Humber Teaching NHS Foundation Trust

Trust Board Meeting 28 May 2025
Agenda - Public Meeting

For a meeting to be held at 9.30am Wednesday 28 May 2025, via Microsoft Teams

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

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

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

		Lead	Action	Report Format
	Standing Items			
1.	Apologies for Absence	CF	Note	verbal
2.	Declarations of Interest	CF	Note	√
3.	Minutes of the Meeting held on 26 March 2025	CF	Approve	√
4.	Action Log, Matters Arising and Work Plan 2025/26	CF	Approve	√
5.	Patient Story – Perinatal Mental Health Team: A patient Journey Story	KF	Discuss	√
6.	Chair's Report	CF	Note	√
7.	Chief Executives Report including: • Policies to Ratify	MM	Discuss/Ratify	√
8.	Publications and Highlights Report	MM	Note	√
	Patient Safety and Quality			
9.	Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Report	LP	Approve	√

10.	Care Quality Commission Mental Health Act Report 2023-24	KF	Approve	√
	Building a Shared Purpose and Vision			
11.	Freedom To Speak Up – Reflection and Improvement Plan 25/26 Alison Flack, Freedom to Speak Up Guardian attending to present	MM	Approve	√
12.	Emerging NHS England and ICB Developments	MM	Discuss	√
	Investing in People and Culture			
13.	National Staff Survey Results 2024 IQVIA attending to present	VM	Discuss	√
14.	Board Effectiveness Reviews 2024/25 (Including Terms of Reference)	CF	Approve	√
15.	Committee Effectiveness Reviews 2024/25 (Including Terms of Reference)	SJ	Approve	√
	Developing Leadership Behaviours			
16.	Fit and Proper Person Compliance	CF	Note	√
17.	Insightful Board Update	SS/SJ	Note	√
	Embedding Improvement into Management Systems and Processes			
18.	Finance Report	PB	Note	√
19.	Performance Report	PB	Note	√
20.	Report on the Use of the Trust Seal	MM	Note	√
21.	Review of Standing Orders, Scheme of Delegation and Standing Financial Instructions	PB/SJ	Ratify	√
22.	Compliance with the Provider License – Annual Review	PB/SJ	Discuss	√
23.	Board Assurance Framework Update Oliver Sims, Corporate Risk & Incident Manager attending	MM	Note	√
	Assurance Committee Reports			
24.	Finance Committee	KN	Assurance	√

25.	People & Organisational Development Committee	DR	Assurance	√
26.	Quality Committee Committee Assurance Report	PE	Assurance	√
27.	Mental Health Legislation Committee Assurance Report	SP	Assurance	√
28.	Audit Committee Assurance Report	SMcKE	Assurance	√
29.	June Board Strategic Development Meeting Agenda	CF	Note	√
30.	Items to Escalate including to the High Level Risk Register & for Communication	CF	Note	verbal
31.	Any Other Urgent Business	CF	Note	verbal
32.	Review of Meeting – Being Humber • Has the Board focused on the right areas? • Did the quality of the papers enable Board members to perform their role effectively – did they enable the right level of discussion to occur? • Was debate allowed to flow and were all Board members encouraged to contribute? • Has the meeting been conducted in accordance with the Trust's cultural and behavioural standards framework (Being Humber)	CF	Discuss	verbal
33.	**Exclusion of Members of the Public from the Part II Meeting**			
34.	**Date, Time and Venue of Next Meeting** Wednesday 30 July 2025, 9.30am via Microsoft Teams			

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Agenda Item 2

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Declarations of Interest
Author/s:	Rt Hon Caroline Flint Trust Chair
Recommendation:	

To approve		To discuss	
To note	✓	To ratify	
For assurance			

Purpose of Paper:

The report provides the Board with a list of current Executive Directors and Non-Executive Directors interests. Changes have been made to the following declarations:

- Addition to Priyanka Perera
- Addition to Peter Beckwith
- Removal from Dean Royles
- Removal from Phillip Earnshaw
- Removal and addition to Keith Nurcombe

Key Issues within the report:

Positive Assurances to Provide:
- Updated declarations

Key Actions Commissioned/Work Underway:
- N/A

Key Risks/Areas of Focus:
- No issues to note

Decisions Made:
- N/A

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail) Monthly Board report	✓ 26.03.25

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
✓	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
✓	Fostering integration, partnership and alliances
	Developing an effective and empowered workforce
	Maximising an efficient and sustainable organisation
✓	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Directors' Declaration of Interests

Name	Declaration of Interest
Executive / Directors	
Ms Michele Moran Chief Executive (Voting Member)	• IMAS partner • Humber and North Yorkshire ICB Board Member • Non-Executive Director DHU Healthcare (a Social Enterprise organisation) • Co-opted Parish Councillor – Bamford with Thornhill
Mr Peter Beckwith, Director of Finance (Voting Member)	• Trustee of Heathstars, and Executive Lead for Humber Teaching NHS Foundation Trust • Son is a Student at Hull York Medical School • Daughter is a Nursing Student at York St John University
Dr Kwame Opoku-Fofie, Medical Director (Voting member)	• Director of Bluewaters Healthcare Limited • Spouse is Director of Bluewaters Healthcare Limited • Spouse is the Deputy Chief Pharmacist of Humber Teaching NHS Foundation Trust • Executive Lead for The Trust Research Department – which receives grant and funding to the department • Spouse is Clinical Director Harthill Primary Care Network (PCN)
Mrs Lynn Parkinson, Chief Operating Officer (Voting Member)	• Husband works for HMRC • Son works for Labour MP as Communications Lead • Son works for Department of Health and Social Care
Mrs Sarah Smyth, Director of Nursing, Allied Health and Social Care Professionals (Voting Member)	• No interests declared
Mrs Karen Phillips, Associate Director of People and Organisational Development (non voting)	• No interests declared
Non Executive Directors	
Rt Hon Caroline Flint – Chair (Voting Member)	• Husband is a Doncaster MBC Councillor and Cabinet member • Chair of the Committee on Fuel Poverty which is an advisory non-departmental public body sponsored by the Department for Energy Security and Net Zero (DESNZ)
Mr Dean Royles, Non-Executive Director (Voting Member)	• Director of Dean Royles Ltd • Trustee of Health People Managers Association (HPMA) • Owner of Dean Royles Ltd • Associate for KPMG • Chair of NHS Professionals Strategic Advisory Board • Non-Executive Director at Sheffield Teaching Hospitals NHS Trust

Dr Phillip Earnshaw, Non-Executive Director (Voting Member)	• Director of Conexus GP Federation • Owner of Phillip Earnshaw Ltd • Trustee of Prince of Wales Hospice • Five Towns PCN Clinical Director • Board Member of Wakefield District Health & Care Partnership • Chair and Trustee Smawthorne Community Project is a local charity in Castleford • Non-Executive Director for Lincolnshire Integrated Care Board
Mr Stuart McKinnon-Evans, Non-Executive Director (Voting Member)	• No interests declared
Mr Keith Nurcombe, Non-Executive Director (Voting Member)	• Director of Dietary Assessments LTD • Director of WMSG (Part of West Midlands Combined Authority • Crown representative – Cabinet Office – UK Government • Chair of the Avalon Group • Chair of Derbyshire Health United (CIC)
Ms Stephanie Poole, Non-Executive Director (Voting Member)	• Husband is a Trustee of Yorkshire Coast Sight Support (YCSS), a registered charity
Priyanka Perera (Mihinduklilasuriya Weerasingha Indrika Priyankari Marguerite Perera) Associate Non-Executive Director (Non-Voting Member)	• Managing Director of B. Cooke & Son Ltd, Hull • Son in Law works as Brand Lead – New Dermatology and Portfolio Strategy for Sanofi

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Trust Board Meeting

Minutes of the Public Trust Board Meeting held on Wednesday 26 March 2025, 9:30am via Microsoft Teams

Present:

Rt Hon Caroline Flint, Chair
Mrs Michele Moran, Chief Executive
Dr Phillip Earnshaw, Non-Executive Director
Mr Peter Beckwith, Director of Finance
Dr Kwame Fofie, Medical Director
Ms Stephanie Poole, Non-Executive Director
Mr Keith Nurcombe, Non-Executive Director
Mrs Lynn Parkinson, Deputy Chief Executive/Chief Operating Officer
Mrs Hilary Gledhill, Director of Nursing, Allied Health and Social Care Professionals
Mrs Sarah Smyth, Director of Nursing, Allied Health and Social Care Professionals
Mr Dean Royles, Non-Executive Director
Ms Priyanka Perera Associate Non-Executive Director

In Attendance:

