitoring of financial position and discussed with budget holders (regular confirm and challenge). 6. NHSE regional assessment / risk stratification outcome.	1. The overaching ICS financial position and the ability for Commissioners to invest 2. Short term nature of Financial Planning from an ICS perspective	Medium term financial planning has been provided by NHSE with uplifts of 0.3% for 2026/27 and 0.0% for 2027/28 and 2028/29	Possible	Catastrophic	15	Significant	1. Ongoing maintenance of relationships with Commissioners (31/03/2027) 2. Continue to bid for national resource as and when it becomes available (31/03/2027)	15/07/2026	Iain Omand	Peter Beckwith	Directorate Business Meeting; Executive Management Team	Board	Rare	Catastrophic	5	Moderate
5	MH187	There is a risk that pressures within the Hull Community Mental Health Team relating to caseload management, patient allocation processes, leadership capacity, waiting list management, workforce availability, patient safety oversight and team culture could result in patients not receiving timely, effective and safe care. Failure to effectively manage demand and capacity may lead to increasing waiting times, difficulties in maintaining "waiting well" arrangements, inequitable caseload distribution, reduced staff well being and diminished assurance regarding patient safety and quality of care. Causes: •High and increasing demand for Community Mental Health Team (CMHT) services. •Workforce vacancies, recruitment challenges and sickness absence. •Inconsistent or ineffective caseload management and allocation processes. •Limited leadership capacity to provide operational oversight and support. •Growth in waiting lists and challenges in maintaining robust waiting well arrangements. •Variation in risk management, supervision and patient review processes. •Pressures impacting staff morale, engagement and team culture. •Increasing complexity and acuity of patients being managed within community settings.	Objectives	Almost Certain	Severe	20	Significant	1.Regular operational oversight of caseloads and patient allocation processes. 2.Team leadership and management structures in place. 3.Waiting list monitoring and review meetings. 4.Waiting well processes to maintain patient contact and risk review whilst awaiting intervention- reporting has now been developed to support oversight 5.Clinical supervision and safeguarding arrangements. 6.Routine review of incidents, complaints and patient safety concerns. 7.Workforce recruitment and retention initiatives. 8.Escalation processes for high-risk patients and capacity concerns through operational governance arrangements. 9.Performance reporting through Division and Trust governance structures including targeted support meetings, from Executives as part of the Patient Care, Accountability & Oversight Framework and Bi-weekly Task Force Group	1.CMHT Performance Dashboard, 2.Waiting List Reviews, 3.Caseload Audits, 4.Patient Safety Reviews, 5.Workforce Metrics, 6.Clinical Supervision Records, 7.Staff Survey Results, 8.Divisional Governance Meetings and Quality Committee Reports, Performance and Productivity minutes	1.Framework has been agreed -Caseload allocation SOP and trajectory 2.Trajectory: Expected Clearance of 918 Patients 3.This is to also include a clear and consistent plan of contact with patients on the waiting list. Implement structured waiting-list contact plan including initial assessment, tiered interval check-ins, triggered reviews, and escalation pathways. All contacts logged in clinical system. senior clinician oversight for non-response or concerns. Re-prioritisation protocol ensures timely response to risk change. 4.Workforce capacity remains an ongoing risk 5.Trajectory is based on allocating a minimum of 130 per week across active staff. Backlog clears in 7-8 weeks	1. Gaps in assurance and oversight are currently limiting visibility of risk across waiting list management, allocation processes, and overall patient flow. There is insufficient systematic validation of data accuracy, threshold compliance, and timeliness of administrative actions, resulting in reduced confidence in performance and safety reporting	Likely	Severe	16	Significant	1. Monthly Caseload reviews (31/12/2026) 2. Develop a clear and consistent plan for contact with patients on the waiting list (31/12/2026) 3. Timeframes from Referrals to discharges to be established (31/12/2026) 4, Prioritisation of high-risk patients (31/12/2026)	20/08/2026	Claire Jenkinson	Lynn Parkinson	ODG / EMT	Trust Board	Unlikely	Severe	8	High
6	OPS41	Due to ongoing financial challenges within East Riding (ER) Local Authority, there is a risk that reduced social care capacity and service investments will adversely affect patient flow, discharge processes and integrated care pathways for older adults. This includes: Increased discharge delays resulting from constraints within social care and care home placements. Lack of Local Authority support for the Care Home Inreach Service, which aims to prevent deterioration of care home residents and avoid escalation into secondary care. Plans to disaggregate Local Authority social workers from integrated community teams, reducing multidisciplinary working and impacting coordination of patient care and discharge planning. If these issues continue, there is a risk of increased length of stay, poorer patient outcomes and experience, increased admissions	Objectives	Almost Certain	Severe			1. Agreement secured for a dedicated social worker to support older adult inpatient services and facilitate discharge planning. 2. Trust continues to maintain the Care Home Inreach Team despite lack of Local Authority funding contribution, preserving support to care homes and preventing unnecessary escalation into secondary care. 3. Ongoing engagement and escalation through Place and System partnership forums. 4. Regular operational oversight of discharge delays and complex cases through discharge and flow meetings. 5. Monitoring of admissions from care homes and delayed discharge metrics.	1. Clinical Ready for Discharge and OOA monitoring. 2. Transformation Programme led by the DCOO include focus on reduction in Clinical Ready for Discharge/NCTR 3. Weekly step down occupied report 4. LOS and Occupancy performance reporting 5. Older Adult dedicated social worker identified working with the team	1. Significant financial pressures and savings requirements within Local Authority services. 2. Reduced investment in preventative and intermediate care services. 3. Proposed withdrawal of social work resource from integrated community teams. 4. Limited social care capacity and care home market pressures.	1. MH Inpatient Clinical Ready for Discharge patient - 31st December 2025 (MH 7) - June 13 cases (7 social, 5 NHS and 1 both responsible)	Likely	Severe			1. Continue discussions with Local Authority leadership regarding long-term social work integration arrangements (31/03/2027) 2. Develop evidence of impact and value generated by the Care Home Inreach Service to support future funding discussions (31/03/2027) 3. Escalate risks through Place Board and Integrated Care System governance arrangements (31/03/2027) 4. Review contingency options should social workers be withdrawn from community teams (31/03/2027) 5. Undertake impact assessment on patient flow, quality, workforce and finance (31/03/2027)	24/08/2026	Claire Jenkinson	Lynn Parkinson	ODG / EMT	Trust Board	Unlikely	Severe	8	High

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 27

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	People and Organisational Development Committee Board Assurance Report
Author/s:	Carrie Wollerton, Non-Executive Director
Recommendation:	

To approve		To discuss	
To note	√	To ratify	
For assurance	√		

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	This paper provides an executive summary of the key discussions and outcomes from the People and Organisational Development Committee meeting held on 12 August 2026. The Committee operates as a formal sub-committee of the Trust Board and is responsible for providing assurance on matters relating to workforce, organisational development, and equality, diversity and inclusion (EDI). The report highlights key points for the Board's attention and consideration.

