ST HUGH'S HOSPITAL

Quality Account

2025/2026

EMPOWERING PEOPLE AND INNOVATING HEALTHCARE, TOGETHER.

38,567

Patients seen between April 2025 - March 2026

5694

Physio appointments made between April 2025 - March 2026

13,443

Nurse led appointments between April 2025 - March 2026

19,430

Consultant appointments made between April 2025 - March 2026

Inspected and rated by

CareQuality Commission

Good	Good	Good	Good	Good
SAFE	CARING	RESPONSIVE	EFFECTIVE	WELL-LED

CONTENTS

STATEMENT OF EXECUTIVE DIRECTOR OF REGULATION, GOVERNANCE AND STANDARDS

This reporting period has been one of exceptional progress and transformation for St Hugh's hospital, culminating in the achievement of an overall "Good" rating following the most recent inspection by the Care Quality Commission. This represents far more than an improvement in rating, it is a affirmation of the dedication and professionalism demonstrated by our teams across every level of the organisation.

The journey from "Requires Improvement" to "Good" has required focus and a shared determination to challenge ourselves. We have not just responded to regulatory feedback, we have embraced it as a opportunity for lasting change. Through stronger governance and sharper clinical oversight, we have embedded quality and safety as the foundation of everything we do.

There has been a huge cultural shift that underpins this achievement. There is now a srong sense of pride and collective responsibility among staff. Teams are more empowered, more connected and more confident to speak up. This has ultimately led to improvements in patient safety, clinical effectiveness and patient experience, with feedback reflecting the kindness and respect that defines our care.

We have invested significantly in our people, recognising that high-quality care begins with a supported, skilled and motivated workforce. Through improvements in training, leadership development and more targeted recruitment, we have built more resilient teams who are equipped to deliver consistently high standards of care.

Importantly, this achievement has been reached while maintaining a clear focus on our patients. Their voices have shaped our improvements, and their experiences continue to guide our priorities. We are seeing the impact not only in metrics, but in the stories and outcomes that matter most to those we support.

While we celebrate this significant achievement, we do so with a clear understanding that "Good" is not an endpoint. Our ambition is firmly set on excellence. We will continue to build on this momentum, and ensure that every patient, receives the highest standard of care every time.

This report outlines the progress made and reflects an organisation that has not only improved but has strengthened its capacity to sustain and exceed high standards into the future.

Andrea Hayward
Executive Director of Regulation, Governance and Standards
Responisble Individual

HOSPITAL DIRECTOR STATEMENT

It has been a pleasure to take up the role of Interim Hospital Director during this reporting period. This reporting period has demonstrated how HMT's strategic ambitions have been translated into improvements at the frontline. From an operational standpoint, the focus has been on embedding the strengthened governance, safety and quality frameworks into everyday practice. Our team has put lots of effort has into ensuring that improvements are not only effective, but delivered consistently.

Close collaboration with our system partners, particularly the local Integrated Care Boards (ICBs), has been important in enabling this progress. We have worked collectively to improve patient pathways and have been better able to respond to demand pressures. This partnership has also supported a more integrated model of care, aligning the hospital's priorities with those of the wider health system.

The operational reality, however, has remained challenging. Frontline teams have continued to navigate workforce pressures, delivering improvement alongside business-as-usual activity. Teams have embraced change, contributed to problem-solving and sustained focus on delivering care in often demanding circumstances.

There has also been a emphasis on supportive leadership, ensuring that the voice of the frontline informs decision-making and that teams feel empowered to deliver the required standards.

As reflected in the improved rating, the hospital is now in a stronger, more stable position. The priority moving forward is to sustain this alignment by continuing to embed consistency and build on system partnerships to ensure that improvements are both enduring and continuously evolving. I am excited to build on this foundation, working alongside our teams and system partners to sustain improvement and continue delivering high-quality, patient-centred care.

This report therefore reflects not only what has been achieved, but how those achievements have been realised, through the combined strength of strategic direction and frontline delivery.

Ellen Colley
Interim Hospital Director

CHARITABLE MISSION

Provide market leading **care solutions** to those with **complex needs** within **marginalised** and **deprived** community settings.

VISION

To be the most **innovative** and best **quality** provider of **niche** health and social care services.

PURPOSE

Our purpose is to **make every contact count**, ensuring every **resident** and **patient** receives the best possible experience and outcome.

We focus on **teamwork** and put our **residents**, **patients**, and **people** first in everything we do. Doing the right thing for them is our top priority.

We're always looking for new and better ways to do things, staying connected with the latest and **best practices** out there. We're not afraid to be **bold** and **change** things for the better.

We love what we do, and so does our team. We bring our **true selves** to work, finding **joy** and **fun** in our tasks. We provide **care** and **clinical** services with **compassion**, making sure they meet each person's unique needs.

HMT
HEALTHCARE MANAGEMENT TRUST

Our values & behaviours

CARING

WARM - ENGAGING - HELPFUL - FRIENDLY - EMPATHETIC - COMPASSIONATE - SUPPORTIVE - KIND - CARING - APPROACHABLE

AUTHENTIC

GENUINE - TRUSTWORTHY - ETHICAL - CREDIBLE - HONEST - INCLUSIVE - RESPECTFUL - SINCERE

ACCOUNTABLE

RELIABLE - DEPENDABLE - COMMITTED - LEARN

RESOURCEFUL

WISE - CAREFUL - PRAGMATIC - PRACTICAL - COMMERCIAL

ENTERPRISING

ENERGY - ENTHUSIASM - IMPROVE - DYNAMIC - INNOVATIVE - ADAPTABLE - PROACTIVE - CREATIVE

OUR STRATEGY

2025 saw the launch of HMT's 5 strategic pillars:

Quality, Experience and Outcomes

We are committed to delivering safe and high-quality care that achieves the best possible outcomes. We focus on continuous improvement, listening to feedback, and ensuring every resident and patient has a positive and compassionate experience.

Collaboration and Commercial

We work in partnership with the NHS, commissioners, insurers, and local organisations to deliver sustainable services. By being commercially responsible, we reinvest in our people, facilities and services to support long-term growth.

Innovation and Development

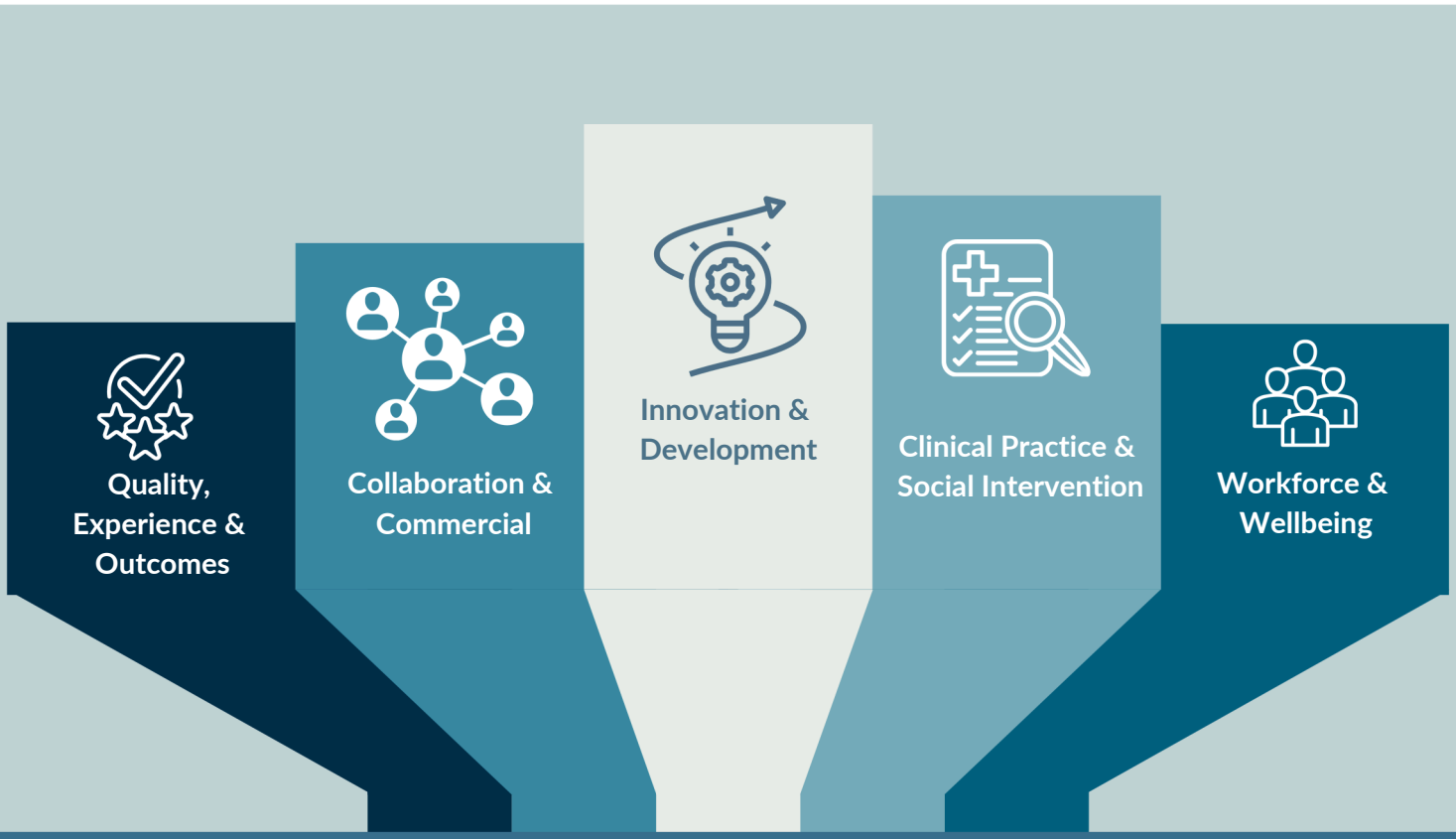
We embrace innovation to improve care delivery and efficiency. Through service development, new models of care, and the use of technology, we continuously evolve to meet changing needs.

Clinical Practice and Social Intervention

We deliver evidence-based clinical care alongside preventative and social interventions that support long-term health and wellbeing. Our approach recognises the wider factors that impact health and quality of life.

Workforce and Wellbeing

Our people are at the heart of our organisation. We invest in recruitment, development, leadership and wellbeing to build a skilled and supported workforce that can deliver excellent care.



HMT HOSPITALS & CARE HOMES

HMT operates both hospitals and care homes across England and Wales. With two private acute hospitals, one in Swansea and one in Grimsby - providing general surgery, investigations and supporting their local NHS integrated Care Boards by providing NHS surgeries to reduce waiting times.

HMT also operates four care homes, which has grown from the previous year due as a result of the acquisition of St Quentin Residential Homes Ltd in 2024.

HMT is really beginning to grow its care offering and expand services in with it provides throughout all its sites.

Compliance:

Our services are regulated by both the Care Quality Commission (CQC) and the Healthcare Inspectorate Wales (HIW).

TREATMENTS & CARE PROVIDED ACROSS HMT HOSPITALS & CARE HOMES

OPHTHALMOLOGY	ORTHOPAEDICS	GENERAL SURGERY	PLASTIC SURGERY	GYNAECOLOGY
UROLOGY	ENT	GASTROENTEROLOGY	VASCULAR SURGERY	ELDERLY CARE

QUALITY PRIORITIES IN 2025/2026

Priority 1: Improve pre-operative assessment and reduce avoidable clinical cancellations

Why: This was identified as a priority through our patient safety improvement work and review of cancelled procedures. Late identification of risks such as poorly controlled long-term conditions, smoking status, nutrition and fitness for surgery was contributing to avoidable same-day cancellations, poorer patient experience and inefficient use of theatre capacity. Strengthening pre-operative assessment supports safer care, better preparation for surgery and improved use of resources.

Actions: We introduced an earlier and more proactive pre-operative assessment pathway, beginning on the same day as the initial surgical consultation and before a procedure date is confirmed. This enabled earlier identification of patients requiring optimisation and strengthened links with community partners, including GPs, pharmacists, social prescribers and community health teams, so that patients could access timely support to improve fitness for surgery.

Outcomes: Earlier risk identification improved the quality of pre-operative planning and supported patients to optimise long-term conditions before surgery. This resulted in a marked reduction in same-day surgical cancellations, with a reduction in the region of 50%, and provided stronger assurance that patients were proceeding to surgery as safely as possible.

Impact: This work improved patient safety, reduced avoidable disruption for patients and families, and strengthened operational efficiency through better use of clinical time and theatre capacity. It also supported a more personalised and preventative approach to care by helping patients engage earlier with the support needed to prepare for treatment.

Priority 2: Improve patient experience

Why: Patient experience is a core indicator of service quality and provides important insight into communication, access, involvement in care and overall satisfaction. Feedback identified opportunities to improve how patients access information, understand what to expect, and engage with services more easily throughout their care journey.

Actions:

- Implementation of the Patient Plus portal to improve access to appointment information, test results and communication with patients.
- Use of patient feedback, including Friends and Family Test results, complaints themes and local "You Said, We Did" actions, to drive targeted service improvements.