Mrs Karen Phillips, Associate Director of People and Organisational Development
Mrs Laura Roberts, PA to Chair and Chief Executive (Minutes)
Justine Rooke, General Manager (for item 24/25)
Anna Doughty, Consultant Psychologist and Clinical Lead for the Eating Disorder Service (for item 24/25)
Samantha Mckenzie (for item 24/25)
Lisa Weldrick, Team Leader, Hull and East Riding CAMHS Eating Disorder Service (for item 24/25)
Sarah Clinch, Senior Partnerships and Strategy Manager (for item 29/25)
Paul Johnson, Clinical Director (For item 30/25)
Alison Flack, Programme Director (for item 32/25)
Oliver Sims, Corporate Risk and Incident Manager (for item 39/25 & 40/25)

Apologies:

Mrs Stella Jackson, Head of Corporate Affairs
Mr Stuart McKinnon-Evans, Non-Executive Director

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

21/25	**Declarations of Interest** The declarations were noted. Board members have been made aware that any changes to declarations should be notified to the Head of Corporate	

	Affairs. If any items on the agenda present a potential conflict of interest, the person should declare the interest and remove themselves from the meeting for that item. The Chief Executive; Director of Finance; Stuart McKinnon-Evans, Non-Executive Director and Stephanie Poole, Non-Executive Director have a standing declaration of interest regarding items relating to the Collaborative Committee.	
22/25	**Minutes of the Meeting held 29 January 2025** The minutes of the meeting held on 29 January 2025 were approved as an accurate record. **Resolved:** **The minutes were approved by the Board.**	
23/25	**Action Log, Matters Arising and Workplan 2024/25** There were no matters arising. The action log and work plan were noted.	
24/25	**Patient / Staff Story – EDIT Team Eating Disorder Service Story** Justine Rooke, Lisa Weldrick, Samantha Mckenzie and Anna Doughty provided a background and overview of the services provided by the EDIT Team, which included progress on the service aims and objectives. The Chair asked for more details on avoidant/restrictive food intake disorder (ARFRD). Anna Doughty responded that this was a new description which included a phobia of swallowing, eating sensory and texture of food. This is often associated with an Autistic/Autism Spectrum Condition diagnosis. This had been challenging across the country as there were no commissioned pathways and an increase in referrals received, related to eating disorders. However, the team and other services work together to support service users. Priyanka Perera asked about funding options to continue with the service after the 1-year funding. Justine Rooke responded that the service was an NHS England pilot scheme and had received confirmation of recurrent funding to continue the service. Justine added that the service was an alternative to admission to an inpatient unit. Dean Royles asked how the transition of care for a child/young person into adult services was managed. Lisa Weldrick advised that the service does discharge a large number of young people from the service prior to requiring transfer over to adult services. Very few over transition over at the age of 18 years. Lisa added that there were differences in the services of Hull and the East Riding. Anna Doughty added that the transition is aided with careful advanced planning and support to the young person. The service could continue to support the young person over the age of 18 years if required. Phillip Earnshaw asked if there were any service user conditions out of scope and if so, what happens. Anna Doughty responded that ARFRD was such a condition, as some services were not commissioned to provide support. Lynn Parkinson commented that these pathways and services have transformed	

	and improved over the past few years. Lynn asked what the ambitions for the service where and any support required from the Board. Justine responded support regarding the ARFRD pathways and joint working with local acute trusts and multiagency support. Michele Moran asked how the Board could support in relation to the multiagency work and shared stories. Justine responded that an understanding of what was driving the eating disorders in communities and how the services could reach them with information and support to prevent conditions. Michele suggested some research be undertaken to support this. Priyanka Perera asked about the source of referrals received and whether service users could self-refer. Lisa responded that the main team receive referrals from all sources, including professionals and young people or families. **Resolved:** **The Board noted the information.**	
25/25	**Chair's Report** The Chair introduced the Chair's Report and highlighted the following key points: • Recent announcement regarding NHS England to be absorbed into the Department of Health and Social Care over the next year. There were also changes within the senior leadership team. • Following a recent Care Quality Commission visit to Inspire, initial feedback had been positive. The Inspire team were thanked for their work. • The Chair attended an Equality, Diversity and Inclusion launch event on 25 March in the Humber Centre. Yvonne Flynn, the team and a service user were thanked for the work undertaken. **Resolved:** **The Board noted the report.**	
26/25	**Chief Executives Report (Including policies to ratify)** The Chief Executive presented the report and highlighted the following key areas: • Policies for ratification. • Increase in demand seen due to acuity and complexities of cases. Support to staff was being explored. • PROUD Programme continues. • Staff Side Annual General Meeting had taken place. • A new staff birthday email would commence on 1 April, with a reminder of the additional leave day for birthday. • Reporting Groups proposal for approval. • NHS England to be absorbed into the Department of Health and Social Care. Integrated Care Board required to reduce staffing numbers by 50%. Planning guidance awaited on the way forward. • Multi Agency Public Protection Arrangements update. • Culture of care update. • Review of Prevent guidance.	

	• People Directorate – Statutory and Mandatory training update, with training brought over from other organisations in a 'passport', Winter plan and flu campaign discussed by Executives. • Patient and Carer Race Equality Framework would be implemented by 1 April 2025. • The Trust's 8th annual research conference was scheduled to take place on 19 November 2025 at the MKM Stadium in Hull. • New styles of Communications and Health Stars reports included in the report. Lynn Parkinson advised that the Trust OPEL levels were stable with OPEL 3 for Mental Health and OPEL 2 for Community Services. The Mental Health position was due to the rise in demand, particularly the Emergency Department. Some improvements had been seen in systemwide pressures. The system was now reporting via the UEC RADAR app, which produces real-time data. Lynn added that the virtual ward occupancy had improved, as a result of partnership work and changes in pathways. A review of last year's Winter Plan was taking place to assist with preparation for the coming winter. Hilary Gledhill highlighted the Culture of Care work. It was noted that the Trust was leading the way with the work undertaken. A celebration/showcase event had been scheduled for 15 May 2025. Kwame Fofie highlighted the Patient and Carer Race Equality Framework. Stephanie Poole asked how the work relating to sexual violence and misconduct linked in with the 'no excuse for abuse' framework and staff accessibility. Karen Phillips responded that all relevant programmes were aligned with the 'no excuse for abuse' framework. Karen added that John Duncan, EDI Lead was also a member of the Sexual Safety Group. The Reporting Groups proposal was approved. The following policies were ratified by the Board: • Complaints and Feedback Policy • Nutrition and Hydration Policy • Antimicrobial Stewardship Policy **<u>Resolved:</u>** **The Board noted the report.** **All the policies listed were ratified by the Board.** **The Reporting Groups proposal was approved.**	

27/25	**Publications and Highlights Report** The report which provided an update on recent publications was accepted as read. **Resolved:** **The Board noted the report.**	
28/25	**Patient Led Assessment of the Care Environment (PLACE) Update** Peter Beckwith introduced the Patient Led Assessment of the Care Environment (PLACE) Update report and highlighted the following key points: • An assessment of all inpatient facilities had been completed. • The results received on 20 February 2025. • The Trust compared well with Trust national averages. • Scores had improved for organisation food; this had increased from 85% to 95%. This was higher than the national average and the Trust was the 4th highest scoring Trust. • Improvements for disability scores had been seen. With an increase from 80% to 90%. • Resources had been set within capital program to support any areas identified for improvements. The Chair mentioned that Trust Governors would be involved in the next assessments. **Resolved:** **The Board noted the report.**	
29/25	**Health Inequalities Plan 2025-28** Sarah Clinch introduced the Health Inequalities Plan 2025-28 and highlighted the following key points: • The plan was developed through engagement with staff, partners and service users. • The plan was aligned with regional and national policy and the Trust Strategy. • Section included in the paper on the plans/goals and how the impact would be measured. • Previous Board discussions on delaying the plan until the national 10-year Health Plan had been published, which was expected in May 2025. However, the team would now like to progress in light of the NHS England changes. Stephanie Poole asked what health inequalities the Trust would be prioritising, and who would be the key partners. Sarah responded that work had been undertaken to look at the biggest inequalities in some areas, this would link in with the national reporting requirements. Sarah added that there were some initiatives in the plan on improving accessibility to services. Partners include the Integrated Care Board on 'inclusion health' and also working with PLACE and the voluntary sector colleagues. Keith Nurcombe asked how the work would be funded in the future. Sarah responded that additional funding would not be required. There would be a	

