HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL

30th September 2026 at 4.30pm

Present:

Councillor Wilson (in the Chair)
Councillors Crofts (substitute for Shreeve), Henderson, Lindley, Kaczmarek, I. Oliver and Russell.

Officers in attendance:

- Katie Brown (Director of Adult Services)
- Liz Brummer (Head of Finance)
- Lindsay Hudson (Assistant Director of Public Health)
- Helen Johnson (Scrutiny and Committee Advisor)
- Eve Richardson-Smith (Service Manager – Consultancy, Law and Governance)
- Joanne Robinson (Assistant Director Policy Strategy and Resources)
- Stewart Watson (Designated Adult Safeguarding Manager)

Also in attendance:

- Councillor N. Oliver (Portfolio Holder Health, Wellbeing and Adult Social Care)

One member of the public was present at the meeting.

SPH.16 APOLOGIES FOR ABSENCE

Apologies for absence were received for this meeting from Councillor Shreeve.

SPH.17 DECLARATIONS OF INTEREST

There were no declarations of interest received in respect of any item on the agenda for this meeting.

SPH.18 MINUTES

RESOLVED – That the minutes of the Health and Adult Social Care Scrutiny Panel meeting held on 29th July 2026 be approved as an accurate record.

SPH.19 QUESTION TIME

A resident of North East Lincolnshire submitted the following question to the Health and Adult Social Care Scrutiny Panel:

Given that North East Lincolnshire Council (NELC) operates a health and adult social care model by a Section 75 agreement with the Humber and North Yorkshire Integrated Care Board (ICB), local social work and care functions are heavily delegated to local Community Interest Companies (such as Focus, Navigo, and Care Plus Group).

In light of Section 75—which dictates that partnership arrangements do not alter the underlying statutory liability of the local authority:

1. How does the Council actively monitor, evaluate, and ensure the rigorous day-to-day accountability of these external providers to NELC?

2. Can the Panel explicitly clarify and confirm how the Council maintains ultimate legal and statutory accountability for Care Act compliance when delivery is fully delegated to third-party organisations?"

The Chair of the Health and Adult Social Care Scrutiny Panel responded as follows:

North East Lincolnshire Council and the ICB (NHS) jointly oversee the monitoring of the Care Plus Group (CPG) and Navigo with the council having sole responsibility for Focus. Focus and Navigo carry out the majority of Care Act duties on behalf of the council.

The council recognises the importance of accountability with these organisations and undertakes the following activities to ensure assurance as follows: -

- There is a monthly contract meeting which oversees the performance, quality and delivery of the Community Interest Companies (CICs). This is jointly done with the ICB.
- As Focus undertakes the majority of Care Act duties, particular emphasis is placed on quality assurance and performance in regular meetings.
- The Principal Social Worker has a system role and works alongside the three organisations in the development and oversight of social work practice. This includes oversight and development of quality assurance. These activities feed into the

system social work assurance board and CQC improvement board.

- The Principal Social Worker and Assistant Director for Adult Social Care sit on the Focus Quality Assurance Board
- The assistant director for adult social care spends 2/3 days a week working at Focus and provides professional social work supervision for 2 senior managers at Focus. He meets regularly with senior managers and the interim CEO of Focus to ensure issues re practice, process and finances are discussed.
- The Assistant Director chairs the Charging Appeals Panel to ensure consistency in application of financial policies and procedures and ensures complainants receive responses to issues raised.
- The Assistant Director represents the council on the Mental Health Act Committee and the Navigo Contract meeting.
- The Assistant Director oversees complaint responses regarding Adult Social Care from the CICs and in particular from Focus.
- The Assistant Director chairs the System Social Work Assurance Board which includes Focus, Navigo and CPG. This ensures statutory duties shared by the 3 CICs are carried out and that Director is assured of practice across the system.
- Whilst the arrangements in North East Lincolnshire are unique the council's adult social care team are involved with the CICs on a daily basis due to the accountability remaining with the council for the delivery of statutory adult social care services.

SPH.20 FORWARD PLAN

The panel considered the current Forward Plan and members were asked to identify any items for examination by this Panel via the pre-decision call-in procedure.

RESOLVED – That the forward plan be noted.

SPH.21 TRACKING THE RECOMMENDATIONS OF SCRUTINY

The panel considered a report from the Statutory Scrutiny Officer tracking the recommendations previously made by this scrutiny panel, which was updated for reference at this meeting.

At item SPH.57 (Oral Health) - the panel noted that the Oral Health item had now been formally scheduled on the work programme for March 2027 and therefore agreed to remove it from the tracking report.

At item SPH.58 (Dental Commissiong Update) - the panel noted that the Dental Commissioning Update had now been formally scheduled on the work programme for March 2027 and therefore agreed to remove the item from the tracking report.