Outcomes:

- Improved digital access and communication for patients.
- Friends and Family Test positive responses remained strong, with 98% of patients rating their experience as very good.
- Greater use of patient feedback to inform local service changes.

Impact: Improvements in patient access, communication and responsiveness helped strengthen confidence in services and supported a more informed, person-centred experience. This work also created clearer mechanisms for listening to patients and translating feedback into practical improvements.

Priority 3: Strengthen learning from qualitative safety themes and build PSIRF response capability

Why: In line with PSIRF principles, we recognised the importance of learning not only from trends visible in routine data, but also from areas where risks and improvement opportunities are often more qualitative in nature. This includes themes such as the quality of informed consent, communication, involvement in decision-making and other aspects of care that may not be fully captured through incident counts alone. At the same time, reducing same-day clinical cancellations remained a key priority because of their impact on patient safety and clinical risk, patient experience, operational efficiency and use of resources, and organisational reputation. We also identified the need to strengthen internal capability and capacity to undertake proportionate learning responses and support a sustainable PSIRF approach.

Actions: Use of PSIRF to focus improvement work on priority themes with the greatest potential for learning and impact. This included targeted work on informed consent, where we reviewed the quality of documentation and consent processes, strengthened our audit approach and introduced the BRAN (Benefits, Risks, Alternatives, and the option of doing nothing) framework to support clearer, more meaningful conversations with patients.

We also progressed work to reduce same-day clinical cancellations through earlier pre-operative assessment and medical optimisation. Alongside this, we invested in developing staff capability through PSIRF training and systems-based learning response training, helping to build internal capacity to undertake proportionate reviews, involve patients and families effectively, and translate insight into improvement.

Outcomes:

- Improved visibility of qualitative safety themes, including informed consent and patient understanding, that are not always evident in routine quantitative data.
- A more robust and meaningful approach to consent review and documentation, supporting safer and more person-centred decision-making.
- A marked reduction in same-day clinical cancellations, with associated benefits for safety, patient experience and operational efficiency.
- Increased organisational capability to undertake learning responses in line with PSIRF principles through targeted training and development.

Impact: This priority has supported a broader and more mature approach to patient safety improvement by ensuring that learning is informed by both qualitative insight and measurable data. It has strengthened informed consent practice, reduced avoidable same-day cancellations, and improved the organisation's ability to carry out proportionate, learning-focused responses under PSIRF. Collectively, this has enhanced patient safety, experience and confidence, while also improving resource use and supporting the organisation's reputation for safe, high-quality care.

QUALITY PRIORITIES IN 2026/2027

Priority 1: Enhance clinical audit programme

Why this is a priority:

Enhancing clinical audit is a key priority for 2026/27 because it plays a central role in improving patient safety, care quality and organisational accountability.

A robust and systematic audit process enables the early identification of gaps between current practice and established standards, ensuring that care delivery remains evidence-based and consistent.

Strengthening clinical audit also supports better data collection and analysis, allowing teams to make informed decisions, track improvements over time and respond proactively to emerging risks.

In addition, it promotes a culture of continuous learning and transparency, engaging multidisciplinary teams in reflective practice and shared responsibility for outcomes.

As regulatory expectations and patient complexity continue to grow, investing in effective clinical audit processes will be essential to drive measurable improvements, demonstrate compliance, and ultimately enhance patient experience and outcomes.

How will we know we are successful?

We will know the clinical audit programme has been successfully enhanced when audits are delivered in line with a clearly defined annual plan, with high levels of completion and timely reporting.

Audit findings will consistently identify actionable insights, with evidence that recommendations are implemented and lead to measurable improvements in practice. Re-audit activity will demonstrate sustained change and reduced gaps between current practice and established standards.

There will be increased engagement from multidisciplinary teams, with clinical audit embedded as a routine part of governance and quality improvement processes.

Improved data quality and more effective use of audit results in decision-making forums will further indicate progress.

Additionally, external reviews, inspections, and internal assurance processes will reflect strong compliance and a proactive approach to quality and safety, ultimately contributing to improved patient outcomes and experience.

Priority 2: Enhancing outcomes analysis and measurement

Why this is a priority:

Strengthening outcomes analysis and measurement is a key priority for 2026/27 to ensure that care delivery leads to meaningful, measurable improvements for patients. By enhancing how data is collected, validated, and interpreted, the organisation can better understand clinical effectiveness, identify variation in outcomes and target areas for improvement.

A more sophisticated approach to measurement enables benchmarking against best practice and supports evidence-based decision-making at all levels. It also allows for more transparent reporting of performance, helping to demonstrate value, improve accountability, and guide resource allocation.

Ultimately, improving outcomes analysis ensures that quality initiatives are driven by real impact, leading to safer, more effective, and patient-centred care.

How will we know we are successful?

Success will be demonstrated through the availability of high-quality, reliable data that is consistently used to inform decision-making at all levels. We will see clear evidence of improved clinical outcomes over time, supported by regular reporting and benchmarking against national and local standards. Variations in practice will be identified and reduced, with targeted improvement actions leading to measurable change.

Increased staff engagement with data, along with routine use of dashboards and outcome metrics in governance meetings, will further indicate progress.

Ultimately, success will be reflected in demonstrable improvements in patient safety, effectiveness of care, and overall performance indicators.

Priority 3: Policy Management

Why this is a priority:

Enhancing policy management is a priority to ensure that all clinical and operational practices are underpinned by clear, up-to-date and accessible guidance.

Effective policy management supports consistency in decision-making, reduces risk, and ensures compliance with regulatory and professional standards. By streamlining the development, review and dissemination of policies, the organisation can ensure that staff are working to current best practice and are aware of their responsibilities.

Improved governance processes also enable timely updates in response to new evidence, legislation, or internal learning. Strengthening policy management will foster greater accountability, support staff confidence and contribute to a safer and well-governed care environment.

How will we know we are successful?

We will know policy management has improved when all policies are current, easily accessible and consistently followed in practice. Compliance rates with policy review cycles will increase, and there will be clear evidence that staff are aware of and understand relevant policies.

Audit findings and incident reviews will show reduced variability in practice and fewer issues linked to outdated or unclear guidance.

Additionally, streamlined processes for policy development and approval will result in more timely updates in response to new evidence or regulatory changes. Staff feedback indicating confidence in accessing and applying policies will further demonstrate success.

Priority 4: Patient Experience

Why this is a priority:

Improving patient experience remains a fundamental priority, as it provides critical insight into the quality and effectiveness of care from the patient's perspective. By systematically capturing and analysing feedback, the organisation can identify strengths and areas for improvement in communication, access and overall care delivery.

Strong focus on patient experience supports person-centred approaches, ensuring that services are responsive to individual needs and preferences. It also enhances engagement, trust and satisfaction, which are closely linked to better clinical outcomes.

Continuing to prioritise patient experience will help to embed a culture of compassion, respect and continuous improvement, ensuring that care is not only clinically effective but also positively experienced by those who receive it.

How will we know we are successful?

Success in improving patient experience will be evident through improved patient feedback, including higher satisfaction scores and more positive qualitative comments.

There will be increased response rates to surveys and engagement initiatives, indicating that patients feel their voices are valued. Themes identified from feedback will show measurable improvements over time, particularly in key areas such as communication, dignity and involvement in care decisions.

Complaints and concerns will decrease or demonstrate faster, more effective resolution. Ultimately, success will be reflected in a consistently positive patient journey, where individuals feel heard, respected, and well cared for.

STATEMENTS OF ASSURANCE

3.1 Review of Services

St Hugh's Hospital is part of The Healthcare Management Trust Group and serves the population of North-east Lincolnshire and surrounding areas such as Hull, Goole, Yorkshire, Grimsby and further afield.

The onsite facilities include one ward consisting of 24 single rooms and one double room, two laminar flow theatres and eight consulting rooms. The hospital's other clinical departments include a physiotherapy department, a radiology department with ultrasound and x-ray. The hospital provides surgery and outpatients with diagnostic imaging services.

The hospital provides services to privately insured patients, self-funding individuals and NHS patients who exercise choice through the e- referral system. Staff offer care to adults over 18, covering the full pathway from outpatient consultation and diagnostic imaging into surgical treatment and recovery.

St Hugh's Hospital provides the following services:

- Cosmetics
- Ear, Nose and Throat
- Gastroenterology
- General surgery
- Gynaecology
- Ophthalmology
- Orthopaedics
- Physiotherapy
- Pain Management
- Urology
- Cardiology
- Diagnostics
- Menopause Clinic
- Uro-Gynae Nurse Led Clinic

Following a comprehensive review of operational performance and financial sustainability, the Board took the difficult decision in 2025 to close the endoscopy department at St Hugh's Hospital. The service closed in June 2025.

Despite efforts to optimise utilisation and manage costs, the service was not achieving the level of activity required to be commercially viable. The decision reflected a continued focus on allocating resources to areas of the organisation that deliver sustainable returns and align with HMT Group's strategic priorities. The Board recognises the impact of this decision on patients, staff and stakeholders and appropriate measures through close working with partner stakeholders have been implemented to ensure continuity of care through alternative provision and support offered to affected employees during the transition.

3.2 Registration with the Care Quality Commission

St Hugh's Hospital is registered with the Care Quality Commission (CQC) to carry out the regulated activities of Treatment of disease, disorder or injury, Surgical procedures and Diagnostic and screening procedures to adults.

During the reporting period, the hospital underwent a comprehensive inspection by the Care Quality Commission, which included diagnostic imaging, outpatients, and surgical services. The outcome of this inspection, moving from an overall rating of "Requires Improvement", with a rating of "Inadequate" in the Well-led domain, to a "Good" rating across all key domains, represents an exceptional and transformative milestone for the organisation. This remarkable progression reflects an unwavering commitment to quality, patient safety and strong, values-driven leadership at every level.

The improvement in the Well-led domain is particularly significant, demonstrating a fundamental strengthening of governance, culture and strategic oversight, which has driven and sustained improvements across all areas of the hospital. This achievement is the result of determined, coordinated effort from staff, leaders and stakeholders, who have worked collaboratively to embed robust systems, enhance accountability, and foster a culture of openness and continuous improvement.

Achieving a "Good" rating in all domains is a powerful endorsement of the quality of care provided and a testament to the dedication, professionalism, and resilience of the entire workforce. It provides clear assurance that patients are receiving consistently safe, effective, caring, responsive and well-led services. This outstanding accomplishment marks a defining moment in the organisation's journey, demonstrating not only how far it has come but also establishing a strong and sustainable foundation for continued excellence.

The report has provided St Hugh's with the opportunity to further strengthen clinical governance, patient safety, operational oversight, and workforce development across the organisation.

The assessment also highlighted several areas where improvement activity has already commenced, demonstrating a proactive and responsive approach from operational and clinical leaders.

Key areas of focus include enhancing governance assurance processes, improving training compliance and documentation standards, strengthening escalation and patient safety systems, and further developing staff competencies and leadership capability. Positive progress has already been made through the commencement of competency workbook development within OPD (Out-patient Department) services, initiation of business case planning for additional radiology reporting support, implementation of staff briefing schedules, and delivery of targeted CPD (Continuous Professional Development) sessions.

Additional actions are being progressed to improve patient experience and operational effectiveness, including enhanced monitoring of outpatient waiting times, strengthened housekeeping and environmental oversight, improved use of interpreting services, and clearer escalation pathways for clinical concerns. Audit and monitoring processes are also being expanded to provide greater assurance around record keeping, NEWS2 (National Early Warning Score 2) compliance, diabetes management, and mandatory training completion.

St Hugh's Hospital remains committed to continuous improvement and has developed a structured action plan with clear accountability, measurable outcomes, and defined review processes. Progress will continue to be monitored through governance meetings, audit activity, and performance reporting to ensure improvements are embedded and sustained over time.

CQC REPORT FEEDBACK

"Staff involved service users when assessing their needs. They reviewed assessments, taking account of people's communication, personal and health needs. Care was based on latest evidence and good practice."

Feedback on diagnostic imaging department from CQC as part of CQC inspection in December 2025

"We spoke to ten outpatients and their relatives. All were very postive and complimentary about the service."

Feedback from patients on outpatient department to CQC as part of CQC inspection in December 2025

"Patients we spoke to were very postiive about their experience, they felt safe and cared for. The service was repsonsive and patients felt their needs were well met. They were given pain relief and told us the staff were excellent."

Feedback from patients on surgery department to CQC as part of CQC inspection in December 2025

"People were treated with kindness and compasion. They treated people as individuals and supported preferences. Staff were welcoming and appraoched people in a caring way."

Feedback on diagnostic imaging department from CQC as part of CQC inspection in December 2025

Appointment of Ellen Colley as Interim Hospital Director:

During the reporting period, there was a change in Hospital Director leadership, with the role being assumed by an existing senior clinical lead from within St Hugh's Hospital. This transition has provided continuity and stability, as the new Interim Hospital Director brings an in-depth understanding of the hospital's services, culture and operational processes. Their prior experience within the organisation has ensured that there has been no loss of organisational knowledge, enabling a seamless handover and sustained focus on quality, safety and performance. The appointment also provides clinical leadership at a director level, supporting informed decision-making and reinforcing the organisation's commitment to delivering high standards of patient care.