	communications campaign, for which the funding had already been agreed for this work. Staff training on interactions with service users was raised by Phillip Earnshaw. Sarah advised that alignment with other initiatives was taking place which included a trauma informed approach, working cultural care, health and equalities training and looking at person centred care. Sarah added work with the divisions and leads would take place to see how the plan was being implemented in teams. **Resolved:** **The Board noted the report.** **The plan was approved.** **The Board approved the progression of the plan, without awaiting the national 10-year Health Plan.**	
30/25	**Learning from the Review of Nottingham Healthcare** Paul Johnson introduced the Learning from the Review of Nottingham Healthcare report and provided a background, which included the 12 recommendations from NHS England (NHSE) for all organisations to review. Paul advised that good assurance was provided for the Trust, which could be seen in the table of the report. Work had been undertaken, including with staff and service users with actions acquired as a result. It was added that updated action plans were required to be submitted to NHSE by 30 June 2025. The Quality Committee would continue to have oversight of the work. **Resolved:** **The report was noted.**	
31/25	**2025/26 Board Assurance Against Planning Priorities** Peter Beckwith introduced the 2025/26 Board Assurance Against Planning Priorities report. He advised that the report detailed the current position against operational planning as detailed in the planning guidance, as well as the position in the wider Integrated Care System plan. Peter suggested that this information be used to compliment the Board Assurance Framework going forward. Phillip Earnshaw suggested that details be included on what initiatives and work would be carried out in relation to GPs. This could also be linked in with planning guidance for blood pressure and cholesterol checks, as well as NICE guidance in Mental Health learning disability check ups. Stephanie Poole enquired about the reduction in waiting times for elective care in community and the 278 patients waiting more than 18 weeks and what actions were being taken to address the matter. Lynn Parkinson responded that this was mostly due to the increased demand outstripping Trust resources. Lynn added that the service and model were constantly reviewed, with supply and demand and skills mix work being undertaken. Conversations were also ongoing with PLACE colleagues and commissioners. Stephanie	

	asked if the governance relating to the MSK service was via the Quality Committee. Lynn confirmed this was the case, they also monitor and receive assurance relating to all 18 week waits. Stephanie Poole asked for figures relating to the impact of Trust Services on Emergency Department (ED) waiting times and how responsive Trust services were in ED. Lynn Parkinson responded that demand had increased in ED, with the Trust having a Mental Health Liaison Service based there. Lynn added that there was an associated KPI for a response within 1 hour of referral to the Trust service, this was constantly being achieved. However, there are some rare exceptions where the case is complex and involves multiple agencies. The Chair mentioned the increased child and young people access, and asked what data was available to support this and how it would be measured. Peter Beckwith responded that this was included in the long-term dashboard. **Resolved:** **The Board noted the report.**	
32/25	**Humber and North Yorkshire Health and Care Partnership** **Mental Health, Learning Disabilities and Autism Collaborative – Programme Update** Alison Flack introduced the update report and highlighted the following key points: • Work was progressing on developing the future collaborative arrangements with all partners. This was currently in the transition stage. • Strategy and core offer engagement had taken place, with the final version being ready in the next few weeks. • A draft Operational Plan 2025/2026 was submitted to the Integrated Care Board in February 2025, and the final version was expected on 27 March 2025. • Autism and ADHD assessment demands and challenges noted. • Capital funding bid submitted for the Psychiatric Intensive Care Unit (PICU) and Child and Adolescent Mental Health Service (CAMHS). • Focused work relating to patients being sent out of area taking place. • The performance against trajectories could be seen in the report. Phillip Earnshaw asked how the capital that reconfigures the PICU estate, CAHMS and Navigo bedded unit impact on reducing out of area placements. Alison Flack responded that a PICU service that extends across the Humber and North Yorkshire was being explored. This was a similar position with the older adults bid by Navigo. Lynn Parkinson provided assurance that some work had been undertaken relating to the demand for services, which could be used for future planning of the services. Lynn added that some of the out of area placements were due to mixed gender concerns, as a result there was a proposal for single gender provision. **Resolved:** **The Board noted the report.**	

33/25	**National Staff Survey Results 2024** Karen Phillips introduced the National Staff Survey Results 2024 report and highlighted the following key points: • The results were released on 13 March 2025. • The Trust response rate had improved since the previous year and a better response rate was reported compared to benchmarking and national figures. • The Trust had reported higher-than-average scores across all the 9 People Promise Themes. • Some deterioration had been seen across section 6a, 'I feel that my role makes a difference to patients / service users', where some focused work would be undertaken. • The five core questions were reported as a good position. • Some areas where further work was required would be discussed by the Executive Management Team (EMT). • IQVIA would be attending the next Board meeting to present the results in more detail. • The results would be discussed with the divisions and individual action plans developed. EMT would discuss any overall Trust actions. Priyanka Perera asked if there were any 'quick fix' solutions that could be implemented whilst the psychological support to staff was being explored. Karen Phillips responded there was support packages in place through Trust Occupational Health Services, Karen added that post incident support was also being explored. **Resolved:** **The Board noted the report.**	
34/25	**Associate Hospital Manager Appointments and Reappointments** Kwame Fofie introduced the Associate Hospital Manager Appointments and Reappointments report. Kwame advised that approval was sought from the Board for the appointment and reappointment of the managers as listed below: • Jenha Denman – Reappoint • Martha Brons - Appoint • Leyan Elyas Brons - Appoint • Maureen Graham Brons - Appoint • Alison Cotterill Brons - Appoint The Chair requested a breakdown of staff for equality, diversity and inclusion purposes. It was advised that the Mental Health Legislation Committee receives assurance relating to staff diversity, which was anonymised. The information would also be circulated to the Board. **Resolved:** **The Board approved the appointments and reappointment detailed.** **An anonymised breakdown of staff for equality, diversity and inclusion purposes to be circulated to the Board.**	**KF**

35/25	**Electronic Patient Record (EPR) Major Projects Strategic Update** Lynn Parkinson introduced the EPR report and highlighted the following key points: • The final phase of go live to SystmOne was completed and successful. Robust planning had taken place, with some lessons learned throughout all the phases. • Good training levels had been achieved. • EPR extension (archive) had been successful rolled out. **Resolved:** **The report was noted.**	
36/25	**Leadership Competency Framework for Board Members – Update** Karen Phillips introduced the Leadership Competency Framework for Board Members report. Karen advised that the supporting documents were expected to be received in the autumn of 2024, however the revised date of 14 March 2024 was not met. It had been agreed that the Trust would proceed with documents used during 2024 if required. Karen advised that some supporting appraisal tools were being developed. It was added that further information was included in the Chief Executive report of this meeting. **Resolved:** **The report was noted.**	
37/25	**Finance Report** Peter Beckwith introduced the Finance Report as at month 11 and highlighted the following key points: • A Trust breakeven position was forecast. • The Integrated Care System position remained challenged. However, it was expecting that plan would be delivered of a £34m deficit. **Resolved:** **The report was noted.**	
38/25	**Performance Report** Peter Beckwith introduced the Trust Performance Report as at month 11 and advised that the Trust was in a similar position to previous months. Karen Phillips commented that high sickness levels was an area of concern. She advised that some bespoke targeted work by Human Resources was being undertaken with the teams in inpatient areas. **Resolved:** **The report was noted.**	
39/25	**Risk Register Update** Oliver Sims introduced the Risk Register for the Trust position for quarter 3 and highlighted the following key points: • There were 5 risks on the Risk Register, with the current position been	

	discussed at the Executive Management Team (EMT) meeting. • Several risks had been closed since the last report to the Board. It was suggested that a new risk be added to the Risk Register in relation to Integrated Care System target challenges for 2025/26. The risks would continue to be monitored and reported to EMT and the Operational Delivery Group. **Resolved:** **The report was noted.** **The amendments to the Risk Register were approved.**	
40/25	**Board Assurance Framework Update** Oliver Sims introduced the Board Assurance Framework (BAF) for quarter 3 and highlighted the following key points: • The BAF would be reported to the Board three times per year. • The BAF had been represented at the appropriate Trust Committee and Executive Management Team meetings. • The BAF would be linked to the Trust Strategic goals. • The template was undergoing review and would be updated during quarter 1 of 2025/26. **Resolved:** **The report was noted.**	
41/25	**People & Organisational Development Committee** Dean Royles presented the People & Organisational Development Committee Assurance Report and highlighted the following key points: • Updates had been received from three reporting groups. • Metrics and KPIs were discussed, reduction in vacancy and turnover rates were noted. Work was ongoing to improve Consultancy vacancy rates further. • Guardian of Safe Working Hours Report had been received. • Mental Health Social Work in the NHS had been discussed following NHS England guidance. • Reviews of the Committee had also taken place. **Resolved:** **The report was noted.**	
42/25	**Quality Committee Assurance Report** Phillip Earnshaw presented the Quality Committee Assurance Report and highlighted the following key points: • Quality Committee would continue to have oversight of the recommendations following the Nottingham homicides. • The Thematic Report to be presented at the Committee in 6 months. • The Executive Management Team to look at risk profiling the estate as a result of receiving the Annual Ligature Report.	