Key issues:

Positive Assurances to Provide:

Overall workforce position is stable and well managed, with temporary staffing costs reduced, with establishment broadly aligned to plan, and Month 3 financial performance at breakeven.

Safer staffing remains strong, with inpatient staffing arrangements providing assurance despite higher acuity, operational pressures and wider NHS workforce constraints. Mandatory training and appraisal compliance remain high

Health and wellbeing interventions are delivering positive outcomes and Trust's EDI performance is strong.

Freedom to Speak Up arrangements are effective, with the number of concerns raised increasing which suggests greater use of the mechanism. Internal audit also provided a Significant Assurance rating.

Medical education remains positive, with endorsement from NHS England Education and

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

Sickness absence: targeted interventions in hotspot teams, strengthened return-to-work processes, revised sickness policy, Health and Wellbeing Conversations, Occupational Health/psychological support and the Rapid Response to Sickness Intervention Model.

Recruitment and retention: targeted action on consultant and Occupational Therapy vacancies, stay conversations.

Temporary staffing: implementation of the Bank and Agency Optimisation Plan. Stronger divisional accountability and integrated Finance/workforce reporting.

Safe staffing: targeted staffing-model and establishment reviews, review of night staffing where required.

DRAFT

Hull York Medical School and no issues requiring escalation. Employee relations remain well controlled, and no immediate patient safety concerns were identified through Guardian of Safe Working reporting.	EDI and culture: delivery of WRES, WDES and Gender Pay Gap action plans; Trans Inclusion Action Plan; roll out Respect in Care. FTSU and employee relations: increased ambassador visibility, triangulation meetings. Flu 2026 action plan implementation.
Key Risks/Areas of Focus: Sickness absence is the most significant workforce risk with rolling absence remaining around 5.5% against a 5% target. Around 70% is long-term sickness and Mental health accounts for 39% of FTE days lost and over half of Occupational Health referrals. All operational divisions remain above target. Recruitment and retention pressures remain concentrated in key groups, particularly Consultant vacancies at 20.7%. and Occupational Therapy vacancies at 16.4%. There is early-career attrition, with almost 40% of leavers leaving within two years. Work-life balance remains the principal reason for resignation. While EDI measures remain strong there are risks requiring sustained focus, particularly racial abuse, bullying and harassment by patients, presentism affecting disabled staff, potential disproportionality in employee relations/bank processes, and prolonged investigations/suspensions.	**Decisions Made:** Strong overall assurance was provided to the Committee that the Trust is making good progress towards a safe, effective, inclusive and sustainable workforce. The Committee approved the EDI Annual Report for publication as part of statutory reporting. The EDS22 Report was approved for submission. The Committee agreed that the priority now is delivery and demonstrable impact, particularly sustained improvements in sickness absence, retention, workforce resilience, temporary staffing reliance and staff experience. The Committee considered the meeting effective, with high-quality, evidence-based papers enabling meaningful scrutiny and informed decision-making.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	The emphasis on prevention, early intervention, staff wellbeing and partnership working supports a shift towards care and support outside traditional hospital settings. Physical Health MOTs, Health and Wellbeing Conversations, Occupational Health interventions and work on health inequalities aim to identify issues earlier and prevent escalation. Collaboration with the ICB, NHS England Education and other partners including patients, volunteers and carers, also supports more integrated workforce and service planning across organisational boundaries.
Analogue to Digital	Workforce and operational transformation increasingly uses digital workforce intelligence, e-rostering, safer staffing dashboards, real-time flu monitoring and integrated finance/workforce reporting. These approaches support better use of data, more proactive workforce planning and improved decision-making. The development of digital approaches to rota monitoring and workforce reporting also supports greater efficiency and oversight.
Sickness to Prevention	The Health and Wellbeing programme moves beyond managing sickness once it occurs towards early identification, prevention and maintaining workforce health. Physical Health MOTs identify previously undetected conditions; wellbeing conversations and psychological support seek to prevent longer-term absence; and targeted interventions in hotspot teams aim to address underlying causes. The flu vaccination programme, data-led targeting and peer vaccination model similarly support prevention and workforce resilience.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	√
Enhancing prevention, wellbeing and recovery	√
Fostering integration, partnership and alliances	√
Developing an effective and empowered workforce	√
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	√

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	√

Public Exemption:

Is the report exempt from public disclosure	No

Committee Chair Assurance and Escalation Report:

1. Positive Assurances gained at the People and Organisational Development (POD) Committee meeting:

Health and wellbeing: Physical Health MOTs and one-to-one wellbeing support continue to provide meaningful preventative interventions. Repeat MOT data indicates improvement in health indicators for a significant proportion of attendees, while previously undetected health concerns are being identified and appropriately referred.

Workforce stability: Vacancy rates remain below the 9% target at 6.52%, while turnover remains comparatively favourable in several areas, and establishment remains closely aligned to plan.

Safer staffing: Overall assurance remains that inpatient staffing arrangements are safe and effective, with care hours per patient day generally meeting or exceeding recommended levels. Statutory training, supervision and workforce governance remain strong. Mandatory training and appraisal compliance remain strong at 94.7% and 95.1% respectively.

Temporary staffing: Agency expenditure has reduced by 33% and bank expenditure by 11% compared with the same period in 2025/26, supported by recruitment and workforce optimisation activity.

Finance and Workforce Controls Assurance: The Trust achieved a breakeven position at Month 3, consistent with the approved financial plan. The committee noted that the Trust's strong performance in reducing temporary staffing costs places it in a favourable position ahead of the introduction of new national oversight arrangements. Overall, the report provided assurance that workforce and financial performance remain stable and well managed.

Equality Diversity and Inclusion (EDI): Gender Pay Gap, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) performance is better than relevant national/Integrated Care Board (ICB) comparators, while Equality Delivery Standard (EDS22) performance has improved from the previous year. New staff network chairs have also been recruited. Committee were advised that there had been positive national recognition for the Trust's equality, diversity and inclusion work. The NHS Race and Health Observatory contacted the Trust after identifying its anti-racism work through Health Service Journal Award submissions and expressed an interest in featuring the organisation's work on its national Health Action Resource Platform. The platform highlights examples of good practice that other NHS organisations can learn from, particularly in relation to tackling racial and ethnic inequalities.