3.3 Quality Governance

We have a robust Quality Governance Framework in place to ensure consistent delivery of safe, effective, and high-quality care across the hospital. This framework provides a clear and structured approach to quality governance, with defined roles and responsibilities at all levels of the organisation, from frontline clinical teams through to senior leadership and the Board. It enables effective oversight, accountability and assurance that quality and patient safety remain central to all activities. Our Quality Governance Framework was reviewed and updated during 2025/26.

A key strength of our framework is our well-established quality governance meeting structure, which ensures that information flows effectively from ward to Board. Issues identified at ward and departmental level are escalated through a series of formal governance forums, allowing for timely review, discussion, and action at the appropriate level. This structured approach ensures that risks, incidents, audit findings and patient feedback are visible, scrutinised, and addressed, while also enabling strategic oversight and assurance at Board level.

This governance structure is supported by strong central leadership, including dedicated roles such as the Head of Patient Safety and Improvement and the Head of Clinical Practice and Nursing. These roles provide expert oversight, coordination, and consistency across the organisation, ensuring that quality and safety priorities are aligned, best practice is shared, and improvement initiatives are effectively implemented.

Risk management is a core component of our quality framework. We have robust systems in place for the identification, assessment and management of risks at all levels of the organisation. Risks are recorded on local and corporate risk registers, regularly reviewed and escalated through the governance structure as appropriate. This ensures that significant risks are clearly understood, mitigated effectively, and monitored over time.

Our incident reporting and investigation processes further support this by enabling timely identification of safety concerns, thorough investigation of incidents and the implementation of actions to prevent recurrence.

Learning from incidents and risks is actively shared across teams to promote continuous improvement and strengthen patient safety.

Our framework also includes a clinical audit programme, supported by well-established risk management systems and a strong incident reporting and investigation process. These systems enable us to identify, assess, and respond to risks in a timely manner, while embedding learning from incidents and sharing good practice across teams.

We utilise a range of quality indicators, which are regularly reviewed through governance meetings to monitor trends, measure performance, and drive continuous improvement.

Patient experience is a key component of our quality framework. We actively seek and analyse feedback through surveys, complaints and engagement initiatives, using these insights to inform service improvements and enhance the patient journey. Alongside this, we prioritise staff engagement and development, fostering a culture of openness, learning and shared responsibility for quality outcomes.

Together, these elements ensure that our quality framework is dynamic, responsive and focused on continuous improvement, providing assurance to patients, regulators and stakeholders that high standards of care are consistently delivered.

3.4 Sub-contracting and Partnership working

Working with the NHS

We recognise the continued and significant opportunity for independent healthcare providers to support the NHS in delivering its core priorities and the NHS England 10-year plan, particularly in reducing elective waiting times and expanding patient choice. National policy and partnership agreements between the NHS and the Independent Healthcare Providers Network emphasise the important role of the independent sector in providing additional capacity, with the potential to deliver millions of additional appointments and procedures to help address backlog pressures.

However, despite this clear opportunity and proven capability, NHS funded activity levels within our organisation have reduced over the past year, reflecting a wider trend reported across the sector. This reduction in referrals and commissioned activity appears to be influenced by financial and commissioning constraints within local systems, with some areas slowing or limiting the use of independent sector capacity despite ongoing demand for elective care.

We remain committed to working in partnership with NHS organisations to ensure available capacity is fully utilised in support of patients and to responding flexibly to future commissioning intentions as system priorities evolve.

Visit from Martin Vickers, MP

Martin Vickers, Conservative Party Member of Parliament for Brigg and Immingham, recently visited St Hugh's Hospital, marking his first visit to the local Grimsby hospital in seven years. During his visit, he was given a tour of our not-for-profit private hospital to see first-hand, the developments and advancements that have taken place since his last visit.

Mr Vickers expressed keen interest in the improvements made to the hospital, including enhancements in patient care and technology. St Hugh's Hospital also delivers a variety of NHS treatments to support local hospitals in reducing their patient waiting lists. The visit provided an opportunity for discussions on local healthcare, as well as the challenges currently facing health and social care sectors.

Speaking about the visit, Martin Vickers said: "It is great to be back at St Hugh's Hospital and see how the facility has developed over the years."
The visit highlighted the importance of continued collaboration between government representatives and healthcare providers to ensure the best possible outcomes for patients in the region.

Primary Care and Community Integration

Our collaboration with Peaks Lane Private Care Network and Roxton GP Practice at the Peaks Lane Campus represents a joint strategic commitment to integrated care delivery. This model brings together primary care community services and hospital provision, to support smoother patient pathways and improved care for the local community.

With closer partnership working, we aim to support preventative approaches and increase access to care for local populations in Grimsby.This campus-based approach aims to also strengthen relationships with local clinicians and communities, reinforcing our role as a trusted local healthcare provider.

Frailty Sector Network

St Hugh's Hospital also continues to play an active role within the North East Lincolnshire (NEL) Frailty Sector Network, supporting wider system collaboration and integrated redevelopment across the region. Since the launch of the NEL Frailty Sector Network in 2024, significant progress has been made across the frailty agenda, including the commissioning of the NEL PCN (Primary Care Network) Frailty Service through to March 2027 and the launch of the Humber and North Yorkshire ICB Frailty Strategy 2026–2031.

Partnership working across the sector has strengthened through the development of aligned frailty meetings and networks, refreshed priorities within the Frailty Oversight Group, and the establishment of the HCP (Healthcare Professional) Design Group in September 2025, which supported agreement around more integrated models of care. Collaborative system mapping work has also been undertaken to identify opportunities to improve real-time data sharing and reduce barriers across services.

Frailty priorities are additionally being aligned with the Neighbourhood Health Framework published in March 2026, demonstrating the organisation's ongoing commitment to proactive, person-centred care and stronger partnership working for people living with or at risk of frailty.

The Safeguarding Training Forum St Hugh's Hospital attend the quarterly Safeguarding Training Forum which brings together safeguarding leads from provider organisations across the sector to review current safeguarding training provision, share examples of good practice, and explore opportunities for greater collaboration across health and social care services.

The forum provides a valuable opportunity for organisations to showcase their existing training approaches, including blended learning models, face-to-face training, virtual delivery methods, newsletters, and innovative workbook and video-based resources.

Discussions focus on the importance of achieving greater consistency in safeguarding training standards, improving access to multi-agency learning opportunities, and ensuring training has a measurable impact on practice. Attendees also explore the potential development of a shared safeguarding training resource and a wider training passport that could support staff working across organisations.

This forum highlights a strong collective commitment to partnership working and continuous improvement, with agreement on the need for an overarching safeguarding training strategy to support future workforce development, compliance, and integrated learning across the sector. Follow-up actions are agreed to support ongoing collaboration and the development of shared training resources and strategic priorities.

QUALITY PERFORMANCE

4.1 Patient Safety

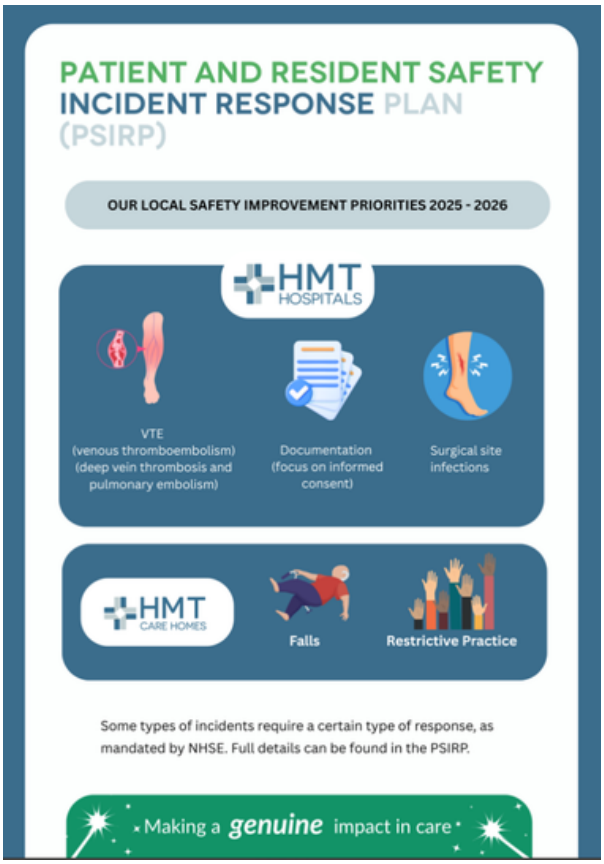
During 2025/26, we continued to make strong progress in implementing the Patient Safety Incident Response Framework (PSIRF), strengthening our approach to learning from patient safety incidents and improving the quality of care we provide.

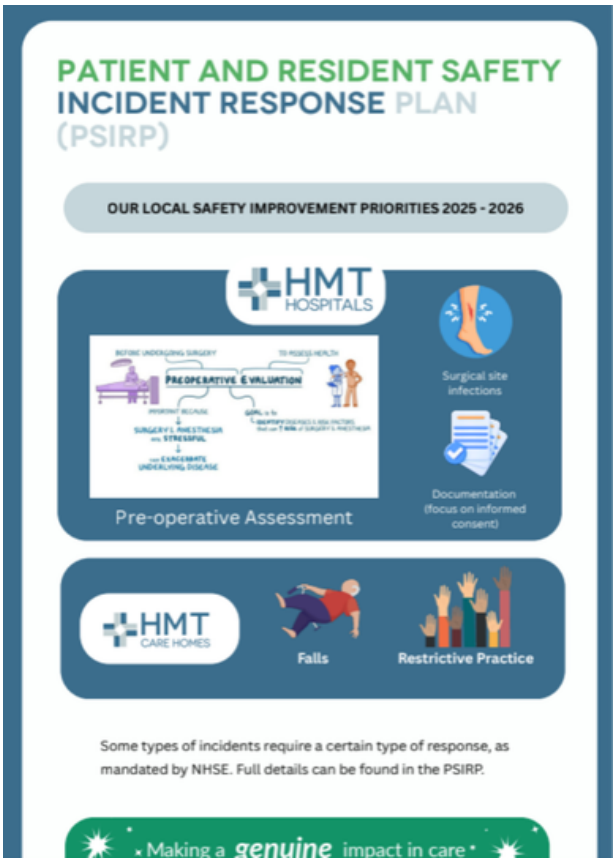
PSIRF represents a significant shift from traditional investigation-focused models to a more flexible, proportionate, and learning-centred approach. Our implementation has focused on embedding these principles across the organisation, ensuring that responses to patient safety incidents are driven by insight, compassion and improvement rather than process alone.

Key achievements in 2025/26 include:

The further development of our Patient Safety Incident Response Plan (PSIRP), which clearly sets out how we prioritise and respond to patient/resident safety incidents based on risk and learning potential and the areas prioritised for quality improvement. Insights are both quantitative and qualitative in nature, and include feedback from our stakeholders . This has supported more consistent and timely decision-making, while ensuring that resources are focused where they will have the greatest impact on safety. The PSIRP is a live document that continually evolves, meaning that as we head into 2026-27, some of our priorities have refreshed.

2025-2026 Priorities





We have invested in building capability and confidence across teams through targeted training and engagement, supporting staff to understand PSIRF principles rooted in Human Factors and Restorative Practice.

This included providing systems-based investigation and involvement training to senior hospital staff, resulting in promotion of a fair and learning culture, encouraging open reporting and constructive reflection on safety events. This was delivered by our in-house Patient Safety Specialist, who is qualified to Level 3/4 of the Patient Safety Syllabus.

Following the successful implementation of the Ulysses incident reporting and risk management system in 2024, significant progress has been made in building on its development and functionality.

Throughout the year, we focused on refining the system to better reflect operational needs and to strengthen our ability to learn from incidents, near misses, and patient safety concerns. Key developments included a comprehensive review and update of reporting categories, ensuring they are clear, consistent, and aligned with national guidance and local priorities. These improvements have enhanced the quality and accuracy of data captured, enabling more meaningful analysis and learning.

We also improved the way in which we capture and oversee Duty of Candour statutory notifications, with the support of the Ulysses team in building a weekly report, as well as making changes to the way in which the system captures data, to ensure it is accurate and reliable, promoting compliance with our regulatory obligations.

We also invested in improving dashboards to provide clearer, more accessible insight for teams at all levels of the organisation. Enhanced dashboards now offer real-time visibility of trends, themes, and areas of risk, supporting timely decision-making and targeted improvement actions. Managers and clinical leaders are better equipped to identify emerging issues, monitor performance, and track the impact of safety interventions.

As staff confidence in using the system has grown, reporting has become more consistent and purposeful, reinforcing a positive culture of openness and learning. Ulysses is increasingly being used not only as a reporting tool, but as a platform to support continuous improvement, quality assurance, and governance across the organisation.