	Resolved: **The report was noted.**	
43/25	**Mental Health Legislation Committee Assurance Report** Stephanie Poole presented the Mental Health Legislation Committee Assurance Report and highlighted the following key points: • Assurance had been received for Quarter 3 (Q3) performance. • A slight reduction in the use of restraints had been seen during Q3. • An increase in acuity had been seen, with seclusions been in normal control limits. • A presentation had been received from the Hull and East Riding Crisis Care Concordat. • An assurance report for the governance relating to Multi-Agency Public Protection Arrangements was received. • Work would be undertaken on the potential impact on the Trust and resource linked to The Mental Health Bill 2024. **Resolved:** **The report was noted.**	
44/25	**Audit Committee Assurance Report** The Audit Committee Assurance Report was accepted as read; any questions were to be submitted to Stuart McKinnon-Evans. **Resolved:** **The report was noted.**	
45/25	**Collaborative Committee Assurance Report** The Collaborative Committee Assurance Report was accepted as read; any questions were to be submitted to Stuart McKinnon-Evans. **Resolved:** **The report was noted.**	
46/25	**April Board Strategic Development Meeting Agenda** The agenda for the April Board Strategic Development Meeting was accepted as read. **Resolved:** **The agenda was noted.**	
47/25	**Items to Escalate including to the High Level Risk Register & for Communication** There were no items to escalate.	

48/25	**Any Other Urgent Business** Hilary Gledhill was thanked for her work and service in the Trust and to the NHS. There were no other items of business raised.	
49/25	**Review of Meeting – Being Humber** The Board agreed the meeting had been held in the Being Humber style.	
50/25	**Exclusion of Members of the Public from the Part II Meeting** It was resolved that members of the public would be excluded from the second part of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest. The meeting concluded at 11:50am.	
51/25	**Date, Time and Venue of Next Meeting** Wednesday 28 May 2025, 9.30am via Microsoft Teams	

Signed …… Date …….

Chair

Humber Teaching NHS Foundation Trust

Agenda Item 4

Action Log:
Actions Arising from Public Trust Board Meetings

Summary of actions from March 2025 Board meeting and update report on earlier actions due for delivery in May 2025 *Rows greyed out indicate action closed and update provided here*						
Date of Board	**Minute No**	**Agenda Item**	**Action**	**Lead**	**Timescale**	**Update Report**
26.03.25	There were no new actions arising from this meeting.					

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

Humber Teaching NHS Foundation Trust

Board Public Workplan April 2025/March 2026 *(v8)*

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

Board Dates:- Reports:	Strategic Headings	LEAD	28 May 2025	30 Jul 2025	24 Sep 2025	26 Nov 2025	28 Jan 2026	25 Mar 2026
Standing Items - monthly								
Minutes of the Last Meeting	Corporate	CF	x	x	x	x	x	x
Actions Log	Corporate	CF	x	x	x	x	x	x
Chair's Report	Corporate	CF	x	x	x	x	x	x
Chief Executives Report includes:- Policy ratification, Comms Update, Health Stars Update, Directors updates	Corporate	MM	x	x	x	x	x	x
Publications and Highlights Report	Corporate	MM	x	x	x	x	x	x
Performance Report	Perf & Fin	PB	x	x	x	x	x	x
Finance Report	Perf & Fin	PB	x	x	x	x	x	x
Work plan	Corporate	SJ	x	x	x	x	x	x
Board Assurance Framework	Corporate	MM	x	x	x	x	x	x
Quarterly Items								
Finance Committee Assurance Report	Assur Comm	KN	x	x		x	x	
People & Organisational Development Committee	Assur Comm	DR	x		x	x		x
Quality Committee Assurance Report	Assur Comm	PE	x		x	x	x	x
Mental Health Legislation Committee Assurance Report	Assur Comm	SP	x		x	x		x
Audit Committee Assurance Report	Assur Comm	SMcKE	x		x	x		x
Collaborative Committee Report	Assur Comm	SMcKE		x		x	x	x
Risk Register (March, July, November)	Corporate	SS		x		x		x
Communications Plan Quarterly Update (January, May July and November)	Corporate	RK/MM	x (from 2026)	x		x	x	
Humber and North Yorkshire Integrated Care System – Mental Health and Learning Disabilities Collaborative Programme Update Update	Corporate	MM		x		x		x
Six Monthly and Annual Agenda Items								
MAPPA Strategic Management Board Report (inc in CE report)	Strategy	LP			x			x
Safer Staffing 6 Monthly Report (July, January)	Corporate	SS		x			x	
Research and Development Annual Report	Corporate	KF		~~x~~	x			
Suicide and Self-harm Strategic Plan (next due September 2025)	Strategy	KF			x			

NHS
Humber Teaching
NHS Foundation Trust

Board Dates:- Reports:	Strategic Headings	LEAD	28 May 2025	30 Jul 2025	24 Sep 2025	26 Nov 2025	28 Jan 2026	25 Mar 2026
Recovery Strategy Framework Update (from 2026)	Strategy	LP						
Patient and Carer Experience Forward Plan (2023 to 2028 – next due September 2028))	Strategy	KF						
Presentation of Annual Community Survey Results	Corporate	KF		x				
Guardian of Safeworking Annual Report	Corporate	KF			x			
Patient & Carer Experience (incl Complaints and PALs) Annual Report	Corporate	KF			x			
Infection Control (Enabling) Plan (three yearly – next due in Sept 2026)	Strategy	SS						
Infection Prevention Control Annual Report	Quality	SS			x			
Safeguarding Annual Report	Quality	SS			x			
Annual EPRR Assurance Report	Quality	LP	x					
EPRR Core Standards	Corporate	LP				x		
Patient Led Assessment of the Care Environment (PLACE) Update	Quality	LP						x
NHS England - Annual Self-Assessment for Placement Providers	Quality	KF			x			
Annual Operating Plan	Strategy	PB						x
Freedom to Speak Up Annual Report (and Six Month Update)	Corporate	MM		x			6 month update	
Annual Non-Clinical Safety Report	Quality	PB			x			
Annual Associate Hospital Manager Review	Quality	KF						x
Report on the Use of the Trust Seal	Corporate	MM	x					
Review of Standing Orders, Scheme of Delegation and Standing Financial Instructions	Corporate	SJ	x				SFI Thresholds	
Charitable Funds Annual Accounts	Corporate	PB					X Separate meeting of Trustees	
A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D – Annual Board Report and Statement of Compliance	Corporate	KF			x			
Gender Pay Gap	Corporate	KP		x				
WDES Report — reports into Workforce & Organisational Development Committee, but separate report to the Board	Corporate	KP		x				
WRES Report reports into Workforce Committee with report to Board	Corporate	KP		x				
Equality Diversity and Inclusion Annual Report	Corporate	KP			x			

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Board Dates:- Reports:	Strategic Headings	LEAD	28 May 2025	30 Jul 2025	24 Sep 2025	26 Nov 2025	28 Jan 2026	25 Mar 2026
Board Terms of Reference Review (inc in Effectiveness review)	Corporate	CF	x					
Annual Committee Effectiveness Reviews & Terms of Reference (one paper)	Corporate	SJ	x					
Reaffirmation of Slavery and Human Trafficking Policy Statement in Chief Executive report	Corporate	MM					x	
Fit and Proper Person Compliance	Corporate	CF	x					
Winter Plan	Corporate	LP			x			
Compliance with the New Provider License	Corporate	SJ	x					
Staff Survey Presentation to Board (IQVIA attending)	Corporate	KP	x	~~x~~				
Staff Survey Progress Report	Corporate	KP			x			
Annual Non-Clinical Report	Quality	KF			x			
Review of the Constitution	Corporate	SJ		x				
EDS22 Report	Corporate	KP			x			
Auditors Letter	Corporate	PB				x		
Annual Members Meeting Minutes	Corporate	CF				x		
Adhoc/future Items								
Freedom to Speak Up Strategy 2024-2027 (next due May 2027)	Corporate	MM						
Review of Committee Membership and NED Champions (part of Chair report)	Corporate	CF			x			
Research Strategy 2024-2026 (next due 2026)	Quality	KF						
Electronic Patient Record (EPR) Optimisation Update (include in CEO report)	Corporate	LP	x	x	x	x	x	x
Health inequalities	Corporate	KF	~~x~~	x		x		x
Insightful Board Update	Corporate	SS/SJ	x	x				
Mental Health Inpatient Redesign and Granville Court Development Progress Update (requested at the April Strategic Board Development meeting)	Corporate	PB				x		
Deleted /Removed Items								

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Agenda Item 5

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Sophie Wilkinson – '*A thank you letter to the Perinatal Mental Health Team. My journey*'
Author/s:	Sophie Wilkinson (Service User) supported by: Sammi Daniels (Specialist Perinatal CBT Psychotherapist, Perinatal Mental Health Team) Fernanda Marbrow (Patient and Carer Experience Manager)
Recommendation:	To approve: ; To discuss: ✓ To note: ; To ratify: ; For assurance:
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	Sophie will tell her story to the Trust Board to share her experience of care provided by our Perinatal Mental Health Service, and the impact of this care on herself and her family. By sharing '*A thank you letter to the Perinatal Mental Health Team. My journey',* Sophie will demonstrate to the board the value of effective partnership delivery of essential specialist mental health and wellbeing care. Sophies Journey is one of recovery and hope, and her wish is that this be used to help others who may find themselves in need of support. Sophie also requests her story to be used to evidence the work taking place within the Perinatal Mental Health Team, and to raise the profile of this invaluable specialist service.