At item SPH.61(Non-Obstetric Ultrasounds) - the panel wished for this item to remain on the tracking report.

At item SPH.61 (NLAG Performance) - the Panel were informed of the joint meeting scheduled for 21st October 2026 and requested that the item remain on the tracking so that it could receive feedback following the meeting.

At item SPH.8 (Council Plan Performance mid-year report) - the panel agreed that the transformation schemes item could be removed from tracking, as it had already been included as a scheduled item on the panel's work programme.

At item SPH.8, following receipt of a response regarding the Disabled Facilities Grant (DFG) indicator, the panel agreed to remove this item from tracking.

At item SPH.8, Members noted that the Housing and Adult Social Care figures would be reported separately to avoid any potential misrepresentation of the data. Having received confirmation that the amendment had been made, the panel agreed to remove the item from tracking.

At item SPH.9 (Reablement Review) - the panel agreed to remove the item from tracking following the response circulated to members concerning engagement with the Citizens Advice Bureau (CAB) and Age UK.

At item SPH.9 (Digital Inclusion) - Members received an update advising that a comprehensive report was expected in mid-October. The report would inform a briefing for the Portfolio Holder for Safer and Stronger Communities, as well as a workshop session with the Health and Wellbeing Board.

At item SPH.10 (Mid-year service transformation update) - the panel agreed to remove the item from tracking as it has been officially scheduled on the panel's work programme.

At item SPH.13 Teenage Pregnancy (workshop-style discussion) - the panel agreed that this item should remain on the tracking report. Members were advised that an all-member briefing had been scheduled for 26th January 2027.

A member initiated a wider discussion on reporting standards across all scrutiny panels, highlighting concerns that many council reports predominantly focused on service activity, processes and inputs, rather than demonstrating the impact of services, outcomes for residents and

areas of emerging concern through early exception reporting. During the debate, members and officers acknowledged the challenges associated with measuring certain qualitative outcomes, particularly in areas such as safeguarding, prevention and wellbeing, where improvements could be difficult to quantify. However, there was broad agreement that reports should, wherever possible, provide clearer evidence of trends, performance outcomes and the difference services were making to residents.

Members expressed support for developing a more consistent and outcome-focused approach to performance reporting across the Council's scrutiny function, enabling panels to better assess progress, identify risks at an earlier stage and hold services to account more effectively.

Following discussion, the Panel agreed that the matter should be referred to the Executive and Scrutiny Liaison Board to consider whether the concerns identified warranted action and, if so, whether a more consistent, council-wide approach to scrutiny reporting could be developed, with greater emphasis on outcomes, impact measures, trend analysis and exception reporting.

RESOLVED –

1. That the report be noted.

2. That the issue of reporting standards be referred to the Executive and Scrutiny Liaison Board to consider whether the concerns identified warrant action and, if so, whether a more consistent, council-wide approach to scrutiny reporting could be developed, with greater emphasis on outcomes, impact measures, trend analysis and exception reporting.

SPH.22 QUARTER 1 2026/27 COUNCIL PLAN PERFORMANCE AND FINANCE REPORT

The panel considered a report from the Portfolio Holder for Finance, Resources and Assets providing information and analysis of the Council’s performance and financial position at the end of quarter one 2026-27, April to June 2026.

Ms Brummer introduced the Quarter 1 Finance Report and advised members that the council was forecasting a net overspend of £1.8 million, primarily driven by a £2.1 million overspend within Adult Social Care. Members were also informed that the capital programme was reporting an underspend of £2.8 million across a number of projects, reflected by programme slippage and the re-profiling of expenditure timelines.

In response to a member's question regarding budget setting, Ms Brown advised that the pressures within Adult Social Care were being driven by a combination of increased demand and delays in the delivery of planned savings. She noted that approximately £1 million of the overspend was attributable to just three high-cost care packages. Members were informed that, despite North East Lincolnshire's Adult Social Care expenditure being close to the lower end of national benchmark comparisons, local demand continued to rise due to an ageing population and increased life expectancy in some areas of the borough.

Ms Brown further outlined the actions being taken to mitigate financial pressures, which included reviews of low-cost care packages to identify any potential over-prescription of support, reassessments of working-age adult care packages, and measures to manage demand at the point of access through prevention and early intervention approaches.

Officers advised that strategic financial pressures continued to be compounded by ongoing funding dialogue with the NHS relating to Continuing Healthcare (CHC) and Section 117 Mental Health Act aftercare responsibilities. Members discussed these issues and expressed an interest in inviting representatives from the Integrated Care Board (ICB) to a future meeting to provide further information and enable scrutiny of the associated financial and operational impacts.