This ongoing development of the Ulysses system demonstrates our commitment to strengthening safety intelligence, learning from experience, and embedding a system-wide approach to improving care quality and outcomes for the people we support.

We introduced a structured approach to learning from good care events, recognising that understanding what works well is just as important as learning from when things go wrong (also known as Safety II). By capturing and exploring examples of excellent care, we are strengthening a positive safety culture and reinforcing the behaviours, systems, and practices that lead to the best outcomes for people who use our services.

Central to this approach is the use of Appreciative Inquiry, a methodology that focuses on identifying strengths, enabling factors, and successful practice. Rather than concentrating solely on deficits, Appreciative Inquiry allows teams to reflect on what enabled good care to happen and how these conditions can be replicated more consistently across services.

Good care events are now being reported and reviewed through our governance and learning structures, providing valuable insight into effective teamwork, communication, leadership, and compassionate care. Learning from these events is shared across teams, helping to spread good practice and inspire improvement.

Early feedback from staff has been positive, with many reporting that this approach feels empowering and supportive, contributing to greater engagement and openness. By valuing excellence and recognising staff contributions, we are fostering a culture where learning is continuous, balanced, and focused on improvement.

As this work continues to develop, our aim is to embed learning from good care events alongside patient safety incident learning, ensuring a holistic approach to quality and safety that supports staff, enhances patient and resident experience, and drives sustained improvement.

Example Good Care Event

'A p*atient came into hospital for a procedure who was on methadone. Head of Clinical Services spoke to the team including the patient's pharmacist, Reisdent Doctor and consultant to ensure that the patient was well managed with her pain and in line with her recovery. This showed a real patient centred approach to the care she provides and makes a huge difference to the patient in terms of short and long term recovery.*'

We introduced the CUSS tool to support staff in speaking up about safety concerns in a clear, structured, and respectful way. CUSS, which stands for Concern, Uncomfortable, Unsafe, Stop, provides a shared language that empowers individuals at all levels to escalate risks and challenge unsafe situations as they occur, with confidence. By embedding the CUSS tool into training and everyday practice, we strengthened psychological safety, improving communication within teams, and reinforcing our commitment to preventing harm through early intervention and open dialogue. We have already seen positive examples of the CUSS tool being used in practice, with staff confidently raising concerns and supporting timely action to maintain patient safety.

C.U.S.S

Our Shared Language of Safety

Safety is everybody's responsibility, and speaking up is always the right thing to do!

HMT
HEALTHCARE MANAGEMENT TRUST

Progress was also made in improving the quality of incident data and learning, supported by enhanced reporting systems and governance structures. Learning from incidents is increasingly shared through structured feedback loops, safety briefings, and quality forums, ensuring that insights lead to tangible improvements in practice.

Compassionate engagement with patients, families, and carers has been central to our approach. We have strengthened processes to ensure people affected by patient safety incidents are listened to, supported and meaningfully involved in the response, in line with the PSIRF Involvement principles of fairness, openness and the Duty of Candour. We have worked with our HR colleagues to implement the NHSE Being Fair Tool, also as well as adapted national PSII support resources for both staff and service users for use in the independent sector to ensure everyone understands what to expect from the Patient Safety Incident Investigation (PSII) process and how they can be involved. A staff questionnaire has been developed to ensure we are continually adapting and learning from staff experience of being involved in a PSII, promoting psychological safety and a trauma-informed approach.

During the reporting period, we were pleased to appoint and welcome a new Patient Safety and Experience Partner as part of our continued alignment with the Patient Safety Incident Response Framework (PSIRF) National Patient Safety Strategy. This role will strengthen the involvement of patients and families in how we understand, learn from and respond to patient safety incidents. By embedding lived experience at the heart of our safety processes, the Patient Safety and Experience Partner will contribute to more open, compassionate and transparent engagement with patients, ensuring their voices meaningfully inform investigations and improvement work. We anticipate that this will enhance the quality of our learning responses, support a more person-centred approach to care and foster a stronger culture of trust, safety and continuous improvement across the organisation.

Patient Safety and Experience Partner

We are pleased to welcome Michelle Webb as our new Patient Safety and Experience Partner to St Hugh's Hospital. This role represents an important step in strengthening patient involvement in our quality and safety agenda and ensuring that the voices of patients, families, and carers are central to service improvement.

The Patient Safety and Experience Partner will work collaboratively with staff, patients, and stakeholders to promote a culture of openness, learning, and continuous improvement. Through engagement activities, participation in quality improvement initiatives, and review of patient feedback and safety concerns, they will help ensure that patient experiences inform decision-making and service development.

Michelle brings extensive senior clinical and leadership experience, underpinned by a registered nursing career that spans acute, community and charitable settings across Lincolnshire. She brings a strong commitment to safe, personalised and evidence-based care, with a clear focus on ensuring that the patient voice informs leadership decisions and service improvement. Her experience also includes developing patient safety information, practical guidance and accessible materials for patients and families, with a strong emphasis on clarity, inclusion and supporting understanding beyond professional audiences. She offers a credible and compassionate voice for patients and staff, bringing integrity, inclusivity and practical experience to support continuous improvement in quality, safety and experience.

The introduction of this role further demonstrates our commitment to delivering safe, compassionate, and person-centred care. We look forward to the valuable contribution they will make in supporting our quality priorities and enhancing the experiences and outcomes of those who use our services.

The role of our Patient Safety and Experience Partner

- Talking with patients and staff about safety, experience and what matters to them
- Helping us understand what we do well and how we can do this more of the time
- Helping to develop patient safety information resources
- Acting as the patient voice on improvement projects
- Supporting some of the patient safety training of staff
- Networking meetings with healthcare partners
- Meetings with executive team members and senior managers to check and challenge.
- Joining interview panels for staff patient safety and experience roles

Case study: Medical optimisation, reducing clinical cancellations and health inequalities

In previous years, a proportion of planned operations were cancelled on the day of surgery because patients were not sufficiently fit to proceed safely. Conditions such as poorly controlled diabetes, hypertension, and smoking-related complications can significantly increase surgical risk. When these issues are identified late in the pathway, it not only compromises patient safety but also negatively affects patient experience and the effective use of clinical time and resources.

In response to this, as part of the development of our PSIRP, we introduced a more proactive approach to pre-operative assessment in 2025. Pre-assessment now begins on the same day as the initial surgical consultation and before a date for surgery is confirmed. This enables earlier identification of health risks and provides patients with timely support to optimise their fitness, nutrition, and long-term conditions ahead of their procedure.

By preparing patients to be in the best possible health, this approach reduces the likelihood of same-day cancellations and lowers the risk of complications during surgery and recovery. It reflects our belief that safe, high-quality care begins well before a patient enters the operating theatre.

A key element of this work has been closer collaboration with local partners, including GPs, community pharmacies, social prescribers, and community health teams. These partnerships make it easier for patients to access the right support early, closer to home.

Through initiatives such as Thrive, Community Health and Wellbeing at Centre4, patients aged 18 to 75 living with long-term conditions, including asthma, diabetes, COPD, hypertension, and epilepsy, can access tailored advice and practical support. By working collaboratively across our local health system, we are helping to reduce health inequalities and improve access to preventative care within our community.

Health optimisation is not only about reducing clinical risk; it is also about empowering patients. Supporting people to prepare for surgery improves confidence, enhances recovery, and enables individuals to take a more active role in their own care.

The impact of this initiative has already been significant, with a marked reduction in same-day surgical cancellations. This has resulted in the first of our first safety improvement priority from our Patient Safety Response Plan (PSIRP) to achieve its aims and sustain improvement and allowing us to update the plan to remove it as a focus.

Sarah Grantham, Head of Outpatients and Cosmetic Lead said, “Safer care begins long before a patient enters the theatre. By working closely with our community partners, we’re helping patients to be in the best possible health for their procedures reducing risks and improving outcomes.
Every same-day cancellation avoided is a safer patient journey and a stronger use of our resources and those of the NHS. Our health optimisation programme prioritises the wellbeing of the patient.”

This work was shortlisted for the Best Provider of Outpatient Services Category at the 2026 HSJ Independent Healthcare Providers Awards, and a case study has been written by NHS England and shared nationally.

Case study: Informed Consent – BRAN

Improving the quality of documentation and record-keeping was identified as part of the development of our PSIRP, particularly in relation to informed consent, as a key patient safety priority for our organisation. Informed consent ensures that patients are fully supported to understand the benefits, risks, and alternatives associated with their treatment, including the option not to proceed, enabling them to make decisions that are right for them.

Reviewing and Strengthening Our Approach:

We undertook a comprehensive review of our existing consent audit tool. While previous audit results consistently reported 100% compliance, we challenged whether the tool was sufficiently robust and truly reflective of the principles of informed consent. This prompted a detailed review of the audit methodology to ensure it measured the quality of consent, not simply the completion of documentation.

The revised audit was informed by established legal and ethical principles, including the Montgomery ruling, which emphasises the importance of discussing material risks that are significant to individual patients. We also considered key recommendations from the Paterson Inquiry, including:

- Writing directly to patients in clear, accessible language, with GPs copied in for information
- Ensuring patients are given adequate time to reflect on diagnoses and treatment options before providing consent

Following the update, audit compliance rates decreased. While this represented a change in reported performance, it provided a more accurate picture of practice and enabled targeted quality improvement work to begin.

Driving Improvement through the implementation of BRAN:

As part of a focused quality improvement workstream, we introduced the BRAN approach to support high-quality consent discussions. BRAN stands for Benefits, Risks, Alternatives, (do) Nothing and provides a simple, structured framework to guide conversations between patients, families, and healthcare professionals.

The BRAN approach encourages consideration of four key questions:

What are the benefits of this test or procedure?	Are there any alternatives?
Are there any risks or side-effects?	What would happen if I did nothing?

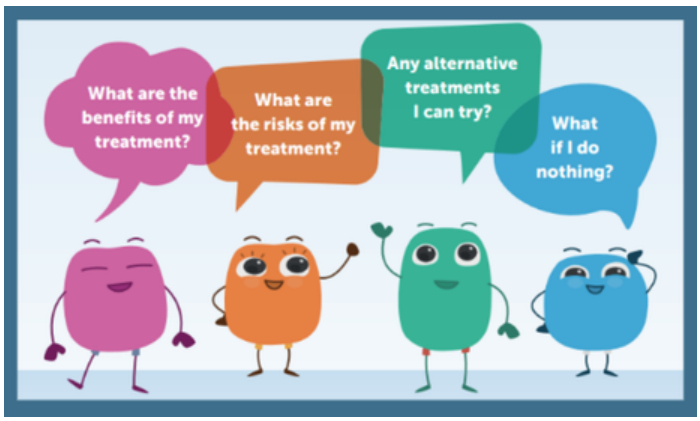
To raise awareness and empower patients, BRAN has been promoted through posters and digital displays across our hospital sites. We are also working to standardise the content and structure of clinic letters so that BRAN is embedded as best practice in written communication. This supports clearer documentation, improves patient understanding, and may contribute to a reduction in complaints and litigation related to informed consent.

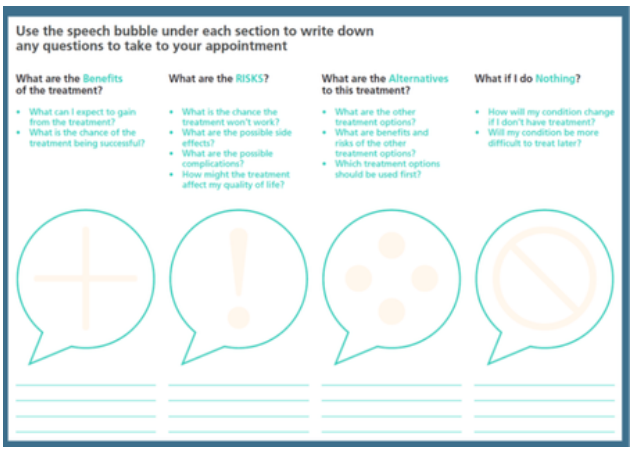
Looking Ahead:

Future developments include incorporating the BRAN framework into appointment letters, allowing patients and families to prepare questions and notes in advance, reducing the need for additional printed materials. Letters will be addressed directly to patients, with GPs copied in for information, reinforcing patient-centred communication.

We are also exploring the expansion of BRAN across our patient portal and website, supported by QR codes in appointment letters to provide easy access to further information. Recognising the diverse communication preferences of our patients, we are committed to offering information in ways that are accessible, inclusive, and responsive to individual needs.

This work demonstrates our commitment to meaningful informed consent, stronger documentation practices, and a culture that prioritises patient understanding, choice, and safety.





Patient Safety Key Performance Metrics

Number of Never Events: 1

Total Incidents (clinical and non-clinical) reported: 712

Number of PSII's completed: 1
All incidents were investigated, and learning was shared across teams.