Key Issues within the report: NA

Positive Assurances to Provide: • Supports the Trusts strategic goals (see section below) • Demonstrates the positive work taking place within our Perinatal Mental Health Service. • Demonstrates the impact of effective partnership delivery between the Trust and Navigo. • Story shared within Navigo Magazine – Spring 2025 Edition.	**Key Actions Commissioned/Work Underway:** • Sophie remains actively involved with PNMHS and is working with the team to identify potential peer support opportunities. • Sophie has provided lived experience support to the ongoing refresh of the following Trust framework – '*Sharing of Patient, Service User and Carer Stories'*
Key Risks/Areas of Focus: • None	**Decisions Made:** •

Caring, Learning
& Growing Together

Governance: *Please indicate which committee or group this paper has previously been presented to:*				
		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
✓	Innovating Quality and Patient Safety
✓	Enhancing prevention, wellbeing and recovery
✓	Fostering integration, partnership and alliances
✓	Developing an effective and empowered workforce
	Maximising an efficient and sustainable organisation
✓	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Patient Story for Trust Board
May 2025

Introduction
Sophie will attend the Board meeting via MS Teams accompanied by Sammi Daniels, Specialist Perinatal CBT Psychotherapist from the Perinatal Mental Health Team and Fernanda Marbrow, Patient and Carer Experience Manager. There will be an introductory overview of the service given by Sammi, followed by Sophie sharing her story '*A thank you letter to the Perinatal Mental Health Team. My journey'.*

Overview of Service
Perinatal Mental Health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 27% of new and expectant mums and covers a wide range of conditions *(NHS England)*. Specialist PMH services provide care and treatment for women with complex mental health needs and support the developing relationship between parent and baby. They also offer women with mental health needs advice for planning a pregnancy.

The service is provided in partnership with Navigo and is available to women who require specialist assessment and interventions for a moderate to severe mental health problem. The multidisciplinary team also works in partnership with other teams and services with a wrap around, person-led approach to promoting positive maternal mental health and wellbeing throughout the perinatal period.

Direct referrals to the PNMH can be made by health and social care professionals involved in an individual's care including GPs, Midwives and Health Visitors.

Background
Sophie began treatment with the perinatal mental health team in early September 2023 after her son was born at the end of August that year. She was referred to the team by a psychologist who visited Sophie during a hospital stay relating to insomnia. She was discharged by the team in February 2025 after they allowed her to stay on as a service user past the usual discharge timeline (her son turning 1). They spent the additional 6 months ensuring Sophie's mental health was stable enough for discharge.

Key Messages
Sophies Journey is one of recovery and hope, and her wish is that this be used to help others who may find themselves in need of support. Sophie also requests her story to be used to evidence the work taking place within the perinatal mental health team, and to raise the profile of this invaluable specialist service.

Links to Trust Strategic Objectives

- **Innovating Quality and Patient Safety**

Sophie was discharged from Perinatal Mental Health Services February 2025. She continues to be involved with the team to share her story in multiple, accessible formats including via service magazines and social media. Sophie hopes that that sharing her care journey will help to raise the profile of perinatal mental health services.

- **Enhancing prevention, wellbeing and recovery**

Sophie's wish is to use her story to provide hope and inspiration to others who may find themselves in need of similar support. Her journey demonstrates an individual's recovery within a supportive environment, with a team who provide the wrap around care required to enhance wellbeing and prevent deterioration in health.

- **Fostering integration, partnership and alliances**

Sophie's story demonstrates the impact of effective working between provider partners, covering a vast demographic and geographical footprint.

- **Developing an effective and empowered workforce**

Sophie is supporting, in a lived experience capacity, with a refresh of the organisation's *Sharing of Patient, Service User and Carer Stories* framework.

- **Promoting people, communities and social values**

Sophies story, and the sharing of her time with our Perinatal Mental Health Service, raises awareness of perinatal mental health, the challenges that many women may face during the postnatal period, and the critical need for such services to be accessible and responsive. It also demonstrates the sustained, positive effect the support she received has had on both her and her family.

Ask of The Board

For Sophie, attending this Board meeting to talk about her experience is very much ‘outside of her comfort zone’ but, as she will tell you herself, she feels that without the support she received from the Perinatal Mental Health Team she would not be here today, and her young son would be without his mum.

Sophie asks the Board to listen to her story and to appreciate the absolute need for the Perinatal Mental Health Service to be supported, developed, and invested in moving forward.

Humber Teaching NHS Foundation Trust

Agenda Item 6

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting – 28 May 2025</td></tr>
<tr><td>Title of Report:</td><td>Trust Chair’s Report</td></tr>
<tr><td>Author/s:</td><td>Rt Hon Caroline Flint</td></tr>
<tr><td>Recommendation:</td><td>
<table>
<tr><td>To approve</td><td></td><td>To discuss</td><td></td></tr>
<tr><td>To note</td><td>✓</td><td>To ratify</td><td></td></tr>
<tr><td>For assurance</td><td>✓</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Purpose of Paper: Please make any decisions required of Board clear in this section:</td><td>To provide updates on the Chair, Non-Executive and Governor activities since the last Public Board meeting.</td></tr>
<tr><td colspan="2">Key Issues within the report:</td></tr>
<tr><td colspan="2">
<table>
<tr>
<td>Positive Assurances to Provide:

• Update from the last Board Strategic Development meeting.
• Continued high level engagement with Humber and North Yorkshire Integrated Care System, NHS England and national networks
• CQC Inspection Inspire receives Good rating
• Attended Finance, Quality and People and Organisational Development Committees
• Culture of Care Quality Improvements
• Governor Elections nearly completed</td>
<td>Key Actions Commissioned/Work Underway:

• Mental Health, Learning Disabilities and Autism Collaborative progressing
• Improvements to Board Assurance Framework and Performance Report
• Mental Health Redesign and Granville Court Redevelopment</td>
</tr>
<tr>
<td>Key Risks/Areas of Focus:

Turmoil and uncertainty still in terms of changes nationally, regionally and</td>
<td>Decisions Made:

NA</td>
</tr>
</table>
</td></tr>
</table>

at Integrated Care Board as well as resourcing for 2025/26 and 2026/27.	

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

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

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
✓	Innovating Quality and Patient Safety
√	Enhancing prevention, wellbeing, and recovery
✓	Fostering integration, partnership, and alliances
✓	Developing an effective and empowered workforce
√	Maximising an efficient and sustainable organisation
✓	Promoting people, communities, and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Trust Chair's Board Report – 28 May 2025

Congratulations to our staff at Inspire who received a Good rating following a Care Quality Commission (CQC) inspection. Staff within the Trust have been provided with a suite of information (via the intranet) in preparation for a CQC inspection of their services and the Board have met to discuss our readiness and increase our learning about the new CQC inspection regime.

I'm pleased to have taken part in interview panels for Beverley Community Mental Health Team Consultant and Hull Integrated Care Team for Older People Consultant Psychiatrists on the 9 April. For both positions the panel was able to approve candidates.

Humber's Culture of Care Showcase took place on 15 May, and I was delighted to open the event alongside Clinical Director Paul Johnson. The day showcased the work of four wards Townend Court, Swale, Avondale and Westlands. They are part of this national project developing a set of standards based on a co-produced, reimagined vision of care for all NHS funded mental health inpatient settings. I visited Townend Court on the 14th May and am looking forward to visiting the other wards over the next few months. It was great to hear from Experts-by-Experience Nikki Gratton (who presented recently to Board too) and Amber Waddington on co-production as well as speakers on autism-informed wards, anti-racist practice and Patient and Carer Race Equality Framework, trauma informed wards and health inequalities.

At time of writing this report I am due to attend and close Humber's Equality, Diversity and Inclusion Annual Event on 22 May. I look forward to a good turnout and discussion.

Trust Board Strategic Development Meetings

These meetings include a small number of key items on the agenda which enable Board members to have a detailed discussion regarding matters of strategic importance. Time is also allocated, as appropriate for the Board to work on its own development. In addition, at each meeting over a sandwich lunch we meet and hear from a group of staff.

Trust Board Strategic Development Meeting 30 April 2025

The Board discussed:

- **Mental Health Inpatient Redesign and Granville Court Redevelopment** -The Board requested an update in six months' time regarding the progress being made with the projects and approved two contract awards.
- **Care Quality Commission Well Led: Evidence Underpinning Quality Statements 1 Shared Direction and Culture and 2 Capable, Competent and Inclusive Leaders -** Sarah Smyth and Kate Baxendale presented the evidence based on teams' self-assessments. A Board paper regarding the role and focus of Performance and Accountability Reviews would be produced.
- **The Board Assurance Framework (BAF) against the Trust Strategic Goals –** Pete Beckwith presented outlined proposals to strengthen assurance and a worked example of the new format. It was agreed the Board sub-committees

consider the new format/information during their next review of the BAF and provide feedback to Executive Management Team (EMT) via the Committee Executive lead and that the BAF should be forwarded to each Board meeting.