Committee received strong assurance that the Trust has effective EDI governance, strong leadership accountability and clear evidence of improving equality outcomes for both staff and patients.

Equality Human Rights Commission (EHRC) Code of Practice: Governance arrangements and Terms of Reference are established, with legal advice and supporting reviews underway. The EDI Policy and Equality Impact Assessment have been completed with Rainbow Alliance Network involvement.

Lord Mann Review: Committee received strong assurance that the Trust is well positioned to meet the requirements arising from the Lord Mann Review and to continue strengthening its approach to tackling discrimination and promoting an inclusive organisational culture.

Medical education: No issues or concerns require escalation, with positive endorsement from NHS England Education and Hull York Medical School.

Freedom to Speak Up (FTSU): Increased reporting indicates greater use of speak-up mechanisms, and with 97.42% Level 1 mandatory training compliance and significant assurance from internal audit, Committee were assured on the systems and processes in place. Committee welcomed the introduction of multidisciplinary case review meetings involving colleagues from Operations, POD and Nursing and

Quality. Work has already demonstrated benefits in identifying trends, areas of concern and potential hotspots within services. Noted as excellent triangulation of information.

Employee relations: Case volumes remain stable, Employment Tribunal exposure is low compared with peers, and there is evidence of improved timeliness and increased use of informal resolution.

Flu vaccination: The 2025/26 campaign achieved 66% frontline uptake representing improved performance, with data-led targeting and peer vaccinators contributing to improved accessibility.

Guardian of Safe Working: No exceptions were identified that raised an immediate patient safety concern, and there were no exceptions relating to attendance at educational sessions.

2. Key Risks/Concerns/Gaps in Assurance:

Sickness absence and staff wellbeing: This remains the most significant workforce risk, however a comprehensive programme of targeted interventions are underway.

Recruitment and retention: Overall workforce stability is positive, but risks remain concentrated in specific professions and services. Mitigating actions and plans are in place. The Trust have developed a triangulated approach which enables a broader understanding of workforce experience and identifies areas requiring targeted support.

Safer staffing and operational pressures: Overall staffing is safe, but some services continue to require targeted interventions such as targeted staffing model reviews and establishment reviews which are planned or in place as appropriate.

Temporary staffing and medical workforce: Temporary staffing costs are moving in the right direction, but medical agency utilisation and consultant vacancies remain important risks. The Bank and Agency Optimisation Plan provides a clear route to further reduction.

EDI and organisational culture: The overall EDI position is positive, but several cultural risks require sustained attention including areas also highlighted through the EDS22 return. Although the EDS22 return was an 'Achieving' rating, further improvement is required to reach the highest standard. The adoption of the IHRA working definition of antisemitism and the government definition of anti-Muslim hostility are important developments alongside continued delivery of the Respect in Care, Patient Carer Race Equality Framework (PCREF) and No Excuse for Abuse programmes.

3. Key Actions Commissioned/Work Underway:

The workforce programme is focused on building a healthy, resilient, inclusive and sustainable workforce, with action underway across sickness absence, recruitment and retention, staffing efficiency, culture and staff experience. Work is progressing to reduce sickness absence through targeted support to hotspot teams, stronger return-to-work arrangements, improved Health and Wellbeing Conversations and enhanced psychological and Occupational Health interventions. In parallel, efforts to improve recruitment and retention are addressing key vacancies, strengthening early-career retention and career progression, and using stay conversations and workforce intelligence to support longer-term workforce planning.

The programme also seeks to optimise staffing and reduce reliance on temporary workforce, through bank-first principles, improved rostering, establishment reviews and integrated finance and workforce reporting. Safe staffing remains a priority, with targeted staffing model business cases, reviews of night staffing, improved clinical supervision compliance and stronger safer staffing and red-flag reporting. Alongside this, the organisation continues to strengthen EDI, culture and staff experience through delivery of WRES, WDES, Gender Pay Gap and Trans Inclusion actions, Respect in Care, PCREF and Health Inequalities work, while further developing our staff networks.

A further focus is on speaking up, employee relations and just culture, including increasing access to Freedom to Speak Up, developing ambassadors, sharing learning and strengthening early resolution.

The 2026 Flu Campaign is being integrated into wider winter planning, with data-driven targeting of areas with historically low uptake, team-level dashboards, peer vaccinators and work to better understand and address vaccine hesitancy. Overall, the actions are designed to improve workforce stability, staff wellbeing and engagement while ensuring safe, effective and financially sustainable staffing.

4. Deep Dives, Thematic Reviews and Significant Reports

Key findings from the reports presented to the POD indicate that the Trust is making positive progress across workforce wellbeing, employee relations, speaking up and EDI, but significant challenges remain around sickness absence, retention and workforce experience.

Sickness absence remains above the 5% target, primarily driven by long-term sickness and mental health, although year-end monthly absence fell below target and remains below the national average for Mental Health Trusts. Return-to-work compliance has improved, with targeted interventions and Occupational Health support focused on hotspot areas. Turnover remains a concern, particularly among early-career staff and specific frontline and Band 5/support roles, with work-life balance the main reported reason for leaving. Actions are therefore focused on retention, career development, flexible working, onboarding and succession planning.

Employee relations casework is broadly stable, with low Employment Tribunal exposure and increasing use of informal resolution and Just Culture approaches. However, potential disproportionality affecting ethnically diverse bank workers, alongside prolonged investigations and complex cases, remains an area of focus. Freedom to Speak Up shows encouraging progress, with a significant increase in concerns raised and high mandatory training compliance, suggesting greater awareness and use of the process.

Safe working arrangements remain broadly assuring, with no immediate patient safety concerns identified through Guardian of Safe Working Hours reporting. The main opportunity is to improve engagement with rota monitoring and work intensity.

EDI performance is also positive and improving, with stronger WRES, WDES, Gender Pay Gap and EDS22 results, although racial abuse, bullying and harassment from patients, and presentism affecting disabled staff, remain important challenges.

Overall, the reports provide assurance that improvement activity is delivering progress, while highlighting the need for continued focus on absence, early-career retention, workforce experience, equitable treatment and staff wellbeing.

5. Strategic Alignment

The POD Committee reports demonstrate alignment with all five Trust strategic goals.

The work supports quality and patient safety through safer staffing, clinical supervision, mandatory training, e-rostering, Freedom to Speak Up and Just Culture, helping ensure safe care and organisational learning. It contributes to prevention, wellbeing and recovery through Health and Wellbeing initiatives, Occupational Health, mental health support, sickness absence interventions and flu vaccination, strengthening staff health and workforce resilience.