Reduction in clinical cancellations: in the region of 50%

4.2 Clinical Effectiveness

Development of magic model

During 2025, we developed our care model to ensure it remains responsive, person-centred, and aligned with best practice. We recognise that the UK population is facing increasingly complex health and social care needs that are currently struggling to meet the standard we believe our communities deserve. This evolving crisis is due to an ageing population, rising levels of chronic conditions and increased pressure on our health and social care system. The impact of health inequalities and lifestyle factors contributes to the challenges people face in staying healthy and living in the community.

We believe that everyone has the right to direct and decide the healthcare and support that is right for them and choose where and how they want to live. We have developed integrated models of clinical and social care support to optimise health and enable people to live full lives in community settings, overcoming the challenges they face.

Our model is holistic and integrated, prioritising prevention, early intervention, and sustainable healthcare solutions, reducing the strain on statutory services and improving outcomes for customers.

The HMT MAGIC Model, which stands for 'Making a Genuine Impact on Care', is a support model designed to focus on the needs of the individual and what matters to them, ensuring that their preferences, needs and values guide clinical and care decisions. It provides a new structured approach with domains and clear principles linked to organisational values and aims is to provide quality care, support and treatment that is both respectful and responsive to individuals' needs. HMT uses the MAGIC model across various services, including hospitals, community and care homes. The individuals in HMT services include a wide range of complexities, including dementia, mental health, neurodiversity, and frailty, to name a few.

Four Domains:

The MAGIC model covers domains that are important to a person's life, assisting them to live independently and focusing on what they can do rather than what is wrong.

They include:

Domain 1: Physical Health, which delivers expert medical, nursing and therapeutic care, evidence-based, tailored to health needs, whilst supporting recovery. Proactive health promotion and coaching are key to our approach.

Domain 2: Independence, where individuals can retain choice, self-care and meaningful engagement over their lives.

Domain 3: Environment that is thoughtfully designed with spaces that promote safety, comfort and connection. Where care and treatment are delivered to enhance wellbeing, recovery and independence

Domain 4: Well-being is integral to the model in the delivery of holistic care that nurtures emotional, psychological, spiritual and social health

Core Principles and Values Based:
The MAGIC model is built on the idea that 'Making a Genuine in Care' has been developed in alignment with our organisational core values. We believe that HMT's strength comes from our people, patients, residents' families, colleagues and partners bringing a collective energy which has been channelled into our approach. It captures the 'Magic of our People and the Power of our Care', which is our new brand identifier.

This includes:
Creativity in HMT encourages fresh thinking about the possibilities of novel technologies, implementing the latest therapeutic solutions, being part of creating meaningful moments of joy or exceeding people's expectations

Collaboration in HMT means facilitating and promoting full inclusion and participation for everyone who uses our services. Our teams also bridge disciplines to create a well-coordinated, unified approach, achieving more integrated clinical and care outcomes.

Compassion in HMT begins by acknowledging individual experiences, recognising that behaviour and symptoms often reflect deeper emotional needs. Our approach is to humanise care through kindness, respect and understanding, which fosters trust and improves engagement.

Values-based Practice in HMT ensures that care and treatment is fair, inclusive and guided by respect for individuals' autonomy, rights, culture and beliefs. We recognise that some people using services, because of their needs or circumstances, require additional help and support to achieve the best possible outcome.

MAGIC - Making A Genuine Impact in Care - is more than a framework. It represents the magic in our clinical and care practice, rooted in compassion, co-production, and clarity. It captures the Magic of Our People and the Power of Our Care, and with it, we are shaping a future where care is not only delivered but deeply felt.

As communities grow and face more complex health challenges, the need for a bold, holistic, and integrated response has never been more urgent. The MAGIC model gives us a clear, confident voice.

In 2026, we will continue to embed and refine the care model, strengthening evaluation, supporting staff development, and working collaboratively with partners to meet future demand and improve the lives of those we support.

Development of resusitation and deterioration group

In 2025, we established a Resuscitation and Deterioration Group to strengthen oversight, coordination, and improvement of practice across health and social care services. The Group was created in recognition of the importance of early identification of clinical deterioration and consistent, high-quality resuscitation practice in safeguarding patient and resident outcomes.

The Group provides a multidisciplinary forum, bringing together clinical leaders, care professionals, educators, and governance representatives. This collaborative approach supports shared learning, consistent standards, and joined-up decision-making across different care settings.

Key objectives of the Group include:

- improving the recognition and management of clinical deterioration
- providing oversight of resuscitation policies, training, and compliance
- supporting consistent use of escalation processes and decision-making
- reviewing incidents, audits, and learning related to deterioration and resuscitation

Since its establishment, the Group has overseen a review of existing practices and guidance, identifying areas for improvement and standardisation. This has included strengthening escalation pathways, improving clarity around roles and responsibilities, and promoting the use of evidence-based tools to support early recognition of deterioration.

Education and training have been a central focus, with the Group supporting access to appropriate resuscitation and deterioration training for staff across health and social care settings. This ensures staff are confident, competent, and supported to respond effectively in emergency situations while respecting individual care plans and advance decisions.

The establishment of the Resuscitation and Deterioration Group represents a significant step in strengthening patient safety and quality of care. In the coming year, the Group will continue to embed improvements, expand data-driven oversight, and support continuous learning across services.

> “Working together across services has helped us build a stronger approach to recognising and responding to deterioration, ensuring people receive the right care at the right time.”
>
> **Mags Guest, Head of Learning and Development at The Healthcare Management Trust**

Appointment of Kelly Chequer as head of Nursing and Clinical Practice

2025 marked an important milestone with the appointment of a new Head of Nursing and Clinical Practice, Kelly Chequer. The creation and appointment to this role reflects our continued commitment to strong clinical leadership, professional excellence, and the delivery of high-quality, safe, and effective care.

The Head of Nursing and Clinical Practice provides strategic leadership across nursing and clinical disciplines, with a focus on strengthening standards of care, supporting professional development, and ensuring evidence-based practice is embedded across services. The role plays a key part in aligning clinical practice with organisational priorities, regulatory requirements, and national best practice.

Since their appointment, the Head of Nursing and Clinical Practice has focused on enhancing clinical governance, supporting workforce development, and promoting consistent, high-quality care delivery. This includes oversight of clinical standards, education and training, clinical audit, and the translation of learning from incidents, feedback, and reviews into practice improvement.

The role also strengthens professional leadership and visibility, supporting nurses and clinical staff to deliver compassionate, person-centred care. By working closely with multidisciplinary teams, the Head of Nursing and Clinical Practice helps ensure collaboration, shared accountability, and continuous improvement across services.

The appointment reinforces our commitment to investing in leadership capacity and building a culture that values learning, safety, and excellence in clinical practice. Looking ahead, the Head of Nursing and Clinical Practice will play a central role in advancing quality improvement, supporting innovation, and improving outcomes and experiences for patients and residents.

> “I am incredibly proud to be joining HMT. Nursing and clinical practice sit at the heart of compassionate, safe, and high-quality care, and I look forward to working alongside dedicated colleagues to strengthen our practice, support our workforce and improve outcomes for the people and communities we serve.”
>
> **Kelly Chequer, Head of Nursing and Clinical Practice**

Clinical Audits

A clinical audit programme is in place across the organisation, forming a key component of our quality framework and supporting the delivery of safe, evidence-based care.

Clinical audits are undertaken across services to assess compliance with agreed standards and to identify opportunities for improvement. Audit findings are reported through our established governance structure, ensuring that results are reviewed at the appropriate level and that any areas of non-compliance are addressed through clear, time-bound action plans. Progress against these actions is monitored, and re-audit activity is undertaken to demonstrate sustained improvement and embed changes in practice.

The clinical audit programme is supported by central oversight, including input from senior clinical and quality leadership, ensuring consistency, methodological rigour and alignment with wider quality and patient safety objectives. Audit outcomes are triangulated with other sources of information, including incidents, complaints, and risk data, to provide a comprehensive view of quality and to inform organisational learning.

We are assured that completed audits demonstrate good to strong compliance across priority patient safety domains. Where audits were undertaken, results consistently indicate safe, effective and person-centred clinical practice.

Development and implementation of new pain assessment tool and audit

In 2025 SHH introduced a new pain assessment tool based on the Wessex Pain Scale. This tool supports consistent assessment and reassessment of patients pain in alignment with the WHO analgesic ladder. By capturing each reassessment following analgesia administration, the tool ensures that pain management decisions are evidence based and responsive to the patient's needs, ultimately improving the quality of care delivered.

Alongside this SHH implemented a monthly pain scale audit. This audit provides regular assurance regarding patient outcomes, compliance and pain assessment standards and the overall effectiveness of pain management practices.

NHS Venous Thromboembolism Risk Assessment Data

Submission to the NHS Venous Thromboembolism Risk Assessment Data Collection for this reporting period revealed an average score of 97.6% compliance.

Fall Thematic Review

A thematic review of falls was undertaken in 2026. This examined 8 inpatient falls over a 6-month period, excluding three incidents that did not meet the NICE (National Institute for Health and Care) inpatient fall definition. Data was extracted from incident reports, clinical documentation and post fall assessments. Each case was evaluated against 13 predefined safety and compliant indicators including, falls risk status, anticoagulation, anaesthetic type, wittiness status, neurological monitoring and escalation to nursing staff. The review benchmarked practice against NICE post-fall assessment standards and internal policies using both quantitively coding and qualitive thematic analysis to identify patterns such as unwitnessed falls, gaps in documentation, inconsistent escalation and postoperative vulnerability following joint replacement surgery. All data was anonymised and although the small sample size limited generalisability the review provided a structured evaluation of current falls management and highlighted areas requiring improvement in m monitoring, communication and adherence to the fall's pathway.

Audit Key Performance Summary (2025–26)

During 2025–26, the hospital delivered a comprehensive programme of clinical, safety, and operational audits. Analysis of completed audits demonstrates consistently high levels of compliance, with an overall average typically above 95%, and a large proportion of audits achieving 100% compliance.

High performance was seen across several key areas:

- Radiology and Theatres, where the majority of audits scored between 95–100%, reflecting strong adherence to safety standards and well-embedded processes

- Infection Prevention and Control, particularly hand hygiene, which remained consistently near 100% across all departments

- Medicines management and safety systems, including controlled drugs and NEWS monitoring, which also demonstrated sustained high compliance (predominantly 95–100%)

- Clinical audit areas within ward and outpatient services showed strong overall performance, generally within the 90–100% range, with evidence of improvement over time in areas such as pain management, prescribing, and patient assessment.

Overall, these results provide robust assurance that high standards of care are being consistently achieved, supported by effective governance systems, strong clinical engagement, and a well-established culture of safety and continuous improvement.

Infection Prevention Control

Infection Prevention and Control (IPC) is a fundamental component of patient safety and high-quality care within the hospital. We continue to maintain robust systems and processes to minimise the risk of healthcare-associated infections and to ensure a safe environment for patients, staff, and visitors.

During this reporting period, we have sustained a strong focus on adherence to IPC standards, including hand hygiene, environmental cleanliness, and the appropriate use of personal protective equipment (PPE). Regular audits have been undertaken to monitor compliance, with feedback provided to clinical teams to support continuous improvement. The organisation is committed to providing safe,effective care,and infection prevention and control (IPC) remains a fundamental component of the patient safety and quality agenda within the hospital.

Overall, our IPC performance remains stable, supported by strong governance, ongoing training, and a culture of shared responsibility. We will continue to prioritise infection prevention and control, ensuring that high standards are maintained and that any emerging risks are promptly identified and managed.

During this reporting period we have continued to align our practices with national guidance, to ensure compliance with the Health and Social Care Act 2008 (updated 2015) and the Care Quality Commission (CQC) Code of Practice. i. Policies and procedures have been reviewed and updated in line with the National Infection Prevention and Control Manual for England April 2022 (updated July 2025) ensuring that our approach reflects current best practice. The Infection Prevention and Control Board Assurance Framework (BAF) updated (2025) by NHS England (NHSE) continues to provide IPC assurance and supports the organisation in maintaining the safety of patients,service users and staff in an evidence-based manner.

Staff education has remained a priority, with mandatory IPC training in place for all staff groups with alignment to the Infection prevention and control education framework 2023. Additional targeted sessions have been delivered in response to UK Health Security Agency (UKHSA) emergent infection notifications, and where audit findings or incident reviews have identified areas for improvement. This has supported staff in maintaining high levels of awareness and competence in infection prevention measures.

Surveillance systems continue to be used to monitor infection rates and identify any trends or areas of concern. Where infections have occurred, appropriate investigations have been undertaken, with learning shared across the organisation. There has been no evidence of significant outbreaks during the reporting period.

Cleaning

Environmental cleaning standards have been maintained in line with the National Standards of Healthcare Cleanliness 2025 (NSoHC)through regular monitoring and collaboration with housekeeping teams and local NHS Trust auditors, ensuring that clinical and non-clinical areas meet the required standards.

Patient Led Assessments of the Care Environment (PLACE)

The hospital registered and undertook a successful PLACE visit in November 2025. The results of which are tabulated below and are shared nationally. The national average score for cleanliness was 98.6% which St Hugh's exceeded scoring 99.11%. There were also high scoring areas in Ward Food (94.12%) and Condition, Appearance and Maintenance (92.94%).