It was noted that public health trends indicated that lifestyle-related conditions, including diabetes which resulted in amputations and chronic respiratory disease, were contributing to individuals who required adult social care at an earlier age, particularly within the 45 to 55 age group. Members were advised that the Joint Health and Wellbeing Strategy sought to address these challenges over the longer term, through a 5 to 10-year programme of preventative measures, including the Food Health Action Plan and smoking cessation services.

A panel member queried the performance indicators, particularly the reduction in the percentage of eligible individuals offered direct payments from 65% to 40% in Quarter 1. Ms Brown advised that the decrease was primarily attributable to administrative and recording issues relating to whether direct payments had been formally recorded as having been offered, rather than a reduction in service provision. She confirmed that a robust improvement plan was in place, with direct oversight from the council, to address the recording and reporting issues.

The panel also discussed a red-rated indicator relating to wellbeing service referrals. Officers clarified that the reported decrease from Quarter 4 was attributable to the planned cessation of the mental

wellbeing support service in November 2025. Members were advised that the Quarter 1 figure of 131 referrals was potentially inaccurate and that the correct number of stop-smoking referrals was 219.

RESOLVED –

1. That the report be noted.

2. That the Humber and North Yorkshire Integrated Care Board be invited to a future meeting to provide information and respond to member's questions concerning funding relating to NHS Continuing Healthcare and Section 117 aftercare.

SPH.23 COUNCIL TAX RELIEF FOR THE TERMINALLY ILL

The panel received a briefing note from the Interim Section 151 Officer on the Council Tax Relief for the terminally ill following full Council's proposed 2026/27 budget amendment.

The panel received a briefing paper presented by Ms Brummer on the proposed introduction of a 100% council tax relief scheme for terminally ill residents, due to commence in April 2027. Formal approval to adopt the scheme would be included in the Council Tax Base report for 2027/28 that would be considered by full Council in December 2026. Members were advised that eligibility would be determined through the submission of an SR1 medical form.

Ms Brummer explained that, based on estimates derived from blue badge data, if all potentially eligible residents applied for the scheme, the anticipated cost to the council was estimated at approximately £160,000 in foregone council tax income. Ms Brummer emphasised that the amount was estimated; the actual number of people eligible to claim was unknown.

The panel was informed that the relief would operate as a discretionary discount and would be applied after all statutory discounts and exemptions had been calculated. This approach would minimise any impact on overall council tax collection rates whilst reducing the eligible resident's liability to nil.

Members were advised that the discount would be granted for a maximum period of 12 months. In the event of the death of the eligible resident, provision would be made for the relief to continue for up to a further two months to support the remaining household members.

RESOLVED – That the briefing note be noted

SPH.24 SECTION 75 ARRANGEMENTS

The panel received an update from the Director of Adult Social Care on Section 75 arrangements.

Ms Brown provided a brief update to panel members on the Section 75 agreement with the NHS, advising that staff who transferred into the council were now fully settled.

The panel noted that transition arrangements and relationship building with the Integrated Care Board (ICB) had progressed positively despite significant organisational changes, including the departure of key personnel. Members were advised that engagement with the Humber Health Partnership (HHP) had improved considerably, with NHS England actively overseeing the partnership and facilitating discussions with local authorities. It was reported that HHP had committed to working closely with place-based arrangements, scrutiny panels, and health and wellbeing boards as functions transitioned back to constituent organisations.

A member sought assurance on whether the Section 75 transition had delivered benefits for North East Lincolnshire and how staff had managed the change. Ms Brown advised that strategic alignment between partners remained strong and that NHS staff transferring into council arrangements had reported feeling well supported throughout the process, particularly through assistance provided by the council's legal, procurement, and communications teams.

Ms Brown further advised that a comprehensive review of jointly held contracts had now been completed. In response to a question from the Chair regarding funding arrangements, Ms Brown explained that contracts predominantly focused on social care services or operating solely within the North East Lincolnshire footprint had been successfully novated to the council. Larger strategic contracts continued to be managed by the ICB.

A member queried whether the revised arrangements represented a move away from pooled budget arrangements. Ms Brown clarified that the pooled budget remained fully in place and that the structural changes related only to contract hosting requirements due to the changes in the ICB's responsibilities. Strategic oversight and decision-making arrangements continued to be undertaken jointly by the council and the ICB.

RESOLVED – That the update be noted.

SPH.25 JOINT HEALTH AND WELLBEING STRATEGY AND MARMOT PLACE UPDATE

The panel considered a report from the Director of Public Health on the progress of the joint Health and Wellbeing Strategy and Marmot Place.