There is strong partnership and system alignment, with collaboration across NHS England Education, Hull York Medical School, the ICB, our community of volunteers, patients and carers and other partners on workforce planning, education, EDI and health inequalities. Most significantly, recruitment and retention, wellbeing, flexible working, career development, leadership, succession planning and EDI directly support the development of an effective, inclusive and empowered workforce.

Workforce planning, vacancy management, establishment reviews, improved rostering and reduced bank and agency reliance contribute to a more efficient and financially sustainable organisation. Overall, the suite of papers presented the POD demonstrates how workforce priorities are supporting safe care, staff wellbeing, partnership working, organisational culture and financial sustainability, while directly advancing the Trust's strategic objectives.

6. Chair's Overall Summary

The POD Committee provides strong overall assurance to the Board that the Trust is making good progress in developing a safe, effective, inclusive and sustainable workforce, with alignment to all five strategic goals.

There are particularly positive indicators in recruitment, workforce stability, mandatory training, appraisal compliance, safer staffing, medical education, EDI and temporary staffing reduction. Vacancy rates remain below target, agency and bank expenditure is reducing, and staffing arrangements across inpatient services continue to provide assurance around patient safety. The Health and Wellbeing programme, Freedom to Speak Up arrangements and EDI initiatives also demonstrate a continued focus on staff experience, prevention and organisational culture.

The deep dives and thematic reviews provide a balanced view, identifying areas where performance is improving but where further work is required. The most significant ongoing workforce challenges are sickness absence, long-term and mental health-related absence, early-career attrition, work-life balance, consultant vacancies, temporary staffing dependency and workforce pressures in specific services. Cultural risks, including racial abuse, bullying and harassment, presentism and potential disproportionality in employee relations processes, also require sustained attention.

A substantial programme of actions and improvement work is underway, including targeted sickness absence interventions, enhanced Occupational Health and wellbeing support, recruitment and retention initiatives, staffing model reviews, Bank and Agency optimisation, strengthened EDI programmes, Just Culture and Freedom to Speak Up activity, and improved workforce intelligence and reporting.

Humber Teaching NHS Foundation Trust

Agenda Item 28

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Quality Committee Chair Assurance and Escalation Report – August 2026
Author/s:	Dr Phillip Earnshaw, Non-Executive Director and Chair of Quality Committee
Recommendation:	

To approve		To discuss	
To note		To ratify	
For assurance	√		

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	The Quality Committee is one of the sub committees of the Trust Board. The paper provides a summary of discussions held at the Quality Committee on 20th August 2026 with a summary of key issues for the Board to note.

Key issues:

Positive Assurances to Provide:
The Committee Received positive assurances through the following reports

- BAF review and strategic Goal 2 Section Deep-Dive
- CQC CMHT Update Report
- Quality Insight Report
- Quality Committee Risk Register Summary
- Infection Control Annual Report 2025-26
- PACE (including complaints and feedback) Annual Report 2025-26
- Equality and Diversity (patients element) Annual Report 2025-26
- Safer Staffing Report
- Quality Impact Assessment (QIA) Report

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):
The Committee discussed work planned and underway including.

- Development of a Trust implementation plan for the NHS Quality Strategy
- Continued delivery and monitoring of the CMHT improvement workstreams
- To Present future audit outcomes relating to clozapine physical health monitoring
- Add regular CQC updates to the Quality Committee workplan

Key Risks/Areas of Focus:
The Committee agreed key areas of focus are

- CMHT Improvement Programme
- Waiting lists and patient flow within Strategic Goal 2 in the BAF
- Falls Improvement work in Older Peoples Services
- Health inequalities and the National Quality Strategy
- Continued Deep-Dives on the BAF strategic goals

Decisions Made:
The Quality Committee approved the following reports for presentation to Trust Board

- Infection Control Annual Report
- PACE (inc Complaints and Feedback) Annual Report.

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	Strong focus on CMHT improvement, neighbourhood working, partnership arrangements, reducing out-of-area placements and supporting recovery within community settings
Analogue to Digital	Assurance received regarding compliance with information governance standards and implementation of recommendations arising from reviews of patient record access arrangements
Sickness to Prevention	Focus on prevention, wellbeing and recovery through Strategic Goal 2, infection prevention and control, physical health monitoring and reducing health inequalities

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		**Date**
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	√
Enhancing prevention, wellbeing and recovery	√
Fostering integration, partnership and alliances	√
Developing an effective and empowered workforce	√
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	√

Public Exemption:

Is the report exempt from public disclosure	No

Humber Teaching NHS Foundation Trust

Agenda Item 28

Quality Committee Chair Assurance and Escalation Report: August 2026

1. Positive Assurances gained at the Committee meeting:

- **Quality & Patient Safety**
  - The Committee received positive assurance regarding the Trust's quality governance arrangements, with 97.4% of incidents resulting in no or low harm, 224 active quality improvement projects, and full compliance with clinical policy and safeguarding training. Improvements were also reported in VTE compliance, complaints management, and incident reporting trends.
  - The Committee noted significant progress against the Community Mental Health Team (CMHT) improvement programme following the CQC inspection. Improvements were evidenced through reduced waiting times, increased referral closures, strengthened risk stratification processes, enhanced multidisciplinary review arrangements and improved clozapine monitoring arrangements. Executive oversight is in place with weekly monitoring through the Executive Management Team.
- **Patient Experience.** Strong assurance was received regarding patient and carer engagement and co-production activity. The Committee recognised the continued growth of the Experts by Experience programme, co-production initiatives, improved feedback mechanisms and positive use of patient experience information to drive service improvement. The PACE Annual Report was approved for submission to Trust Board
- **People & Culture.** The Safer Staffing Report provided assurance that all inpatient wards continue to meet or exceed recommended staffing levels. Improvements in vacancy rates, sickness absence and bank workforce utilisation were reported, alongside ongoing recruitment activity within CMHT services.
- **Audit & Governance.**
  - The Committee undertook a detailed review of Strategic Goal 2 within the Board Assurance Framework (BAF). Members challenged controls, assurance measures and risk mitigations and identified several enhancements to strengthen Board oversight, particularly regarding recovery, patient flow, trauma-informed practice, co-production and reduction of out-of-area placements.
  - The Quality Impact Assessment (QIA) process provided positive assurance that robust governance controls are operating effectively, demonstrated by the rejection of a scheme where sufficient assurance could not be provided.
- **Digital & Data Quality.** The Committee received assurance that the Trust had undertaken a review against new national guidance on unlawful access to patient records, with positive findings reported and recommendations being managed through the Information Governance Group.
- **Partnerships & System Working.** Positive assurance was received regarding collaborative working with Integrated Care Boards, provider collaboratives, social care partners and neighbourhood teams. The Committee noted partnership activity aimed at reducing out-of-area placements, supporting recovery and addressing health inequalities.
- **Infection Prevention & Control.** The Annual Infection Prevention and Control Report provided strong assurance, demonstrating sustained performance with high compliance in hand hygiene and PPE standards, no trust-attributable infections or outbreaks during the reporting period, and successful delivery of key improvement programmes. The report was approved for submission to Trust Board.