Examples of patient feedback from the day included:

"Very clean, calm, no banging or clattering"

"Treated with dignity"

"The experience has been excellent from my outpatient appointment to the hostess to the Consultants…"

"On the whole a beautiful place, clean, staff are amazing, caring and supportive "

Waste compliance

The hospital continues to support the national sustainability agenda by following the guidance for the disposal of waste in healthcare as per NHS England and HTM 07-01 : Safe and sustainable waste management for health and social care. This requires hospitals to reduce clinical and sharps waste disposal and increase waste disposed of as offensive with diligent segregation. An external audit was carried out in February 2025 with excellent feedback received.

Similarly an external sharps audit was undertaken in October 2025 this showed the hospital to be 99.4% compliant overall.

Decontamination

All surgical instrumentation utilised by the hospital continues to be decontaminated off site via the 'Steris' hub at Diana Princess of Wales Hospital or are single use.

Washer disinfectors and drying cabinets as utilised by the prior endoscopy service on site have been decommissioned.

Reusable patient equipment at ward/department level is decontaminated as per the National Infection prevention and control manual(NIPCM) guidelines ensuring any risk of cross-contamination is removed.

Decontamination is a standing agenda item on the Infection Prevention and Control Committee which meets quarterly. This discusses items forwarded by the hospital decontamination lead who represents St Hugh's hospital at the local NHS Trust decontamination group and who provides liaison and feedback.

Legionella/Water Safety

The water safety group meets quarterly to discuss the water management plan and to review legionella testing results (all of which have passed within the reporting period) Any exceptions are discussed at the IPC Committee meeting which is held monthly and of which this is a standing agenda item.

Ventilation compliance and exceptions are also currently brought to the IPC Committee meeting where such is discussed and minuted.

Seasonal Flu vaccination programme 2025

Delivery of a successful Hospital staff vaccination programme was undertaken during October and November with an uptake of 52.5%.

Antimicrobial Stewardship

Antimicrobial stewardship within the hospital is monitored via compliance audits on the Ulysses electronic system.

The hospital does not have access to electronic medication prescribing at this time , however data collection is ongoing. Attendance at the quarterly Humber & North Yorkshire Integrated Care System Antimicrobial Stewardship Steering Group continues by IPC and the onsite Lead pharmacist.

Antimicrobial Stewardship is a fixed agenda item on the Infection Prevention Control Committee agenda for the hospital.

During the reporting period the hospital engaged with 'World Antimicrobial Awareness Week' in November 2025. IPC facilitated activities to inform both staff and patients. Utilising the recommended question set, 43 staff responses were received. Knowledge overall was deemed good.

Clinical Effectiveness Data, Key Performance Indicators and Metrics:
Healthcare associated infections (HCAI) surveillance 2025/2026

Mandatory reporting is required for :

- Meticillin Resistant Staphylococcus Aureus (MRSA) bloodstream infections.
- Clostridiodes difficile infection (formerly known as Clostridium difficile)
- Meticillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections
- Gram Negative bloodstream infections (GNBSI) (E.coli/Klebsiella/Pseudomonas Aeruginosa)

No such infections were recorded during the reporting period.

Surgical site infection (SSI) surveillance 2025/2026

During the reporting period the hospital undertook 4,190 surgical procedures, 52% being orthopaedic procedures, including major and minor joint, and upper and lower limb surgeries. The number of incidents reporting of IPC issues including SSI, were very low in comparison with procedures undertaken.

Hand hygiene Audits – Data submissions

All clinical areas are required to undertake hand hygiene audits monthly. The audit process is recorded and validated through the 'Ulysses' compliance and standards electronic system. Compliance is reported and monitored through Quality Governance, IPC Committee, Heads of Department and Senior Leadership Team forums.

Average compliance over the reporting period was = 95% which remains within the target compliance objective.

4.3 Patient Experience

Patient experience is at the heart of everything we do. We recognise that patients and their families place a high level of trust in our services and we are dedicated to ensuring that every interaction reflects compassion, dignity and respect.

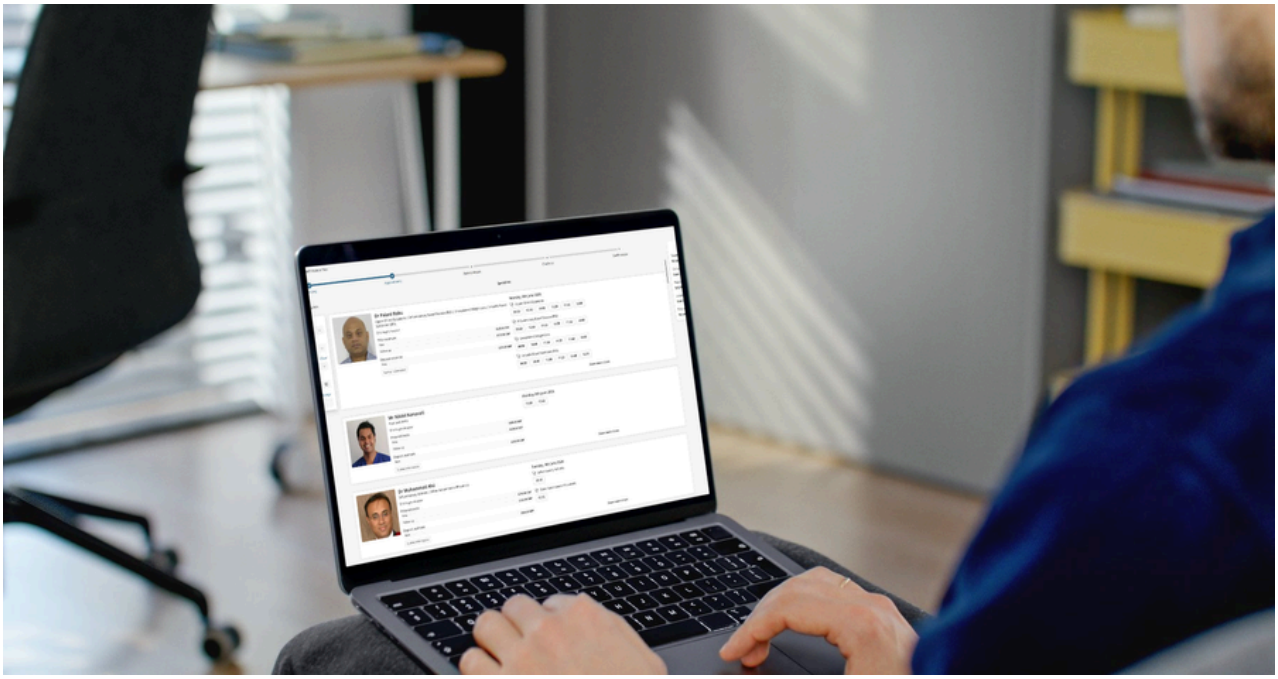
Patient experience is a key indicator of the quality of care we provide. It encompasses all aspects of a patient's journey, from initial contact and admission through to treatment, discharge and follow-up care. We aim to create an environment where patients feel informed, supported and actively involved in decisions about their care. Listening to patient feedback, both positive and constructive, is fundamental to understanding what we do well and where we need to improve. Over the reporting period, we have continued to strengthen our approach to capturing and responding to patient experience data. Insights gathered from these sources inform service improvements, staff training and organisational priorities.

By embedding a culture that values patient voice and experience, we strive to consistently deliver high-quality care that meets and exceeds expectations.

Patient Plus platform

During 2025, we continued to enhance digital access for patients and families through the development of our Patient Plus platform at St Hugh's Hospital.

The implementation of the patient portal has improved the quality of patient care by increasing accessibility, communication and patient engagement. Patients are now able to securely access their medical records, test results, and appointment information online, allowing them to become more informed and involved in managing their health. The portal has also improved communication between patients through secure messaging, leading to quicker responses and more effective follow-up care.



Improving Complaints Handling: Sharing ISCAS Hints and Tips

In line with our commitment to delivering a responsive, transparent, and person-centred complaints process, we have actively embedded guidance from the Independent Sector Complaints Adjudication Service (ISCAS) across the organisation during this reporting period.

A structured programme of "ISCAS Hints and Tips" has been developed and disseminated to staff involved in complaint management. The guidance focuses on improving the quality, consistency and timeliness of responses, with particular emphasis on clarity of language, empathy in communication, and ensuring that responses directly address the concerns raised.

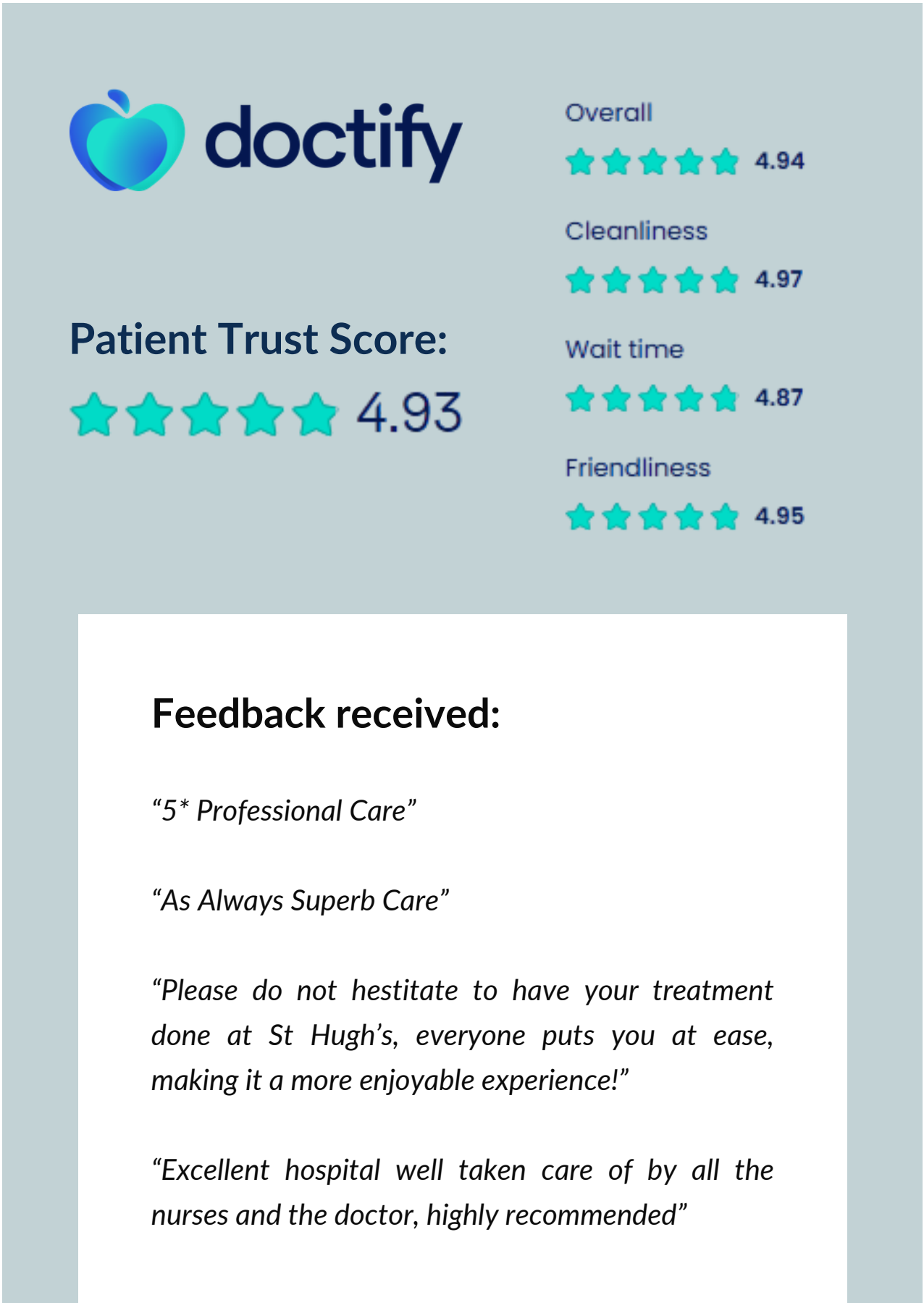
Key themes promoted through this initiative include:

- Providing clear, jargon-free explanations
- Demonstrating empathy and acknowledging the complainant's experience
- Ensuring thorough investigation and evidence-based responses
- Offering appropriate apologies where warranted
- Identifying and communicating learning and actions taken as a result of complaints

We have observed a growing trend in the use of artificial intelligence (AI) tools by complainants to draft or support their submissions. These complaints are often more detailed, structured, and formally articulated. In response, we have reinforced the importance of maintaining a personalised and compassionate approach, ensuring that responses remain tailored to the individual's concerns rather than becoming overly procedural. Staff have been supported to focus on the substance and intent behind complaints, regardless of how they are presented and to ensure that the quality of engagement is not diminished by the format or perceived sophistication of the submission.