Ms Hudson provided an update on the Marmot Place initiative ahead of its formal launch. She advised that a Marmot Place Steering Group had been established, comprising representatives from council directorates and partner organisations, including Horizon Youth Zone and neighbourhood health leads; this group would lead the delivery of the Marmot action plan. Members were informed that task and finish groups would be established to progress individual Marmot Principles once an initial focus had been agreed. A draft public health outcomes dashboard had also been developed to monitor key indicators, including healthy life expectancy, housing, and employment.

Ms Hudson confirmed that the draft Food Health Action Plan, developed following a comprehensive food health needs assessment and stakeholder consultation, was progressing towards formal approval.

The panel received an explanation of Middle Super Output Area (MSOA) data, which showed that healthy life expectancy in some wards was as low as 48 years for males and 49 years for females. Members noted that this meant some residents could expect to spend approximately 30% of their lives in poor health.

Members discussed how Marmot Principles could be embedded within council policies and queried how officers envisaged the initiative influencing future policy development. Ms Hudson advised that, whilst substantial groundwork had been undertaken, significant work remained and described expecting the launch to provide further momentum through a “snowball effect”. She noted that although mobilising the contract with UCL had taken longer than originally anticipated, meaningful advances had been made, and continued progress had been achieved.

Looking ahead to the launch, Ms Hudson stated that the aim was for attendees to clearly understand what Marmot was, how it related to their organisation, and what actions could be taken to support it. Organisations would be encouraged to make a commitment to the initiative. A follow-up webinar would be held approximately one month after the launch, followed by smaller workshops to maintain engagement and momentum. Opportunities for staff training were also being explored.

In response to a question regarding community engagement, Ms Hudson advised that information would be available at the launch and

that a communication plan would be developed. She noted that particular emphasis had been placed on producing easy-read materials that could be distributed through GP surgeries, libraries, and other community venues.

Following discussion, the panel agreed to amend recommendation 3 of the report to ensure that the expectation to champion Marmot Principles extended to all councillors, across their respective portfolios, wards, and political groups, rather than solely to members of the panel.

The panel also highlighted the importance of building and sustaining community momentum and requested that the University College London (UCL) Institute of Health Equity be invited to provide a dedicated briefing session for all elected members.

RESOLVED –

1. That the report be noted.

2. That all councillors be encouraged to champion the Marmot Principles through their respective portfolios, wards, and political groups.

3. That University College London (UCL) Institute of Health Equity be invited to deliver a dedicated briefing session for all elected members.

SPH.26 ADULT SERVICES ANNUAL COMPLAINTS REPORT

The panel considered a report from the Director of Adult Social Care on the Adult Social Care Statutory Complaints and Compliments annual report.

Members received an introduction to the statutory complaints report and welcomed the appointment of Ms Mazingham (formerly Regional Complaints Lead for the ICB) to Focus, in which it was noted that her experience would strengthen qualitative learning and communication processes.

The panel noted that the Adult Social Care Local Government and Social Care Ombudsman annual report would be circulated to members.

Members were advised that, of the seven cases referred to the Ombudsman during the reporting period, two had been upheld. Both cases related to communication failures between providers and issues surrounding responsibility handovers. The panel expressed concern that communication breakdowns and the challenges of navigating a

complex, multi-agency health and social care system remained the primary causes of complaints. Officers advised that work was underway to address these issues through a review of the Single Point of Access (SPA) and the accelerated implementation of Integrated Neighbourhood Teams (INTs) as part of a recently approved social financing trailblazer programme.

The Chair acknowledged that, whilst the overall number of complaints had reduced, the number escalated to the Ombudsman had increased and sought assurance that lessons had been learned from the upheld cases. Officers explained that where concerns were not resolved satisfactorily at the earliest stage, complainants were more likely to escalate matters to the Ombudsman. Officers further acknowledged that there remained additional work to do and assured the Panel that learning from complaints continued to drive service improvement.

The panel commended the service for 287 recorded compliments, representing approximately seven times the number of formal complaints received. Members emphasised the importance of consistently recording compliments, both to recognise and encourage staff and to identify examples of best practice. It was noted that positive feedback was not always formally logged by social workers, resulting in missed opportunity to celebrate good practice and shared learning across the service.

RESOLVED –

1. That the report be noted.

2. That the Adult Social Care Local Government and Social Care Ombudsman report be shared with all Elected Members.

SPH.27 SAFEGUARDING ADULTS BOARD ANNUAL REPORT

The panel received the Safeguarding Adults Board annual report 2025/26 and the Safeguarding Adults Board Strategic Plan 2024/27.

Mr Watson presented the Safeguarding Adults Board Annual Report and Strategic Plan. He advised that delays in the publication of NHS Digital data continued to affect the availability of peer-group comparison information. Mr Watson confirmed that the report would be reissued with the correct comparative data once it became available.