2. Key Risks/Concerns/Gaps in Assurance:

- **Community Mental Health Team (CMHT) Improvement Programme.** Whilst improvements are evident, the Committee recognised the need to sustain improvement beyond the initial 90-day programme. Continued executive oversight is required to ensure improvements in waiting list management, physical health monitoring and workforce capacity remain embedded.
- **Waiting Lists and Patient Flow.** The Committee discussed the need to strengthen Board assurance around waiting list management, waiting well arrangements and monitoring of harms associated with delayed access to care. This remains a key focus within Strategic Goal 2 and associated risks.
- **Falls and Older People's Services.** Falls continue to represent a significant quality risk, particularly within older people's services. Improvement work is ongoing and continues to require close monitoring
- **Health Inequalities and National Quality Strategy.** The Committee acknowledged that whilst the Trust is in a strong position regarding patient safety and patient experience, further work is required to improve visibility, reporting and assurance regarding health inequalities in preparation for implementation of the new NHS Quality Strategy.
- **Board Assurance Framework.** The deep dive identified opportunities to strengthen assurance measures and controls relating to recovery-focused outcomes, patient and family involvement in care planning, trauma-informed practice and reduction of out-of-area placements. Further updates will be incorporated into the BAF

3. Key Actions Commissioned/Work Underway:

- Update the Board Assurance Framework for Strategic Goal 2 to reflect Committee discussions and agreed enhancements.
- Add regular CQC updates, mock inspection outputs and out-of-area placement trajectory reporting to the Quality Committee work programme.
- Continue delivery and monitoring of CMHT improvement workstreams, including waiting list management, physical health monitoring, workforce planning and patient safety initiatives.
- Present future audit outcomes relating to clozapine physical health monitoring to provide continued assurance regarding compliance improvements.
- Develop a Trust implementation plan for the NHS Quality Strategy, including workshops and a framework for monitoring quality, patient experience and health inequalities.
- Enhance reporting to identify areas with zero complaints or incidents to strengthen triangulation and assurance.

4. Deep Dives, Thematic Reviews and Significant Reports

- **Board Assurance Framework Deep Dive.** A detailed review of Strategic Goal 2 was undertaken. The Committee challenged the adequacy of controls, assurance measures and risk mitigations, resulting in several proposed enhancements to strengthen the quality of Board assurance. Key themes included recovery, out-of-area placements, employment support, waiting well processes, trauma-informed practice, patient involvement and partnership working.
- **CQC CMHT Improvement Update.** The Quality Committee has scrutinised performance, patient safety, workforce and medicines assurance in detail. The Committee has sought evidence of improvement trajectories, effectiveness of mitigations and sustainability of actions implemented. The Committee received assurance regarding the completion of medicine management actions and endorsed the CMHT Improvement Task Force and Recovery programmes and were given assurance that immediate patient safety concerns identified by the CQC have been addressed, whilst recognising that delivery of sustained improvement remains dependent upon workforce stabilisation and continued oversight through established governance arrangements. Evidence of improvement was presented across waiting list management, patient safety, workforce capacity and clozapine monitoring, supported by executive-led governance arrangements.
- **Annual Infection Prevention and Control Report.** The report demonstrated sustained compliance against key infection prevention standards, successful implementation of training innovations and completion of significant estates-related safety improvements. The Committee approved the report for Board submission.
- **Patient and Carer Experience Annual Report.** The Committee considered evidence of extensive co-production activity, increased patient engagement, effective management of complaints and

compliments, and developments in national patient experience initiatives. The Committee approved the report for Board submission.

- **Equality and Diversity Annual Report.** The Committee noted continuing progress in anti-racism work and equality initiatives, including the Respect Project and system-wide collaborative approaches to addressing discrimination and racial abuse.

5. Strategic Alignment

- **Innovating Quality & Patient Safety.** The meeting provided assurance regarding quality governance, incident management, CMHT improvement work, infection prevention and implementation planning for the NHS Quality Strategy.
- **Enhancing Prevention, Wellbeing & Recovery.** The Strategic Goal 2 deep dive focused on recovery, prevention, waiting well approaches, reducing out-of-area placements, trauma-informed care and empowering patients in their own recovery journeys.
- **Fostering Integration, Partnership & Alliances.** The Committee reviewed collaborative arrangements with Integrated Care Boards, local authority partners, provider collaboratives and community services to improve outcomes and reduce reliance on out-of-area care.
- **Developing an Effective & Empowered Workforce.** Assurance was received regarding safer staffing, workforce recruitment, improved sickness absence performance, supervision arrangements and staff development through quality improvement and infection prevention programmes.
- **Maximising an Efficient & Sustainable Organisation.** The Committee received assurance regarding robust Quality Impact Assessment processes, effective risk management, quality governance arrangements and oversight of improvement programmes designed to improve patient flow and service efficiency.

6. Chair's Overall Summary

The Committee received substantial assurance regarding the Trust's quality governance arrangements, patient safety performance, safer staffing, infection prevention and control, patient experience and ongoing response to the CMHT CQC improvement plans. Significant progress was evidenced across a number of quality indicators and improvement programmes, supported by strong executive oversight. The principal areas requiring continued monitoring relate to sustaining CMHT improvements beyond the initial recovery period, reducing waiting times and associated harms, strengthening assurance around health inequalities, and embedding the requirements of the emerging NHS Quality Strategy. The Committee undertook a valuable deep dive of Strategic Goal 2 within the Board Assurance Framework and commissioned several enhancements to strengthen Board assurance. No new risks were escalated to the Board or Risk Register at this meeting, although the agreed BAF updates will support stronger strategic oversight going forward.