Early feedback indicates a positive impact, with improvements noted in the tone and structure of written responses, as well as increased confidence among staff in handling complex complaints. This approach supports a culture of openness and continuous learning, ensuring that complaints are used as a valuable source of insight to drive service improvement.

Patient Experience Data, Key Performance Indicators and Metrics:



Feedback received:

"5 Professional Care"*

"As Always Superb Care"

"Please do not hestitate to have your treatment done at St Hugh's, everyone puts you at ease, making it a more enjoyable experience!"

"Excellent hospital well taken care of by all the nurses and the doctor, highly recommended"

Family and friends results

During this reporting period, of those patients completing the 'friends and family test' survey, 98% rated their experience at St Hugh's Hospital as 'very good'.

Outpatient Department – "You Said, We Did" Actions from Patient Feedback

Access & Appointments

You said: Appointments were running late and no one told you why.

We did: Introduced real-time delay updates TV Screens with wait times visible in both waiting areas. Impact: Patients feel informed and less anxious.

Environment & Comfort

You said: The department was confusing to navigate.

We did: Clear signage erected December 2025.

Impact: Fewer late arrivals and reduced stress.

Communication & Information

You said: You didn't understand what would happen at your appointment.

We did: Clear appointment letters, staff check understanding with aid of using BRAN for all new patients on arrival to department.

Impact: Patients feel better prepared.

Dignity, Respect & Inclusion

You said: Some patients felt rushed or not listened to.

We did: Invite patients with concerns to attend a follow up appointment.

Impact: Improved feedback around feeling listened to.

You said: Reasonable adjustments were not always recognized such as flexibility in planning surgery dates. We did: Bookings team place patients on active monitoring

Impact: More personalised care.

Involving Patients in Improvement

You said: You wanted to be more involved in service improvements.

We did: QR feedback cards available in department.

Impact: Increased engagement and feedback.

Complaint Metrics

Total complaints: 42 new stage 1 complaints received between 1 April 2025 and 31 March 2026.

This is in comparison to a total of 30,308 seen during the same period.

As of 19 May 2026, none of the 42 new stage 1 complaints received between 1 April 2025 and 31 March 2026 have escalated to stage 2 or stage 3 of the complaints process

90% of the 42 new stage 1 complaints received between 1 April 2025 and 31 March 2026 were acknowledged within 3 working days

71% of the 42 new stage 1 complaints received between 1 April 2025 and 31 March 2026 were responded to within 20 working days

Key themes from complaints:

The complaints reviewed show that the most consistent themes relate to communication, follow-up and administrative reliability across the patient pathway. Concerns commonly involved unclear or delayed communication, inaccuracies or omissions in clinical documentation and process failures affecting appointments, referrals, waiting times and information transfer.

In response, the actions identified focus on improving communication standards, strengthening documentation accuracy, clarifying pathways and responsibilities and reinforcing staff training, reflection and service oversight to improve patient experience and safety.

4.5 Safeguarding

Safeguarding is a fundamental component of the quality and safety of care we provide. We are committed to protecting all patients from harm, abuse and neglect, ensuring that their wellbeing, dignity and rights are upheld at all times. This responsibility extends to every member of staff, who play a vital role in recognising, responding to and reporting safeguarding concerns.

We care for a diverse population, including adults and who may be vulnerable due to age, illness, or personal circumstances. We maintain robust safeguarding systems and processes aligned with national legislation, local safeguarding partnerships and best practice guidance. These frameworks support staff in identifying risks early and taking appropriate action to keep patients safe.

Throughout the reporting period, we have continued to strengthen our safeguarding arrangements through appointment of a new safeguarding lead, regular staff training, clear policies and effective governance structures.

Our safeguarding lead provides expert advice and oversight, ensuring that concerns are managed promptly and appropriately. We also work closely with external agencies to support coordinated and effective responses when needed.

During 2025–2026, St Hugh's demonstrated strong safeguarding assurance, achieving full compliance with required training levels across the team, reflecting sustained focus on workforce capability. One safeguarding concern was appropriately identified and reported during 2025–2026, providing assurance of effective recognition and escalation processes. Feedback from the Humber and North Yorkshire Health and Care Partnership stated that the service has also promoted organisational learning, particularly in relation to cognitive decline, with strong staff engagement in relevant training. No areas of concern were identified, and the service was assessed as fully assured, evidencing robust safeguarding governance and a positive safety culture.

Safeguarding Data, Key Performance Indicators and Metrics:

1 safeguarding concern was appropriately escalated

Safeguarding Adults Training figures: Level 1: 93.50% Level 2: 95.80% Level 3: 91%	Safeguarding Children Training Figures: Level 1: 93.30% Level 2: 96.80% Level 3: 100%

Safeguarding Level 4 (three yearly refresher): 100%

4.6 Workforce

Our workforce is our most valuable asset and is central to the delivery of safe, effective and high-quality care. We are committed to recruiting, developing and retaining a skilled, compassionate and motivated team who are equipped to meet the needs of our patients. By fostering a positive and inclusive working environment, we enable our staff to perform at their best and deliver exceptional patient care.

We recognise that staff experience is closely linked to patient outcomes and overall service quality. As such, we prioritise staff wellbeing and engagement, promoting a culture where individuals feel valued, respected, and empowered to contribute to service improvement.

We are committed to maintaining safe staffing levels and ensuring that all staff are appropriately trained and competent in their roles.

Workforce and Operational People Metrics

The organisation has continued to maintain safe operational workforce delivery throughout the reporting period despite ongoing sector-wide workforce pressures. Workforce indicators demonstrate a stable and resilient staffing position, supported by effective workforce planning, flexible staffing arrangements, and strong compliance performance.

Overall number of employees: 135 as at March 2026	Average number of clinical staff: 56 (full time equivalent)
Average monthly sickness over the 12-month period 1st April 2025 – 31st March 2026: 2.88%	No suspensions
Minimal ER investigations	Very low levels of disciplinary activity were reported.
Training compliance exceeded 90% across all months within the reporting period	

Seasonal increases were observed during autumn and winter months, with absence peaking at 5.59% in January before improving again toward year end.

The organisation continues to support staff wellbeing through ongoing attendance management processes, wellbeing support, and operational workforce monitoring.

Employee Relations

Formal employee relations activity remained low throughout the reporting period:

- No suspensions were recorded.
- ER investigations remained minimal.
- Very low levels of disciplinary activity were reported.
- This indicates continued workforce stability and a generally positive employee relations environment.

Training and Compliance

Mandatory and statutory training compliance remained consistently strong throughout the reporting period, exceeding 90% across all reported months and reaching 95.21% in February.
This reflects continued staff engagement with mandatory training requirements and supports organisational assurance relating to patient safety, governance, and quality standards.

Overall workforce metrics indicate that the organisation has maintained safe workforce oversight and operational resilience throughout the reporting period. Key areas of positive assurance include:

- Stable clinical staffing levels
- Strong mandatory training compliance
- Low employee relations activity
- Improved sickness performance across much of the year
- Continued operational continuity despite workforce pressures
- Workforce trends will continue to be monitored closely through routine governance and performance oversight arrangements.

Enhancing Staff Experience Through Additional Benefits

During this reporting period, we have increased our focus on the provision, awareness and uptake of additional benefits for staff, recognising their importance in supporting wellbeing, retention and overall workforce satisfaction. Specifically, we have introduced a new Employee Assistance Programme, WeCare, which, amongst other services, provides for 24/7 counselling services for employees and their families.

A programme of work has been undertaken to better promote the range of benefits available, ensuring that staff are aware of and able to access support beyond their core employment package.

This has included improved communication through internal channels, refreshed guidance materials and targeted engagement with teams to highlight available offers and resources.

Key areas of focus have included wellbeing support and financial and lifestyle benefits. Efforts have been made to ensure that these benefits are communicated clearly and consistently, reducing variation in awareness across different staff groups and locations.

Alongside this, we have sought to strengthen the visibility and accessibility of support services. This includes signposting to confidential advice services, health and wellbeing resources and initiatives aimed at promoting work–life balance, stress management and mental health support and guidance.

Early indications (via our annual staff satisfaction survey) suggest improved awareness and engagement with available benefits, contributing to a more positive staff experience. This work supports our wider commitment to being a supportive and inclusive employer, recognising that staff who feel valued and supported are better able to deliver high-quality care.

We will continue to build on this progress, with ongoing evaluation and refinement of our offer to ensure it remains responsive to the evolving needs of our workforce.

2025 Staff Survey Results

During this reporting period, we undertook an organisation-wide staff survey, achieving a response rate of 53%. This represents a solid level of engagement and provides a meaningful insight into staff experience across the organisation, as well as highlighting areas for improvement.

The results highlighted several areas of strength. A clear majority of respondents reported a good understanding of the organisation's purpose, vision, and charitable mission (73% agree/strongly agree), as well as alignment with organisational values (69%). There was also strong clarity around individual roles, with 79% of staff indicating they understand what is needed to meet their goals and objectives. Supportive team dynamics were evident, with 76% of respondents feeling supported by colleagues and 63% feeling supported by their line manager. In addition, 84% of staff reported understanding what Freedom to Speak Up means, demonstrating good awareness of this important concept.

However, the survey also identified a number of important areas for improvement. Levels of overall job satisfaction were mixed, with only 40% of respondents indicating they are happy at work and a notable proportion expressing dissatisfaction (31%). Similarly, only 36% of staff felt their work is meaningful and that they are valued, suggesting a need to strengthen recognition and engagement. Workload and capacity emerged as key concerns, opportunities for professional development also require attention, along with communication and organisation change.

Inclusion and speaking up also present opportunities for improvement. While 32% of staff reported feeling a sense of belonging and inclusion, a similar proportion (34%) expressed dissatisfaction. In addition, although awareness of speaking up processes is high, only 17% of respondents feel confident that concerns raised will be addressed, highlighting a gap between understanding and trust in the process.

Overall, the survey provides a balanced picture, with strong foundations in organisational clarity, teamwork, and awareness of key processes, alongside clear priorities relating to staff experience, workload, communication, and confidence in organisational responsiveness.

In response, targeted actions were developed by the St Hugh's leadership team, in the form of an action plan, with the intention of addressing these themes, including strengthening leadership visibility, improving communication around change, enhancing recognition and development opportunities, and building trust in speaking up processes.

Progress against these actions is being monitored through ongoing staff engagement and future survey activity.

Freedom To Speak Up

We are committed to creating an open, inclusive, and supportive culture where all staff, volunteers, and learners feel safe and confident to raise concerns, share ideas, and speak up about anything that may affect safety, quality, or wellbeing.

Freedom to Speak Up (FTSU) plays a vital role in strengthening patient safety and improving services. We actively encourage speaking up and promote a culture of listening, learning, and continuous improvement. Concerns raised are treated seriously, handled sensitively, and addressed promptly, with a focus on fairness, confidentiality, and learning rather than blame.

Our Freedom to Speak Up arrangements provide staff with a range of options for raising concerns, including access to trained Freedom to Speak Up Guardians and Champions. These roles offer independent, confidential support and guidance, helping individuals to explore their concerns and identify appropriate routes for resolution.

During the year, we have continued to raise awareness of Freedom to Speak Up through induction, training, communications, and leadership engagement. This has helped reinforce the message that speaking up is welcomed and valued at all levels of the organisation.

Learning from concerns raised through Freedom to Speak Up is shared appropriately across teams and governance forums. Themes and trends are reviewed to identify opportunities for improvement, inform quality and safety priorities, and strengthen organisational culture.

We recognise that a positive speaking up culture is essential to staff wellbeing and high-quality care. In the coming year, we will continue to build on this work, focusing on visibility, accessibility, and assurance to ensure everyone feels empowered to speak up and confident that their voice will be heard.

Following a National Conference on Personalised Care, our team was inspired by the focus on caring for staff and the concept of 'agency' - empowering individuals within their roles to help prevent burnout and promote psychological safety.

Our team developed an idea to remain aware of and responsive to each others emotions - supporting one another as we do our patients.

Our first HMT Heroes Recognition Programme and Awards Event

During the reporting year, we introduced the organisation's first company-wide Values-based employee recognition programme, which culminated in staff awards across a variety of categories, and culminated in an awards event and celebration of the winners: our HMT Heroes Awards. The decision to invest in and launch this programme and event reflected the Board's commitment to recognising and celebrating the contribution, dedication, and achievements of staff in delivering the organisation's charitable mission and purpose.

The Board recognised that staff are central to the charity's success and that creating formal recognition opportunities to acknowledge excellence and lived values plays an important role in building a positive, inclusive and high-achieving organisational culture.

The first annual staff recognition programme and awards had a positive impact by:

- Providing a platform to celebrate individual and team achievements
- Reinforcing organisational values and desired behaviours
- Supporting staff engagement, feelings of achievement and a sense of belonging
- Strengthening connections between staff, leadership, and the Board
- Driving a high-performance culture

Feedback from staff indicated that the recognition programme and awards event were well received and helped highlight the breadth and impact of work undertaken across the organisation, whilst recognising and thanking staff nominees and winners for their hard work and contributions.