In response to a member's question, Mr Watson assured the panel that local safeguarding practices were significantly stronger than they had been three years ago. He attributed this improvement to the introduction of robust operational risk management protocols,

Designated Adult Safeguarding Manager (DASM) guidance, and People in Positions of Trust (PiPoT) procedures, which had been implemented since 2018.

The panel was advised that the Board continued to monitor safeguarding referral volumes, which were currently lower per 100,000 population than those of comparable authorities. Officers explained that this was partly attributable to the transition to computerised referral systems. Ms Brown highlighted the effectiveness of low-level risk management interventions, which supported individuals who had mental capacity but were making unwise decisions, helping them to remain safe without the need to escalate matters prematurely to the statutory safeguarding threshold.

Officers also advised that a public awareness campaign and a series of professional webinars were planned as part of Safeguarding Adults Week in November 2026.

RESOLVED – That the report be noted

SPH.28 QUESTIONS TO PORTFOLIO HOLDER

Councillor Henderson submitted the following question to the Portfolio Holder for Health and Adult Social Care.

Councillor Henderson raised five key areas of concern originating from a previous Healthwatch intelligence report.

1. *The complexity of our services and the challenges wayfinding*
2. *Communication and responsiveness, due in part to the above*
3. *Safeguarding*
4. *Oral health*
5. *Access and waiting*

How can we provide comfort that we recognise these issues, if we do, and are doing something about them, especially the complexity of wayfinding?

Councillor N Oliver, Portfolio Holder for Health and Adult Social Care, responded to Councillor Henderson:

On points 1 and 2, there is acknowledgment that the health and social care system can be complicated to navigate. In North East Lincolnshire (NEL) we have tried to simplify it by integrating as much as possible in the Single Point of Access. However, the national issues of communication between primary, secondary care, community health and social care was something that we were always trying to improve.

NEL was part of the Neighbourhood Health Implementation Programme and had recently been accepted on a social financing trail blazer programme to accelerate neighbourhood health. We had started to see the benefits of integrated neighbourhood teams and the social investment would accelerate the coverage of these teams across the borough. This would ensure that teams were working together in local areas to meet people's needs without the need for handoffs and multiple referrals.

On point 3, the statutory safeguarding functions had recently had an external peer review. This was on the whole positive and the areas of improvement were being monitored by the CQC improvement board as well as the Safeguarding Adults Board. During November (adult safeguarding week) an external campaign raising awareness was taking place with the public on safeguarding and how they could report it. This would accompany a week of webinars on all aspects of safeguarding which would be for all professionals within NEL.

On point 4, access to NHS dentistry in NEL was still challenging. The ICB updated scrutiny at the end of last year and they were happy to update further if required. Public health still supported with education around oral health and again were happy to provide any updates the panel would like.

Finally, on point 5, adult social care waiting times have reduced for new people requiring support and this was monitored by the CQC improvement board. There was still significant performance issues with Humber Health Partnership and they were currently being overseen by NHSE. There was a joint scrutiny meeting with the 4 Humber Councils and HHP on the 21st October which would give members the opportunity to ask questions and receive assurance around performance issues related to secondary care.

SPH.29 CALLING IN OF DECISIONS

There were no formal requests from Members of this panel to call in decisions taken at recent meetings of Cabinet.

There being no further business, the Chair declared the meeting closed at 6.47 p.m.

Humber and Lincolnshire Joint Health Overview and Scrutiny Committee Meeting

21st October 2026 at 4.30pm

Present:

East Riding Council

Councillor Boynton
Councillor Saribal

Hull City Council

Councillor Carnall
Councillor Collinson (substitute for Randall)
Councillor Wood

North East Lincolnshire Council

Councillor Charlesworth
Councillor Shreeve
Councillor Wilson (in the Chair)

North Lincolnshire Council

Councillor Davison (substitute for Dart)
Councillor Lee
Councillor Kennedy

Also in attendance:

- Ade Beddows (Humber Health Partnership)
- Katie Brown (Director of Adult Services)
- Zoe Campbell (Senior Scrutiny and Committee Advisor)
- Rob Close (Senior Committee Manager East Riding Council)
- Simon Cox (ICB)
- Alan Downey (Group Chair Humber Health Partnership)
- Sarah Farragher (Interim Director of Recovery Operations)
- Dean Gillion (Senior Democratic Services Officer North Lincolnshire Council)

- Helen Johnson (Scrutiny and Committee Advisor)
- Diane Lee (Director of Public Health)
- Councillor N. Oliver (Councillor N. Oliver (Portfolio Holder Health, Wellbeing and Adult Social Care)
- Therese Patten (Interim Chief Executive NLaG)
- Lyn Simpson (Group Chief Executive Humber Health Partnership)

No members of press or public were present at the meeting.