Humber Teaching NHS Foundation Trust

Agenda Item 29

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Mental Health Legislation Committee Assurance Report following a meeting on 6 August 2026
Author/s:	Stephanie Poole Non-Executive Director and Chair of Mental Health Legislation Committee
Recommendation:	

To approve		To discuss	
To note		To ratify	
For assurance	√		

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	The Mental Health Legislation Committee (MHLC) is one of the sub-Committees of the Trust Board. This paper provides assurance to the Board with regard to the agenda issues covered in the committee held on 6 August 2026

Key issues:

Positive Assurances to Provide:

- Q1 activity remained within control limits, with reduced admissions and assurance received on out of area placements, tribunals, hearings and Section 17 leave.
- Continued improvement in restrictive practice measures, including reduced restraint use, high training compliance and fewer missed seclusion reviews.
- Assurance received on MHA 2025 implementation, advocacy arrangements and the Trust's proactive response to DoLS changes.
- Strong MAPPA governance, partnership working and preparedness for early prisoner release arrangements.
- No concerns identified within the Board Assurance Framework requiring escalation.

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

- Review of all patients subject to DoLS following the June 2026 Supreme Court judgement, with policies, procedures and guidance being updated.
- Continued preparation for MHA 2025 implementation through the Trust's internal project arrangements.
- Ongoing improvement work on restrictive practices, including training compliance, restraint reduction standards, seclusion review compliance and Culture of Care Phase 2.
- Further development of MHA benchmarking and comparative performance reporting.
- Continued implementation of the Personalised Care Framework.

Key Risks/Areas of Focus:

- No new issues were identified which require board attention at this time.

Decisions Made:

- Received assurance across all agenda items, with no matters requiring Board escalation.
- Agreed continued oversight of DoLS changes and MHA 2025 implementation.

	• Supported ongoing restrictive practice improvement work and development of MHA benchmarking. • Agreed to consider Quality Committee oversight of out of area placement improvement plans. • Agreed future focus on detention prevention, equality, MHA reform and CQC Well-Led preparedness.
Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	Focus on preventing detention, reducing restrictive interventions, supporting personalised care, improving discharge planning, reducing out of area placements, and the national move towards community-based support for people with learning disabilities.
Analogue to Digital	Increased use of digital reporting and monitoring, including automated EPR reports for MAPPA, data re-audits, benchmarking development, and improved use of performance data to support oversight and decision-making.
Sickness to Prevention	Emphasis on prevention from detention, recovery-focused care, restrictive practice reduction, Culture of Care initiatives, personalised care approaches, equality considerations, and proactive preparation for MHA and DoLS legislative changes.

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	
Mental Health Legislation Committee	06/08/26	Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	√
Enhancing prevention, wellbeing and recovery	√
Fostering integration, partnership and alliances	√
Developing an effective and empowered workforce	√
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	√

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	√

Public Exemption:

Is the report exempt from public disclosure	No

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Committee Chair Assurance and Escalation Report: Mental Health Legislation Committee 6 August 2026

1. Positive Assurances gained at the Committee meeting:

Include a brief summary of areas where the Committee gained assurance (including areas they challenged and what's going well).

- Activity report for Q1 to end June 2026. Activity within control limits in all areas with a reduction in admissions in the quarter compared to last year. No patients under 18 years admitted to adult wards under a section. Issues raised by the committee included out of area placements; tribunal and hearing requests; s17 leave processes. Assurance was received in all these areas.

- Restrictive Practices Improvement Report Q1. De-escalation Management Intervention (DMI) training compliance has consistently remained above 85% compliance at 89%. Significant work has been undertaken to improve compliance with CTR disengagement training. Use of restraint has continued to reduce. Missed seclusion reviews have continued to reduce and work is ongoing to further strengthen compliance. An update was received on the Culture of Care programme. The committee raised issues regarding seclusion, which had increased in May, and segregation and received assurance regarding the robustness of procedures in these areas.

- Insight Report, including updates on Mental Health Act (MHA) 2025 implementation; Personalised Care Framework (PCF); CQC MHA visits (no new ones this quarter); Q4 and Q1 independent patient advocacy update; Deprivation of Liberty Safeguards (DoLS) changes (Supreme Court Ruling June 2026) and proactive response by the Trust.

- Multi Agency Public Protection Arrangements (MAPPA) – Robust mechanisms are in place to ensure good communication, governance and compliance with duty to co-operate. Appropriate internal and external meetings are attended and working relationships are positive. An additional MAPPA role has been introduced within Community Mental Health Services to further strengthen staff support and compliance. An automated report from the EPR is in regular use and data has been recently re-audited. The Trust is proactively seeking to validate data alongside partner agencies. The committee raised issues around the upcoming plans for early prisoner release and received assurance regarding planning and information sharing.

- Board Assurance Framework – No issues highlighted that required the committee's attention.

2. Key Risks/Concerns/Gaps in Assurance:

Briefly highlight issues requiring Board attention.

No new issues were identified which require board attention at this time.

3. Key Actions Commissioned/Work Underway:

Briefly summarise actions commissioned by the Trust or Committee, progress against previous actions, and any barriers:

- Deprivation of Liberty Safeguards (DoLS). Work is being done to review all patients subject to DoLS following the recent Supreme Court Judgement in June 2026. This involves a small number of patients within the Trust. Policies and procedures are under review, interim guidance has been circulated for all services and briefing session held with service leads.
- Mental Health Act (MHA) 2025 implementation is monitored by this committee, an internal Trust project has been initiated and will progress at pace once a code of practice is available in early 2027.
- Restrictive Practices Improvement Report - Continued focus on RRI training compliance, particularly Conflict Resolution Training (CRT)/Disengagement training which is currently below target. Work will continue with DMI Midlands to pilot the draft Restraint Reduction Network Standards. Continue to address missed seclusion reviews. Continue development of phase 2 of the Culture of Care programme, which will establish ward-based QI teams.
- Benchmarking and performance data - Continued exploration of the introduction of trust-level MHA benchmarking and comparative performance data nationally and regionally.
- Work to implement the Personalised Care Framework (PCF).

4. Deep Dives, Thematic Reviews and Significant Reports

Briefly summarise insights from any deep dives undertaken or major reports considered at the meeting.

Committee's annual development session. The majority of time at this meeting was scheduled to consider emerging issues and future priorities likely to impact the Committee's work over the next two years. These topics were introduced by subject specialists with time for discussion:

1. Prevention from detention, including the national move from hospital-based care towards community provision for people with learning disabilities.
2. Equality and diversity, including emerging national themes and implications for services.
3. Mental Health Act reforms and the Trust's preparations for anticipated legislative changes.

The Medical Director will lead a session at the next meeting on:

4. Care Quality Commission (CQC) Well-Led requirements, future priorities and organisational preparedness.

5. Strategic Alignment

Briefly explain how Committee discussions relate to Trust strategic goals.