- **Annual Review of the Performance Report -** Pete Beckwith introduced a paper which highlighted EMT had reviewed the Performance Report and made recommendations regarding metrics to be removed/added to the document. Trust Board approved the recommendations.
- **Mental Health Host Provider Update -** a full discussion took place on progress talks with providers. Key points of assurance: the Strategic document aligned with the Trust and Integrated Care Board (ICB) strategies and Bi-weekly Trust meetings were occurring involving Non-Executive an Executive Directors.
- **Improving the Child and Adolescent Mental Health Service (CAMHS) Pathway -** Justine Rooke and Sam McKenzie gave a presentation regarding proposed improvements to the CAMHS pathway through a one team approach to tackle challenges and make planned improvements. Engagement with staff had informed the pathway structure and the team had worked with local authorities and the ICB to develop pathways/working relationships. The Clinically-Led workforcE and Activity Redesign (CLEAR) programme was key to the success of the project and outcomes from the work would be measured.
- **Meeting Staff -** over a sandwich lunch we met with staff from teams across the Trust who had supported their colleagues in the Electronic Patient Record team move from Lorenzo to SystmOne. We thanked them for their efforts which have been crucial to delivery and learning.

1. Chair's Activities Round Up

I attended and opened the **Equalities, Diversity and Inclusion (EDI) event at the Humber Centre** on 25 March which was inspired by a patient Nathan supported by Yvonne Flynn to look at how patients' voices could be better heard and supported. Key to this was providing more inclusive activities at Humber Centre and re-energising the Patients' Forum. The afternoon mainly brought patients, families and staff together with a marketplace of different services and activities for people to find out about and join in. Very popular is the redesigned shop which is needed and provides a good social space sited in the dining area which has been redecorated. I also had a look at the new gym which has replaced the swimming pool and is being well used.

Dean Royles (as Senior Independent Director) and I met with **Michele Moran for her 2024/25 Appraisal on 10 April.** Mine and Non-Executive Directors (NEDs) appraisals will take place in June.

At the **NHS Confederation Mental Health Network Annual Conference on 23 April** in Leeds I heard directly from Jim Mackey and other national leaders as well as attending some useful workshops. It was a good opportunity to hear how others are tackling similar challenges and share our own experience and examples of great practice. However, there is still considerable uncertainty about changes at national, regional and Integrated Care Board levels alongside funding for this year and next.

On the **29 April I met with John Lawlor** who as an independent Chair has been working with all the Chief Executives involved in the development of collaborative arrangements. I will be meeting him every 6 weeks or so going forward. On 12 May

Mental Health, Learning Disabilities and Autism Provider Chairs and Chief Executives met. Everyone could see the benefits of greater partnership to deliver better for patients and secure funds. It was agreed to maintain momentum whilst resolving outstanding issues.

Also, on the **29 April I attended Humber's Nurses Forum** which was very informative and heard Sarah Smyth being grilled in a Q&A - she rose to the challenge.

Jason Stamp, the newly appointed Interim Chair for Humber North Yorkshire Integrated Care Board, and I met on 20 May to discuss his priorities and working with him over the next six months.

Internal meetings included:
Freedom to Speak Up Quarterly Review 9 April
Finance Committee 15 April
Remuneration Committee 30 April
People and Organisational Committee 7 May
Quality Committee 8 May
Quarterly 1:1s with NEDs

External meetings included:
Humber and North Yorkshire (HNY) Provider Chairs
HNY System Chairs and CEO
Yorkshire and Humber Chairs
NEY NHS Leaders
NHS Confederation Mental Health Chairs' Network
NHS Confederation Chairs' Network event for NEDs
NHS England Chairs/CEOs event

2. Visits

Chair
My visits since the last Board meeting included the IT and Human Resources Teams on 9 April and the Estates Team on 15 May. It was good to meet and hear from corporate staff whose work is important to our health service delivery and patient care.

I was delighted to visit Townend Court on 14 May and talk with staff and patients about positive changes happening as part of the Culture of Care Standards work at Humber. Thanks to Rachel Watson and colleagues also Leah who showed me around Lilac Ward,

Director/NEDs Unannounced Visits

- **Newbridges**
  Kwame Fofie and Dean Royles

- **Granville Court**
  Karen Phillips and Stuart McKinnon-Evans

3. Governors

The Council of Governors (CoG) met on 17 April. As well as standing items they received presentations from Andy Sainty and Sarah Bradshaw from our Community Mental Health Team and Cllr Linda Chambers the Hull City Council Partner Governor. Governors will be invited to take part in our Patient Led Assessment of Care Environment (PLACE) 2025 visits in the Autumn.

Governor Development and Information

Governor Briefings are open to all governors including our Partner Governors. Non- Executive Directors are welcome to attend too. They take place ten times a year from 0900-1000 online with time for an informal catch up and for a bitesize brief on a specific service or topical issue relevant to governors.

Governor Briefing 27 Mar – How our Multi-Disciplinary Teams (MDTs) work
Governor Briefing 24 Apr – Recruitment Processes

An email Governor Briefing was provided on **managing safe staffing levels.**

The Governor Development Session on 10 July will cover the role of Board Sub Committees; **Audit, Collaborative and Finance led by Non-Executive Director Chairs Stuart McKinnon Evans and Keith Nurcombe; Health Inequalities and Humber Ministry of Justice Contracts /Prisons and Humber Centre Services.**

An updated schedule is attached as Appendix 1.

Governor Elections 2025

The Governor election process began on 6 March as nominations opened for 2 Hull Public, 2 Staff and 2 Service User and Carer vacancies. Nominations closed on 3 April.

Public Hull (2) Brian Swallow was re-elected as there were no further nominations leaving a Public Hull vacancy until the next election round this Autumn.

Service user & Carer (2) **Marilyn Foster and Anthony Houfe** were re-elected as there were no further nominations.

Staff Clinical (1) **Ryan Cockell-Whitehead**, **Sian Johnson and Will Taylor** were nominated, and an election will follow.

Staff Non-Clinical (1) **Simon Mills and Pawel Szczurek** were nominated, and an election will follow.

Contested elections opened on 29 April and close on Friday 23 May. We will move to annual elections every year from 2026.

Congratulations to Brian, Marilyn and Anthony.

Appendix 1

Governor Development/Briefing Schedule 2024-26

Chair of Council of Governors: Caroline Flint **Executive Lead:** Michele Moran

Title	Date	Presenter	GB or GDS
Our Community Services	27/11/2025	Matthew Handley	GB
Overview of Co-Production work across Humber Divisions and Experts by Experience	13/11/2025	Lynn Parkinson Kwame Fofie	GDS
Developing Place and Integrated Care Board	30/10/2025	Michele Moran Pete Beckwith	GB
Peer Support Work	25/9/2025	Tom Nicklin Lynn Parkinson	GB
What services do we provide for children.	31/7/2025	Justine Rooke	GB
Role of the Board Sub-Committees Audit, Collaborative & Finance	10/7/2025	Non-Executive Director (NED) Chairs Stuart McKinnon-Evans Keith Nurcombe	GDS
Humber Ministry of Justice (MoJ) Contracts/ Prisons and Humber Centre Services	10/7/2025	Lynn Parkinson Paula Phillips	GDS
Health Inequalities	10/7/2025	Kwame Fofie	GDS
What Learning Disabilities Services we provide.	26/6/2025	Justine Rooke	GB
Mental Health Team and Emergency Department Streaming at Hull Royal Infirmary	29/05/2025	Lynn Parkinson	GB

How we recruit and ensure safe staffing Recruitment Process and Safe Staffing levels.	24/04/2025	Karen Phillips	GB
How our Multi-Disciplinary Teams (MDTs) work	27/3/2025	Paul Johnson	GB
Role of the Sub-Committees Workforce, Mental Health Legislation & Quality	13/3/2025	NED Chairs	GDS
How we collect feedback from our patients and service users and how we handle complaints	13/3/2025	Mandy Dawley & David Napier	GDS
Yorkshire and Humber Care Record	27/2/2025	Lee Rickles & Ian	GB
Governance and liability for services we commission	30/1/2025	Pete Beckwith	GB
Improving our estates (any major developments, key priorities etc)	28/11/2024	Pete Beckwith & Rob Atkinson	GB
Delayed Transfers of Care – understanding the reasons for a patient's discharge being delayed	14/11/2024	Lynn Parkinson & Claire Jenkinson	GDS
Interweave Connecting Care Information	7/11/2024	Caroline Flint	Email
EPR progress update	24/10/2024	Lynn Parkinson & Lee Rickles	GB
Significant Transactions	15/8/2024	Pete Beckwith	GDS
Understanding the respective roles of the CoG/Board/NEDs/Exec	13/3/2024	Susan Young	GDS