St Hugh's staff had success at the awards, with Claire Coley, Patient Service Manager, being shortlisted in 2025 for the awards of Superb Support and Energetically Enterprising. Those nominating Claire for the awards stated "Claire has spent long hours coming up with a rota for reception which gives us a much better work/life balance. She listens to suggestions we have made and implemented them and is always available to discuss any concerns we may have. I feel I am fully supported and this makes me feel valued and committed."

The Stores Team at St Hugh's were also finalists for the Creatively Collaborative award, with nominations including comments such as "This team ensure that the whole hospital runs smoothly from the kitchen to housekeeping to pharmacy and theatre, they are so underappreciated and a huge part of the hospital",; "They are always innovating and problem solving every day in all aspects of their job" and "They are friendly and approachable- nothing is ever too much trouble."

Lucy Crawford, Deputy Ward Manager, was shortlisted for the Consciously Caring award, with nominations stating, "She turns up to work with a positive and happy attitude, she can tell when someone is struggling and doesn't think twice in putting time aside to help others. I have seen her many times speaking and supporting others."

Communication and Engagement Improvements

Throughout 2025, we enhanced internal communication and engagement through the expanded use of digital communication channels, including newsletters and the launch of a new internal communications platform, Viva Engage. This work has contributed to a more connected workforce across our hospitals, care homes and shared support services. In addition, it has provided us with the platform to promote and reinforce staff benefit and wellbeing offerings, to drive and embed our Diversity, Equity and Inclusion strategy, including promoting and celebrating events and initiatives, such as, National Inclusion Week, and keeping our team members informed.

Induction and Early Workforce Experience

Improving the early experience for new starters was a key area of focus in 2025 for HMT. We developed and launched a new induction toolkit to ensure staff joining the organisation feel welcomed, included and well prepared for their roles.

The development of an induction booklet with lots of helpful information, alongside benefits and wellbeing assets, helped improve consistency across services and ensured staff had a clear understanding of our values and approach to care from the outset. Managers were provided with guidance on how to optimise these assets and processes.

"Our Nurses, Our Future"

The "Our Nurses, Our Future" Tree of Career Progression helps patients and families understand the range of skills, experience, and career opportunities within our nursing workforce. The tree illustrates how nurses develop throughout their careers, gaining additional knowledge, qualifications, and specialist expertise while continuing to provide high-quality care.

The tree symbolises growth, learning, and professional advancement, illustrating how nurses can progress from entry-level roles through to specialist, advanced practice, leadership, education, and management positions.

By supporting ongoing learning and professional development, we ensure that our nursing staff remain up to date with best practice and are equipped to meet the changing needs of our patients. This commitment to developing our workforce helps us provide safe, effective, and compassionate care, delivered by skilled professionals at every stage of their nursing career.

4.7 Equality, Diversity and Inclusion

We remain committed to fostering an inclusive culture where every patient and member of staff feels respected, valued, included and able to contribute fully. We recognise the importance of delivering equitable care and creating a workplace that reflects and supports the diverse communities we serve.

During this reporting period, we have strengthened our approach to Equality, Diversity and Inclusion (EDI) through the introduction and development of a network of EDI Champions, along with the introduction of an EDI Champion Working Group, which meets at least quarterly. These individuals represent a range of roles and departments across the organisation and act as local advocates for inclusive practice. Their role includes promoting awareness, supporting colleagues, and helping to embed the EDI strategy and considerations into everyday decision-making and patient care.

EDI Champions have been instrumental in raising awareness of key topics, supporting local initiatives, and providing a visible point of contact for staff. They have contributed to the development of communications, policy reviews and the introduction of EDI training, participated in awareness campaigns, and supported the celebration of diversity through events and educational activities, such as National Inclusion Week and Neurodiversity Celebration Week. This has helped to foster open conversations and increase engagement with EDI across the organisation.

In parallel, we have continued to review our policies, practices, and patient pathways to ensure they are inclusive and accessible. This includes consideration of cultural needs, communication requirements, and individual preferences, supporting a more personalised approach to care. Staff have also been encouraged to complete EDI training to build understanding and confidence in delivering inclusive care and working effectively within diverse teams.

While progress has been made, we recognise that EDI is an ongoing priority. We will continue to support and develop our EDI Champion network, strengthen data and insight to better understand the experiences of our workforce and patients, and ensure that a proactive focus on inclusion is maintained, enhanced and embedded throughout our organisational values and day-to-day practice.

Equality, Diversity and Inclusion Data and key performance indicators and metrics:

Gender Pay Gap Reporting:

The Healthcare Management Trust (HMT) is committed to complying with all Gender Pay Gap related legislation, reporting process and procedure, and the eradication of any gender-based inequities discovered.

In comparison to the previous period, we were encouraged to see further narrowing of the pay gap at Upper, Upper Middle and Lower Middle quartiles. It is particularly notable that, at the Upper Middle quartile, reduced to only 0.13%. The gap in all quartiles was 2.38% or less; vs 4.78% or less in the prior period. This represents a notable improvement.

		Staff Numbers			%	%	Hourly Pay		
		M	F	Total	M	F	M	F	Gap
Upper Q	Quartile 1	29	128	157	18.47%	81.53%	31.70	31.41	0.89%
Upper Mid Q	Quartile 2	38	119	157	24.20%	75.80%	18.80	18.78	0.13%
Lower Mid Q	Quartile 3	27	130	157	17.20%	82.80%	14.75	14.39	2.38%
Lower Q	Quartile 4	27	130	157	17.20%	82.80%	12.65	12.57	0.66%
Total	**Total**	**121**	**507**	**628**	**19.27%**	**80.73%**	**19.62**	**19.25**	**1.85%**

4.8 Data Quality and Information Governance

Maintaining high standards of data quality and information governance remains a key priority, underpinning safe patient care, effective decision-making and regulatory compliance. We recognise our responsibility to ensure that information is accurate, secure and used appropriately at all times.

During this reporting period, we have continued to strengthen our data quality processes and have reinforced our information governance framework in line with national standards, including compliance with the UK General Data Protection Regulation and the Data Protection Act 2018. Staff have been supported through mandatory training to ensure they understand their responsibilities in relation to confidentiality, data protection, and information security.

We have also promoted good practice in information handling, including secure storage, appropriate sharing of information, and the use of approved systems and processes. Incident reporting mechanisms remain in place to identify and respond to any data breaches or near misses, with learning shared to prevent recurrence.

St Hugh's Hospital underwent an internal information security audit. These assessments provide valuable insights into the current practices surrounding the management of confidential information and the extent to which data protection protocols are being followed across both clinical and administrative environments. The findings illustrated the importance of consistently applying robust protocols in all settings to safeguard sensitive information and maintain organisational compliance with relevant regulations. Actions arising from the audit focused on strengthening existing measures and addressing gaps in practice.

Overall, no significant breaches of information governance were reported during the period.

Cyber Security and Information Protection

HMT successfully secured three cyber accreditations, all endorsed by our independent Data Protection Officer (DPO). This included Cyber Essentials and Cyber Essentials Plus, government-backed certifications that help protect organisations against common online threats through controls such as secure system configuration, boundary firewalls, access controls, patch management and malware protection. Achieving these standards demonstrates HMT's commitment to protecting IT systems and sensitive data, while also meeting compliance requirements for NHS contracting. HMT also achieved IASME (Information Assurance for Small and Medium Enterprises) Cyber Assurance, which evidences a broader approach to cyber security through effective technical controls, policies, processes and staff awareness.

Data Quality and Information Governance Data and key performance indicators and metrics:

7 Information governance and information security incidents
All low/ no harm incidents
Examples of incidents: • Emails sent in error • Confidential documents left unattended • Incorrect redaction of records • Unintended disruption to firewall system

Accreditations and achievements

- National Joint Registry (NJR) - SHH

St Hugh's Hospital is celebrating being named as a National Joint Registry (NJR) Quality Data Provider after successfully completing a national data quality audit programme for their hospital.

The NJR collects and monitors high-quality orthopaedic data on the performance of hip, knee, ankle, elbow and shoulder joint replacement in order to support patient safety, standards in quality of care, and overall value in joint replacement surgery, as well as to provide feedback on surgical performance to orthopaedic clinicians and joint replacement implant manufacturers. The 'NJR Quality Data Provider' certificate scheme was introduced to offer hospitals a blueprint for reaching high-quality standards relating to patient safety and to reward those who have met the registry's high targets in the achievement of the quality of the data collected.

The annual NJR Data Quality Audit compares the number of joint replacement procedures submitted to the registry to the number of procedures that have been carried out and recorded in the local hospital Patient Administration System. The audit ensures that the NJR is collecting and reporting the most complete, accurate data possible in all hospitals performing joint replacement operations, including St Hugh's Hospital.

Medical Director of the National Joint Registry, Mr Tim Wilton, said, "Congratulations to colleagues at St Hugh's Hospital. The Quality Data Provider Award received by the team at this hospital demonstrates the high standards that are being met in ensuring compliance with the registry and is a reflection of the strong departmental efforts to achieve such status."

As well as being a fundamental driver to inform improved quality of care for patients, our registry data also provides an important source of evidence for regulators, such as the Care Quality Commission, to help to inform their knowledge and judgement about the quality of health services."

In September 2025, our Head of Patient Safety & Improvement spoke at the IHPN's (Independent Healthcare Providers Network) Patient Safety Principles Conference, regarding our journey 'Embedding a Learning Culture of Patient Safety' at HMT, which was highly commended by the Patient Safety Commissioner for England, Henrietta Hughes.

"Congratulations to colleagues at St Hugh's Hospital. The Quality Data Provider Award received by the team at this hospital demonstrates the high standards that are being met in ensuring compliance with the registry and is a reflection of the strong departmental efforts to achieve such status."

STATEMENT FROM THE ICB

NHS Humber and North Yorkshire Integrated Care Board (ICB) welcome your sharing of the 2025/26 Quality Account for your services at HMT St Hugh's Hospital. We take this opportunity to express our gratitude to all staff for their dedication and commitment to providing high quality care to our population.

We particularly note the commitment in ensuring the Hospital's mission, vision and values are aligned to the ambitions against the 5 strategic pillars within your Strategy and we have read with interest and pleased to see the progress against the 2025/26 Quality Priorities. We commend the progress made to improve pre-assessment processes, patient access, communication and capturing feedback and how the improvements have been translated meaningfully into practice.

The ICB would like to congratulate the Hospital and its staff following the most recent Care Quality Commission inspection in December 2025 with the hospital rated as "Good" across all domains. We note the improvements made in strengthened leadership and were pleased to hear about your successes in this journey to "Good" within the Well-led inspection domain.

The ICB recognises the attainments detailed within the Account, which includes the significant strengthening of quality governance and leadership with improved oversight of risk and performance. These improvements, together with clearer accountability through the senior leadership team has led to more consistent monitoring of quality and patient safety across all services, with a clear embedding of robust governance processes from "Floor to Board". We note the processes are underpinned by a robust Quality Governance Framework that ensures effective flow of information, strategic oversight and Board assurance.

The ICB acknowledge the progress made with embedding the Patient Safety Incident Response Framework (PSIRF), Quality Priority 3, and welcomes the shift towards a more system-focused, learning-based approach to incident management. The Account evidences a maturing patient safety culture with staff encouraged to raise concerns through a variety of methods including Freedom to Speak Up, and how the Hospital shares learning with a growing emphasis on quality improvement. We note the appointment of the Patient Safety and Experience Partner who will contribute to the embedding of lived experience and strengthen the involvement of patients and families and staff within learning and improvement.

The ICB notes the clinical effectiveness improvements, with care being delivered in line with evidence-based practice. Developments such as nurse-led services in outpatient care have enhanced service capacity, improved patient flow and supported timely access to treatment.

The ICB welcomes the information provided within the Account that reflects a strong commitment to Infection Prevention and Control (IPC) and are pleased to see there is a strong adherence to IPC standards of care with a high level of compliance in mandatory training and no reported Health Care Associated Infections across 2025/26.

The Account provides strong assurance that safeguarding governance is embedded within St Hugh's Hospital, training compliance is excellent for both adults and children, with the Account giving a clear narrative that there is a positive safety culture with safeguarding threaded through all processes.

The ICB commends St Hugh's Hospital for the overall improvements identified in the 2025/26 Account and acknowledge the meaningful progress in strengthening systems, culture and clinical practice, supporting delivery of safe, effective and personalised care.

Humber and North Yorkshire Integrated Care Board confirm that to the best of our knowledge, the Account is a true and accurate reflection of the high quality of care delivered by HMT St Hugh's Hospital. The ICB will continue to work with the Hospital to support delivery of sustained quality improvement and look on with interest to hear of the progress against the Quality Priorities identified for the coming year and the further quality outcomes of this work.

Humber and North Yorkshire Integrated Care Board remain committed to working with HMT St Hugh's Hospital and its regulators to enhance the quality and safety of services with the aim of improving patient care, safety and outcomes.


HMT
HEALTHCARE MANAGEMENT TRUST