For this meeting, the Committee's discussions relate to the following strategic goals:

- **Innovating Quality & Patient Safety:** Continuously improving service safety and quality.

  The Committee received assurance regarding the effective operation of Mental Health Act processes, restrictive practice reduction initiatives, MAPPA arrangements and preparation for forthcoming legislative changes, all of which support the continued delivery of safe, high-quality care.

- **Enhancing Prevention, Wellbeing & Recovery:** Focusing on early intervention and supporting recovery.

  Discussions regarding prevention from detention, restrictive practice reduction and personalised care approaches support the Trust's focus on improving recovery outcomes and reducing reliance on restrictive interventions.

- **Fostering Integration, Partnership & Alliances:** Collaborating with regional partners to deliver integrated care.

The committee received updates on how partnerships contribute to integrated mental health care through MAPPA, work with prisons and work with local authorities.

- **Developing an Effective & Empowered Workforce:** Supporting staff through investment and a positive culture.

  Investment in restrictive practice training along with initiatives such as Culture of Care demonstrate support for staff in creating a positive working culture.

- **Maximising an Efficient & Sustainable Organisation:** Enhancing productivity and environmental sustainability.

- **Promoting People, Communities and Social Values**

  The committee looked at work focused on improving prevention and hospital to community care for learning disabilities and also discussed the emerging themes around inequalities for MHA nationally and locally.

6. Chair's Overall Summary

Provide a clear and concise summary of the meeting (including details of any areas which require Board attention or which impact on the BAF/Risk Register).

Activity Report Q1 - Benchmarking performance
There is continued absence of nationally collected benchmarking and performance measures for Mental Heath legislation. The Trust is showing leadership on this issue. The Medical Director is continuing to lead some work regionally to collect data. The Director of Nursing is looking at raising through MH and LD Chief Nurses Network also, with the possibility of a data sharing agreement.

Activity Report Q1 - Increase in Out of area placements June 2026
It was noted that in June, 9 new detained patients were placed out of area, an increase from 5 in May and 1 in April. The out-of-area placements are primarily affecting older adult services, particularly where dementia beds are under pressure. Delays in securing appropriate social care placements have contributed to prolonged occupancy of beds. The Trust is working with the local authority and has strengthened social work support to facilitate discharge planning. Some out of area placements remain necessary due to gender-specific bed requirements. Planned developments, including the female High Dependency Unit, are expected to support reductions in these placements. Consideration is to be given to Quality committee monitoring improvement plans in this area.

Deprivation of Liberty Safeguards (DoLS)
The recent Supreme Court judgement has changed the legal definition and application of DoLS such that an individual could lack capacity to consent to admission while still being capable of expressing valid wishes, feelings and consent in relation to aspects of their care and confinement. Work is underway to review existing Trust cases, in conjunction with local authority partners to ensure compliance. The Activity Report Q1 indicates a very small number of DoLS put in place (2 in June and 1 in April), mainly in older persons units. The Trust is taking a proactive approach whilst awaiting further national guidance. Assurance was gained from a local authority perspective, who advise that multi-agency working groups are established and specialist support is available to partner organisations throughout the transition period.

Committee annual development session
The Committee used the majority of time at the August meeting to discuss the three topics as above looking at what was on the horizon from MHA learning disabilities and equalities point of view. This future-focused session was thought to be a very useful innovation, enabling the committee to gain a fuller understanding of the issues and to gain assurance around the work already underway in the Trust. It also helped to identify future focus areas and oversight requirements.

Next meeting - 5 November 2026

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Agenda Item 30

Title & Date of Meeting:	Trust Board Public Meeting – 30 September 2026
Title of Report:	Audit Committee Chairs Report to Board
Author/s:	Kath Smart, Non-Executive Director
Recommendation:	

To approve		To discuss	
To note		To ratify	
For assurance	√		

Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	To update the Board on the outcome of Audit Committee work and demonstrate Audit Committee is meeting its Terms of Reference

Key issues:

Positive Assurances to Provide:

- Board Assurance Framework
- Risk Management & Strategic Risk Register –
- Risk Management Divisional Deep Dive – Mental Health division
- Procurement processes & Direct Awards contracts
- Insurances in place for the Trust
- Declarations of Interest Process
- Non-audit work by Mazars
- Internal Audit Report - Losses and Special Payments
- Internal Audit Report - Infection Prevention & Control
- Internal Audit Report - Data Security and Protection Toolkit
- Internal Audit Recommendations Closure rate

Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT):

1. Board Assurance Framework & Risk Management - target risks
2. Benchmarking reports on Cost Improvement Plan; DSPT; Root Cause Analysis and Clinical Stock Management
3. Audit Recommendations from all audits will be followed up by management
4. Business Continuity Plans & EPRR submission triangulation
5. Finance System – Oracle Fusion upgrade to be reviewed by Committee

• Counter fraud assurances • Annual Report & Accounts	
Key Risks/Areas of Focus: 6. Digital Records Retention –Limited assurance 7. Digital Disruption – Limited Assurance 8. Travel Expenses – Limited assurance	**Decisions Made:** • Annual Reports and Accounts changes were approved

Alignment with the Three Shifts in the Long Term Plan (*If not applicable please state*)	
Hospital to Community	
Analogue to Digital	Audit Reports as detailed above (6-8)
Sickness to Prevention	

Governance and Assurance:

Please indicate which committee or group this paper has previously been presented to:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)*

√ *Tick those that apply*

Innovating Quality and Patient Safety	
Enhancing prevention, wellbeing and recovery	
Fostering integration, partnership and alliances	
Developing an effective and empowered workforce	
Maximising an efficient and sustainable organisation	√
Promoting people, communities and social values	

Areas to include within the report:

Please tick to confirm the following areas have been considered and addressed: *Patient Safety, Quality Impact, Risk, Legal, Compliance, Communication, Users and Carers, Inequalities, Collaboration, Equality and Diversity*	

Public Exemption:

Is the report exempt from public disclosure	No

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Audit Committee Chair Assurance and Escalation Report: AC held 14 September 2026

1. Positive Assurances gained at the Committee meeting:

The Committee gained positive assurance in the following areas from management:-

1. Board Assurance Framework – The Board Assurance Framework has been updated and amended to reflect areas identified in the recent Internal Audit Report. Committee reviewed and supported the majority of the BAF, alongside testing if BAF 1 needed a review of its current risk given some of the challenges faced with waiting lists and CMHT CQC report, and what the impact of the Primary Care Transfer will be on the BAF.