GB Governor Briefing **GDS** Governor Development Session

Updated 24/4/2025

Humber Teaching NHS Foundation Trust

Agenda Item 7

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Chief Executive's Report
Author/s:	Name: Michele Moran Title: Chief Executive
Recommendation:	To approve: ; To discuss: ✓ To note: ; To ratify: ✓ For assurance:
Purpose of Paper:	To provide the Board with an update on local, regional and national issues. Areas of note include: Consultant Appointments Requiring Ratification. Ratification of policies for: • Retirement Policy • Care Programme Approach Policy
Key Issues within the report:	
Positive Assurances to Provide: • Work contained within the report	**Key Actions Commissioned/Work Underway:** • Contained within the paper
Key Risks/Areas of Focus: • Nothing to escalate	**Decisions Made:** • Ratification of Policies • Consultant Appointments Ratification

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

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
✓	Innovating Quality and Patient Safety
✓	Enhancing prevention, wellbeing and recovery
✓	Fostering integration, partnership and alliances
✓	Developing an effective and empowered workforce
✓	Maximising an efficient and sustainable organisation
✓	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Chief Executive's Report

1 Policies for Approval

1.1 Trust Policies

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

Policy Name	Date Approved	Lead Director	Key Changes to the Policy
Retirement Policy	25/03/2025	Associate Director of People and OD	The Retirement Gift section of this policy has been amended to ensure a consistent approach is followed across the Trust.
Care Programme Approach Policy	13/05/2025	Medical Director	Section added in the introduction about personalised care planning (PCP) by Adult Mental Health Programme Lead. Principal Occupational therapist (Forensic Division) reviewed section 5.13 CPA and Prisoners. Named Nurse Safeguarding Children reviewed sections 5.8 and 5.8.1 specific to children and young people. CAMHS Senior Clinical Lead and CAMHS Service Manager reviewed sections 5.14 and 5.14.1 specific to CAMHS. Added consideration of virtual / face to face reviews following feedback from lived experience group (Page 20). Amended all references to old EPR system, Lorenzo.

1.1.2 Consultant Appointments Requiring Ratification

Through formal, fully constituted Advisory Appointment Committee (AAC) the following substantive Consultant appointments were made:

1. Dr Salman Afzal – Prison Service (Secure Division), AAC date: 20th November 2024.

2. Dr Vineet Sukumar – Hull Integrated Care Team for Older People (HICTOP), AAC date: 9th April 2025.
3. Dr Shumaila Shahbaz – Beverley Community Mental Health Team (CMHT), AAC date: 9th April 2025.

Ratification of the consultant appointments are now required by the Trust Board.

1.2 Leadership Visibility

I continue my drops in visits across the area including corporate services, which is a major part of my role.
'Meet Michele' is now fully hybrid and well supported.

I have attended a few conferences all staff and service user lead showcasing our great services, co-production and positive outcomes.

Our staff continue to develop services even with the increasing demands of the services.

1.2.1 Around the Trust

NHS Providers

The trust was proud to be mentioned with case studies in the NHS Providers Annual report. a reflection of the hard work of the all the staff involved.

https://nhsproviders.org/resources/providers-deliver-putting-young-people-at-the-heart-of-care/humber-teaching-nhs-foundation-trust

Priorities

Annually the Executive team review following the Boards feedback and comments, review our strategy, alongside triangulation with metrics and highlight areas of focus;

2025/26 are:

- Our Culture/Being Humber Behavioural Framework
- Triangulating Staff Survey results with other metrics
- Our well-led and Insightful Board analysis
- Optimising utilisation of our estates
- Service transformation
- Professional strategies
- Our profile within the ICB and nationally

Patient safety priorities:

Optimising our workforce well-being in response to patient safety incident.

Ensuring safe transfers of care and effective joint working practices.

Involving patients' families and carers in their care journal.

Royal Garden Party

The Trust supported Emma Thompson, Team Leader, from our Mental Health Liaison Service in attending a Royal Garden Party at Buckingham Palace on Tuesday 20 May 2025. Emma was put forward for the opportunity through our ICB for her work in developing and managing the Emergency Department Mental Health streaming service. The ED Streaming service provides a pathway for patients attending A&E who present with mental health concerns. It was shortlisted for several national awards last year. This is a huge honour for Emma and the service to be recognised for this opportunity, the Royal Garden Parties are a way to thank individuals for their public service and contributions.

Collaborative

The Mental Health Collaborative has reached the final stage of the LDA National Awards for our work with Matthews Hub on the Oliver McGowan training.

2 Around the System

Local Election Results
Newly Elected Mayor of Hull and East Riding:
Luke Campbell – Reform

Greater Lincolnshire
Andrea Jenkyns – Reform

ICB Acting Chair
Jason Stamp has been appointed as the new acting Chair of NHS Humber and North Yorkshire Integrated Care Board, on an initial six-month basis.
Jason has been a Participant member of the Board since its inception and is the strategic lead for the development and integration of the voluntary sector into the work of the Humber and North Yorkshire Health and Care Partnership.

He is also the SRO of the Partnership's Workforce Transformation programme, Breakthrough HNY.

York and Scarborough NHS Teaching Trust

York and Scarborough hospitals have confirmed the opening of new Urgent and Emergency Care Centre (UECC), the trust is working closely with the teams as required.

The hospital Trust have invested £47 million to build the new flagship Urgent and Emergency Care Centre at Scarborough Hospital. Commonly referred to as the UECC, the centre includes a two-storey new build, combining and expanding the current emergency department, same-day emergency care, and the acute medical unit. As well as improving outcomes for the frail and elderly, it will also ensure that some of the most critically ill patients in the hospital are cared for in one integrated

clinical ward environment, rather than across a number of different wards and the critical care department.

Services have moved across to the UECC in a phased approach throughout this week (w/c 28 April), with the new emergency department accepting patients from yesterday, Thursday 1 May 2025.

Care Plus Group (CPG) CIC
Shaun Stacey will no longer be joining CPG. Following ratification at Council of Governors Lisa Revell, Deputy Chief Executive, will be undertaking the role of interim Chief Executive, initially until 31 December 2025. This will ensure that consistent leadership is provided. CPG stated: '*With the current changes in the NHS and Social Care, both regionally and nationally, it is important that we have stability within the organisation at this time, so that staff, partners and the wider system and local community can be confident that CPG is continuing to operate efficiently and effectively.'*

National news is covered this month in separate papers.

3 Director Updates

3.1 Chief Operating Officer Update

3.1.2 Leadership Visibility
The Chief Operating Officer continues to undertake a series of visits to in patient units, unannounced and out of hours. Current operational challenges are discussed, areas of transformational change work are considered and any barriers to making progress are picked up and addressed. Overall staff are motivated and committed to service improvement.

3.1.3 Operational Position and Service Planning
This update provides an overview of the operational position and service planning across our clinical services and the arrangements and continuing work in place in the Trust and with partner organisations to manage concurrent pressures.

The collective action that was being undertaken by some GP practices and Primary Care Networks has been resolved contractually through the Local Enhanced Service arrangement and concerns about our shared care prescribing protocols have been addressed. Given the recent focus on these protocols we are however taking the opportunity to review them to ensure that they are as explicit and current as they need to be, this work is being led by the Deputy Chief Operating Officer with the support of the Medical Director.

Our operational pressures continue to be monitored through our daily sitrep reporting processes to identify and respond to pressures quickly across services, ensuring we are clear what our level of pressures are, allowing us to communicate these to the wider system effectively and either respond with or receive mutual aid as necessary. New national, regional and ICS wide OPEL reporting arrangements came into effect last year with the introduction of national, regional and system coordination centres

in line with the OPEL Framework 2023/24. Triggers and action cards associated with each level in the OPEL framework continue to be reviewed to ensure that the actions taken to prevent escalation are robust. Triggers are now in place that stand up daily executive director level response when necessary. We continue to report daily via the new framework onto the national UEC-RAIDR system (a web-based tool that provides real time information on capacity and pressures across providers within an integrated care system).

System mechanisms have now taken place over the last two months to review the effectiveness of the winter plans across the ICB and providers. A number of learning points have been identified and a key area of focus in preparing for next winter is infection prevention and control due to the high prevalence of winter virus's last year and the adverse impact on bed closures and staff sickness absence.

Operational service pressures have been reduced in most areas of the Trust in April and early May. The highest pressures were seen in our Adult Mental Health Division with short periods of high demand and increased mental health presentations in the Emergency Department, this continues to be usual seasonal variation.

The Trusts overall operational pressures in the last two months using the new UEC-RAIDR triggers have been OPEL 2/3 for mental health and OPEL 2/3 for community services.

System pressures reduced in the Humber and North Yorkshire areas during April and early May. Acute hospital partners in all parts of our area have reported pressures during this period predominantly at OPEL 3.