JHOSC.1 APOLOGIES FOR ABSENCE

Apologies for absence were received for this meeting from Councillors Darnall and Hart. Ms Patten sent apologies for Malcom Murray (Interim Chair – NLaG).

JHOSC.2 DECLARATIONS OF INTEREST

There were no declarations of interest received in respect of any item on the agenda for this meeting.

JHOSC.3 QUALITY AND PERFORMANCE

The joint committee invited the Humber Health Partnership to provide assurance regarding the Integrated Care Board (ICB) review, section 29a notices and resident access to continuing health care and the quality concerns in the Trusts.

Mr Downey provided a brief introduction on the challenges facing the Humber Health Partnership (HHP). He advised members that performance across the partnership was not where it needed to be and highlighted the issuance of Care Quality Commission (CQC) Section 29A notices. He also outlined concerns regarding the current organisational culture within the trusts and discussed what he believed could be achieved if the organisations operated as separate trusts.

Ms Simpson then delivered a presentation covering both the Quality and Performance and Humber Health Partnership (HHP) agenda items. With the agreement of the Chair, the minutes record the issues raised under each topic separately and are therefore presented as distinct agenda items.

The joint committee received the following updates on Quality and Performance:

CQC Section 29A Notices: Ms Simpson advised the Panel that the CQC had issued two Section 29A notices during summer 2026 relating to leadership, governance and quality across both trusts. The four key

areas identified as requiring urgent improvement were governance and risk management, learning and safety, complaints handling, and infection prevention and control (IPC).

In response to questions from members, Ms Simpson acknowledged that progress had been made in addressing the requirements of the Section 29A notices; however, she emphasised that it remained at an early stage and that it was therefore difficult to demonstrate measurable improvements at this time.

Members expressed concern that the information presented did not provide sufficient assurance regarding progress made to date. The Panel also commented that having sight of the presentation in advance of the meeting would have been helpful in enabling members to fully scrutinise the issues raised.

Complaints Handling: Ms Simpson advised the Panel that the HHP had commissioned an external review of its complaints process and introduced a new standard operating procedure to address delays in the resolution of complaints. She reported that the backlog of Patient Advice and Liaison Service (PALS) complaints had been reduced by 50%.

Ms Simpson also highlighted the benefits of meeting complainants face-to-face, noting that this approach had proved effective in resolving concerns and improving the overall experience for those raising complaints. In response to questions from members, she advised that approximately 20 per cent of complainants had been seen in person. Feedback from those meetings had been positive and, in her view, the approach had delivered significant benefits in resolving issues more effectively.

Infection Prevention and Control (IPC): Ms Simpson advised the committee that shortcomings in hand hygiene compliance and other fundamental clinical safety practices, including the use of World Health Organization (WHO) surgical safety checklists, had been identified by the CQC as areas that required improvement. She noted that these issues had previously been highlighted through the clinically led improvement plan; however, embedded and sustained improvements would require wider cultural change across both organisations to ensure that safe practices were applied consistently and routinely throughout services.

Performance Improvements: Ms Simpson reported that there were encouraging signs of improvement across the HHP. These included an improvement in the rating for end-of-life care at Scunthorpe, which had moved from “Requires Improvement” to “Good”, improved accident and emergency waiting times at Hull Royal Infirmary, which was ranked

45th out of 134 hospitals nationally, and a 5.5 per cent improvement in Northern Lincolnshire and Goole NHS Foundation Trust’s cancer faster diagnosis standard, placing the Trust among the top four performers in the region.

Despite these improvements, Ms Simpson advised that HHP remained within the national intensive recovery programme as one of the five lowest-performing trusts nationally. While this brought significant regulatory scrutiny, it also provided access to additional regional and national support to assist improvement efforts.

In response to a question from a member regarding what had been done differently to achieve these improvements, Ms Simpson explained that the focus had been on getting the basics right, rebuilding staff confidence, securing staff engagement with the vision for improvement, listening to concerns raised by staff and patients, and implementing changes in response to that feedback. She emphasised that creating a culture in which staff believed in their ability to deliver improvements had been a key factor in the progress made to date.

The Chair queried whether any benchmarking had been undertaken against trusts rated as "Good". In response, Ms Simpson advised that benchmarking was carried out; however, they acknowledged that there was scope to undertake this more extensively and that the findings could help to inform future decision-making. Officers emphasised that, at the present time, it was important to establish a clear and collective understanding of what constituted success and the criteria against which progress would be measured.

Staff Workloads and Morale: Members raised concerns regarding low staff morale, staffing shortages on hospital wards, and reported that some staff felt discouraged from raising concerns through whistleblowing or safeguarding processes due to workforce pressures and shortages.