2. Risk Management Strategic Risk Register – This was found to be satisfactory and supported by Audit Committee, with some work requested on ensuring the mitigating actions would reduce the risk to the desired effect.

3. Risk Management Divisional Deep Dive – Mental Health division presented their risk register which has 25 risks, with 12 risks above the 12+ level which the Committee focussed on. This gave good assurances on the risks the division are managing, including links to the Corporate Risks with the CMHT CQC Outcome and Sickness absence management, and more local safety risks with anti-ligature arrangements.

4. Procurement processes & Direct Awards contracts – The Committee were satisfied that all the listed direct awards and the procurement process appeared to be compliant with SFI requirements.

5. Insurances in place for the Trust - The Committee were satisfied that Insurance arrangements were satisfactory;

6. Declarations of Interest Process – The Committee noted the good progress on improving compliance with DoI, with only two decision makers yet to complete a declaration of interest return. Future monitoring was agreed for EMT twice yearly (with any exceptions escalated to the Committee) and Audit Committee annually.

7. Non-audit work by Mazars – It was confirmed no non-audit work had been carried out by Mazars

8. Internal Audit Report - Losses and Special Payments – Significant Assurance was gained in the arrangements for management approval, oversight, monitoring and reporting of losses and special payments;

9. Internal Audit Report - Infection Prevention & Control – High Assurance was given for the effectiveness and compliance of IP&C measures within the trust including rates of healthcare associated infections, hand hygiene, environmental cleanliness and timely isolation.

10. Internal Audit Report - Data Security and Protection Toolkit – Low Risk/ High Confidence in the arrangements for the cyber assessment framework

11. Internal Audit Recommendations Closure rate – 16 Audit Recommendations were tested by Audit Yorkshire and 100% verified as complete. Management follow up of outstanding audit recommendations showed the majority are moving towards completion, but some remained outstanding and Committee asked for clearer assurances on where management have concerns with implementation.

12. Counter fraud assurances given were positive in relation to fraud prevention and detection

13. Annual Report & Accounts – a number of minor changes to the previously approved annual report have been made following feedback from NHSE and the auditors. The changes are shown in Appendix A and the full annual report is available on the Board portal.

2. Key Risks/Concerns/Gaps in Assurance:

Audit Reports with Limited Assurance:-

14. Digital Records Retention – A limited assurance was assigned to the arrangements ensuring the trust are not keeping data for longer than necessary and information being kept is relevant / secure with a focus on HR records. 4 Recommendations agreed with improvements required HR digital records inventory; SOP's for retention and disposal processes & records

15. Digital Disruption – The audit reviewed the arrangements for business continuity and recovery plans in place in the event of digital disruption covering one corporate and two clinical services and assigned a limited assurance with 6 agreed recommendations. Improvements are required to be made to ensure BCP's are fully tested, debriefed and lessons learnt following testing exercises.

16. Travel Expenses – Limited assurance was given to this audit which assessed the accuracy, validity and compliance of travel expenses, with 7 recommendations being agreed by management. The recommendations cover process for late claims submitted; ensuring the IT system controls work appropriately including for duplicate payments; updating the Travel expenses policy; evidence of valid driving licenses on the IT system;

3. Key Actions Commissioned/Work Underway:

17. Board Assurance Framework & Risk Management – EMT are considering the use of target risk scores in the BAF

18. Benchmarking reports on Cost Improvement Plan; DSPT; Root Cause Analysis and Clinical Stock Management have been shared with EMT for information and appropriate action(s) where required

19. Audit Recommendations from all audits will be followed up by management, then evidenced & checked by Internal Audit. Committee requested clearer indication if there are concerns over any actions not implemented.

20. Business Continuity Plans & EPRR – Committee asked for triangulation between the Audit Report and the future EPRR assurance statement; and management to consider if any changes are required to the Risk Register / BAF.

21. Finance System – Oracle Fusion – The Committee requested oversight of the changes & any internal control implications for the new Finance system yet to be implemented

4. Deep Dives, Thematic Reviews and Significant Reports

All the audit Deep Dives are reported above in the relevant sections.

5. Strategic Alignment

The Internal Audit plan and Board Assurance Framework is relevant to Humbers strategic goals and delivers audits/ assurances across all the areas listed below.

- **Innovating Quality & Patient Safety:** Continuously improving service safety and quality.
- **Enhancing Prevention, Wellbeing & Recovery:** Focusing on early intervention and supporting recovery.
- **Fostering Integration, Partnership & Alliances:** Collaborating with regional partners to deliver integrated care.
- **Developing an Effective & Empowered Workforce:** Supporting staff through investment and a positive culture.
- **Maximising an Efficient & Sustainable Organisation:** Enhancing productivity and environmental sustainability.

6. Chair's Overall Summary

Feedback at the end of the meeting was positive in relation to the Risk Register Deep Dive (Mental health); Triangulated links between Corporate Risk Register, the BAF and Divisional risk on CMHT CQC outcome and Sickness absence; Good quality papers, although room for improvement in the length of the papers pack.

The Internal Audit plan remains on track for delivery, and those items which may affect the BAF are outlined in 1., 15, and 20. Above.

Appendix A – Summary of Amendments to the Annual Report 2025/26

The following amendments have been made to the Annual Report and Accounts following ratification by the Board on 1 July 2026:

- **Page 9 – Resident Doctors:** Additional narrative inserted within the foreword describing actions undertaken by the Trust to support the Resident Doctors 10-Year Plan.
- **Page 117 – Fair Pay Disclosures:** New Fair Pay Disclosure section inserted.
- **Page 122 – Pension Entitlements:** Addition of wording confirming that both Michele Moran and Peter Beckwith chose not to be covered by pension arrangements during the reporting year.
- **Page 122 – Pension Entitlements:** Amendments made to pension entitlement table headings to improve clarity and ensure consistency.
- **Page 122 – Pension Entitlements Footnote:** Additional explanatory wording added regarding the non-availability of a Cash Equivalent Transfer Value (CETV) quotation where an individual has exceeded the NHS Pension Scheme's normal retirement age.
- **Page 123 – Financial Performance:** Surplus figure corrected.
- **Page 124 – Fair Pay Disclosures:** Paragraph amended to read `For employees of the Trust as a whole, the range of remuneration in 2025-26 was from £19,554 to £207,317 (2024-25 £16,816 to £199,343). This is a change between years of 2.87% (increase)'. The 2024/25 table was removed as this was not required.
- **Page 144 – Off-Payroll Arrangements:** Prior year (2024/25) data removed as not required by disclosure guidance.
- **Page 147 – Exit Packages:** Exit packages disclosure table repositioned to improve the flow and presentation of information within the report.