In response, Ms Simpson acknowledged the concerns raised and noted that national benchmarking indicated that the trusts had underperformed in relation to productivity and efficiency. However, they emphasised that any expectation for staff to “work smarter, not harder” must be supported by meaningful engagement with the workforce and a clear understanding of the pressures staff were facing.

Members highlighted the importance of ensuring that staff felt supported to raise concerns and that workforce capacity issues did not impact upon patient safety or staff wellbeing. The Committee therefore requested more detailed information on staffing levels, hours worked and workforce workloads to enable it to monitor these issues and better understand the impact on service delivery and staff morale.

Members acknowledged the assurances provided regarding the work being undertaken to address the concerns raised by the CQC and the progress reported during the presentation. However, they remained concerned that the CQC continued to identify significant areas requiring improvement and were not fully convinced that sufficient progress had yet been demonstrated.

Members emphasised the importance of maintaining effective scrutiny of the improvement programme and recommended that a further meeting of the Joint Health Overview and Scrutiny Committee (JHOSC) be convened in early 2027 to review progress against the improvement plans, assess the impact of the actions taken, and receive an update on the Trusts' response to the CQC findings.

RESOLVED –

1. The presentation be noted.

2. That a detailed report on staffing hours, workforce capacity and staff workloads be provided to members of the JHOSC, to enable the Committee to monitor staffing pressures, assess the impact on staff wellbeing and patient care, and support ongoing scrutiny of workforce performance and organisational improvement.

3. That a further meeting of the JHOSC be convened in early 2027 to receive an update on the disaggregation of the HHP, review progress against the improvement plans and (CQC) requirements and enable members to scrutinise the impact of the changes on service quality, performance, workforce issues and patient outcomes.

JHOSC.4 HUMBER HEALTH PARTNERSHIP

The joint committee invited the Humber Health Partnership to provide an update on their board decision to split the partnership and return to Northern Lincolnshire and Goole Foundation Trust (NLaG)and Hull University Teaching Hospital NHS Trust (HUTH). The joint committee received and reviewed assurances regarding governance and oversight of the change and any impact on improvement programmes, patients, and the workforce.

Ms Simpson reflected on the single improvement journey undertaken by the Humber Health Partnership from Autumn 2025 to September 2026. She reiterated the importance of the improvement programme for the partnership's 20,000 staff and outlined the timeline leading to the proposed disaggregation of the organisations. Mr Downey confirmed that the separation of the HHP was progressing at pace.

He advised that a Chair and Chief Executive had already been appointed for NLaG, and that the establishment of two separate boards was now underway. It was anticipated that the disaggregation process would be completed within a relatively short timeframe.

A member questioned why the presentation focused only on the previous 12 months when many of the challenges discussed had existed for approximately three years. The member also sought clarification on what aspects of the partnership arrangements had not been working effectively.

In response, Mr Downey advised that, as he, Ms Simpson and Ms Patten were all relatively new in post, they were unable to provide detailed commentary on the historical position. However, he stated that upon joining the HHP it had become apparent that the partnership model was not delivering the intended benefits and was not operating as effectively as expected. He explained that this had contributed to the decision to pursue disaggregation and return to separate trust arrangements as part of the wider improvement programme.

The joint committee received the following updates on the Humber Health Partnership:

Dissolution of the Partnership: Ms Simpson advised the Committee that, on 10 September 2026, the HHP Board voted to disaggregate the partnership and return to two separate sovereign organisations. Under the proposed arrangements, Hull University Teaching Hospitals NHS Trust (HUTH) would serve the populations of Hull and the East Riding of Yorkshire, while Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) would serve the populations of North Lincolnshire and North East Lincolnshire.

Ms Simpson explained that the decision followed a review of the partnership’s performance and governance arrangements and reflected a view that each organisation would be better placed to drive improvement, strengthen accountability and respond to the needs of their respective communities as separate trusts. She noted that, despite the move to separate organisational structures, both trusts would continue to work collaboratively where this was beneficial to patients and services.

Reasons for Disaggregation: A member sought clarification on the original rationale for forming the partnership and questioned whether those factors remained relevant. In response, Ms Simpson explained that the partnership had been established, in part, to address challenges relating to service fragility, workforce recruitment and retention, and the long-term sustainability of services.

However, she advised that the HHP, which had been in place for approximately three years, had not delivered the anticipated benefits in relation to workforce recruitment, financial performance or service sustainability. Ms Simpson noted that the geographical separation of the organisations, with sites located on either side of the Humber Bridge, together with differing organisational cultures and the breadth of responsibility placed on a single executive team, had created significant management and operational challenges.

Ms Simpson explained that these factors had contributed to the view that the partnership model was not achieving its intended objectives and that returning to two sovereign organisations would provide clearer accountability, stronger local leadership and a greater ability to focus on the specific needs and priorities of the communities served by each trust.

Carnall Farrar Review**:** Ms Simpson advised that the decision to disaggregate the HHP and return to two sovereign organisations had been informed by the findings of an independent review commissioned by NHS England and undertaken by Carnall Farrar. She explained that the review concluded that separate organisational arrangements would provide a stronger and more focused platform for delivering sustained clinical improvement, strengthening local leadership and accountability, and addressing the specific needs of the populations served by each trust.

During discussion, members requested that a copy of the Carnall Farrar review be provided to the JHOSC when it became available, to assist members in understanding the evidence base underpinning the decision to disaggregate and to support future scrutiny of the implementation process.

Clinical Collaboration and Patient Safety Following Disaggregation: Members sought assurances that patient safety would be maintained throughout the disaggregation process and that established regional clinical pathways, including cardiology, cancer and stroke services, would continue to operate effectively through ongoing collaboration between the trusts.

In response, Ms Patten advised that a set of transition principles had been formally agreed to guide the disaggregation process. Central to these principles was the commitment that “nothing changes unless a conscious decision is made to change it”, thereby ensuring continuity of care and minimising disruption to patients and services.

Ms Patten emphasised that the intention was to preserve successful collaborative arrangements where they delivered benefits to patients. She noted that established clinical pathways and cross-site working

arrangements would continue unless there was a clear and evidence-based rationale for change. She further stated that she was keen to maintain the positive working relationships that had been developed between teams across both sites and to ensure that patient safety remained the overriding consideration throughout the transition to separate organisational structures.

Financial Implications of Disaggregation**:** Members discussed the financial implications associated with the proposed separation of the HHP and questioned whether these costs had been fully considered prior to the decision being announced.

In response, Mr Downey advised that the rationale for disaggregation was not solely, or even primarily, financial. He explained that the decision had been driven by a broader assessment of what organisational arrangements would best support the delivery of high-quality services and improve outcomes for local communities. He noted that maintaining the existing partnership or returning to separate organisations would have made relatively little difference from a purely financial perspective.

Mr Downey acknowledged that the re-establishment of two sovereign trusts would inevitably incur some additional costs, including those associated with the creation of separate boards and the appointment of senior leadership teams. These costs were estimated to be between £1.5 million and £2 million per organisation. However, it was anticipated that the move to more locally focused management arrangements would generate operational efficiencies and strengthen organisational effectiveness over time.

Members were advised that a comprehensive financial stocktake of the disaggregation process was currently being undertaken to fully assess the costs and implications of the transition. It was further confirmed that the resulting financial report would be published and made available to the JHOSC once completed, enabling members to review and scrutinise the financial impact of the proposed changes.

Local Accountability: Members expressed concerns regarding what they perceived to be a historical lack of accountability and engagement by the trusts with local stakeholders and elected members.

In response, Mr Downey reassured the Committee that both organisations were committed to strengthening local accountability following disaggregation. He advised that the trusts intended to maintain regular engagement with Health and Wellbeing Boards, Health Scrutiny Panels, local authorities and local Members of Parliament to ensure that local views continued to inform decision-making and service development.

Mr Downey further confirmed that local authority representatives had been invited to participate in the delivery groups overseeing the transition process. He explained that this would help ensure transparency, provide opportunities for stakeholder input, and support effective partnership working as the trusts moved towards operating as separate sovereign organisations. Members welcomed the commitment to increased engagement and emphasised the importance of maintaining robust accountability arrangements throughout and beyond the transition process.

The Chair thanked the officers for their open and candid responses throughout the discussion and expressed appreciation to members for their thorough examination of both the proposed HHP disaggregation and the quality and performance issues affecting the trusts.

Reflecting on comments made by members during the debate, the Chair emphasised the Committee's shared commitment to supporting improvements in local health services and sought views on what role councillors could play in assisting the transition process. Members stressed the importance of maintaining effective scrutiny, acting as a conduit for community concerns, and supporting engagement between the trusts, local authorities and residents to help ensure that the transition was successfully delivered and remained focused on improving outcomes for patients and staff.

RESOLVED –

1. That the presentation be noted.

2. That the Carnall Farrar review report be circulated to members of the JHOSC once it became available, to enable members to consider the findings and recommendations that informed the decision to disaggregate the HHP and to support future scrutiny of the transition process.

3. That the costing report relating to the disaggregation of the HHP be published and circulated to members of the JHOSC once available, to enable members to review the financial implications of the transition and support ongoing scrutiny of the process.

There being no further business, the Chair declared the meeting closed at 6.39 p.m.