Based on performance data and local insight methodology Humber and North Yorkshire was escalated to **Tier 1** oversight by NHS England. This reflected the increased challenge in achieving the UEC targets for this system, the distance from targets, together with a deterioration on the enabling metrics. As a Tier 1 system the highest level of support is being provided and overseen by the national Integrated Urgent and Emergency Care (IUEC) team, to help achieve improvements.

System work has continued to focus on reducing the number of patients in the acute hospitals who do not meet the criteria to reside in order to improve patient flow, reduce ambulance handover times and to recover elective activity which has been adversely impacted by pressures. Local UEC Boards continue to focus on prioritised plans to address and expedite Urgent and Emergency Care (UEC) performance in our integrated care system.

Waiting times for both children's and adult neurodiversity services continues to be the most significant area of pressure and challenge for operational services. In all these areas demand exceeds commissioned capacity. Dialogue is progressing with the ICB to agree a way forward on waiting times for 2025/26 and beyond. This continues to be an area of national challenge, but it does not receive priority for Mental Health Investment Standard (MHIS) funding. Excessive waiting times for children and adult neurodiversity services are continuing to be challenged across all areas within our ICB and nationally due to exponential rise in demand over recent

years. Unfortunately, some children on the neurodiversity wating lists are continuing to present with mental health needs, this is being monitored very closely. Occupancy and patient flow in our CAMHS inpatient beds continues to be good. Focus continues on our children's early intervention services, particularly embedding the support teams in schools.

Nationally requirements are in place to eradicate the use of out of area mental health beds and our services are implementing plans to achieve this, our data demonstrates that whilst some fluctuation is taking place, overall reduction is being achieved. Our daily bed occupancy has been between 76.3 – 85.5%. Work has been undertaken to reduce the use of older peoples functional out of area bed use with plans now supported by Service Transformation Funding (STF) to expand the use of the Older Peoples Acute Community Service (intensive community support) and to provide the use of step up/step down community-based beds. Work is progressing to finalise a provider for these beds. Out of area placements for our Psychiatric Intensive Care Unit (PICU) continues to be a focus for improvement, demand for these beds has reduced in the last two months and consequently the use of out of area beds has decreased. PICU flow is currently being targeted through improvement methodology to continue to recover the out of area position. Following support from EMT plans are being progressed to change our current PICU based at Miranda House to an all male unit and to make alternative provision for female patients by developing a High Dependency Unit (HDU) within our current estate. This will improve patient flow, reduce the need for out of area placements and provide a further improved position to address mixed gender safeguarding risks.

Patients who are Clinically Ready for Discharge (CRFD) from our mental health beds remains a key priority. Patients are waiting predominantly for specialised hospital placements with other NHS providers or local authority provided residential placements. Escalation mechanisms are in place with partner agencies to take action to resolve the delayed transfers and discharges that our patients are experiencing. Focus is being maintained on improving this position to achieve the best outcomes for our patients and to ensure it does not continue to adversely impact on the improved position we had previously achieved in reducing out of area placements.

By continuing to use the nationally recommended rapid improvement methodology for multiagency discharge event (MaDE) a reduction in the number of bed days lost due to delayed transfers or discharges for those patients who are clinically ready for discharge is being achieved

The overall staff absence position due to sickness is currently at 7.11% (inclusive of 2.25% maternity leave).

The Trust continues to effectively manage the impact of system pressures within its ongoing arrangements. Reducing the number of patients who are clinically ready for discharge/patients with no criteria to reside (NCTR) and reducing out of area placements remains a key operational priority in relation patient flow and access to inpatient mental health beds.

Operational focus remains on recovering access/waiting times where these continue to be a challenge. Divisions continue to pursue a range of service change and transformation programmes which are set out in their service plans, these are reported via the Operational Delivery Group to the Executive Management Team. They demonstrate that they are underpinned by capacity and demand modelling work, respond to external benchmarking data and are supported by a Quality Improvement (QI) approach where this is applicable to improve outcomes for our patients. Focus on improved efficiency and productivity continues. Work is taking place to reduce the Trust's National Cost Collection Index, each service has a targeted plan for those areas above the Trusts target and service transformation plans are required to set out the expected productivity and efficiency gains.

The work undertaken to develop draft service plans for each of the divisions for 2025/26 which incorporate service transformation, workforce, finance and budget reduction plans (BRS). The plans were further reviewed following the publication by NHS England of the Operational Planning Guidance 2025/26 on 30th January to ensure they fully align with this and they have now been approved by EMT.

Whilst the three phases of the implementation of the new **Electronic Patient Record** (EPR) System, for Forensics, Children & Learning Disabilities and the Mental Health Division is now complete, the EPR Programme Board remains in place with a focus on stabilisation and optimising the use of the new system in order to realise the programme benefits as set out in the business case.

3.1.4 Mental Health Streaming Update

National focus on improving Urgent and Emergency Pressures remains very high and recently emphasis is being placed again on reducing both the number of people experiencing mental health issues presenting at Emergency Departments and the duration of their stay there. The Trust opened a dedicated mental health streaming service directly adjacent to the Emergency Department at Hull Royal Infirmary (HRI) in July 2023 and the success of this innovative model continues to attract regional and national attention.

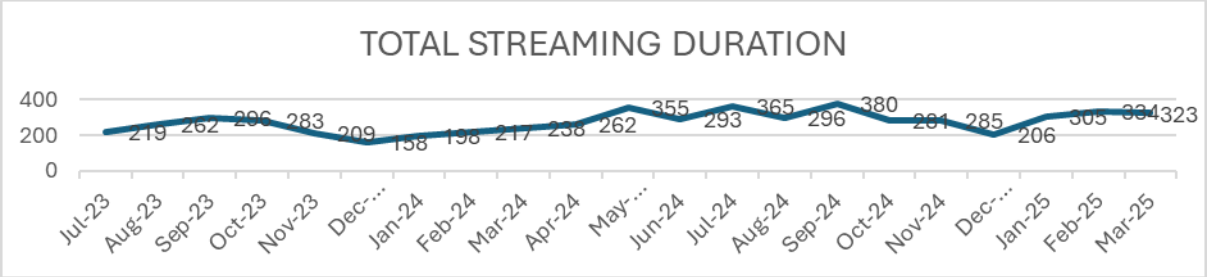
The Streaming area was named the 'Humber Suite' after consultation with patients, carers and staff. There was a commonly held consensus that the name of the area should be discreet, offering those using the service the option to maintain their privacy. The design of the unit encourages both physical and psychological comfort, allowing patients to feel safe to interact with the team effectively. Although the area is named the Humber Suite there is no signage displayed explicitly that labels this as a mental health area, this was a proposal made by service users and carers participating in the co production group established to develop the service to promote privacy and dignity.

Within the Humber Suite is a communal area which is comfortably furnished in a bright and welcoming environment. Off the main communal area there are separate consultation rooms which can comfortably support four people at any one time. A confidential workspace for staff has safe observation and access to the patient area and encourages greater engagement and accessibility. Emergency Department

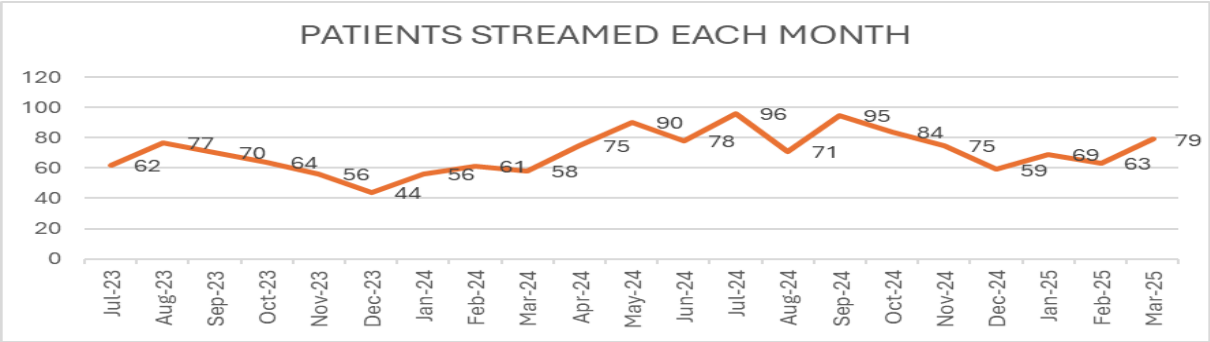
colleagues have direct access to the suite and can consult with Mental Health Hospital Liaison (MHLS) staff.

Throughout the development of the streaming service, the safety of service users was paramount, and through consultation and engagement with the acute hospital medical and nursing team, it was agreed that service users will remain a 'shared patient' until all acute medical and mental health interventions and plans have been developed. It was also established that if there were any medical concerns following transfer to the streaming suite, the service user could easily and swiftly be conveyed back to the Emergency Department for medical care. The clinical pathway is supported by a Standard Operating Procedure (SOP) developed jointly between MHLS and HRI clinical staff, a joint oversight group remains in place and the SOP is reviewed and updated as required. Service user and carer feedback about the service remains very positive.

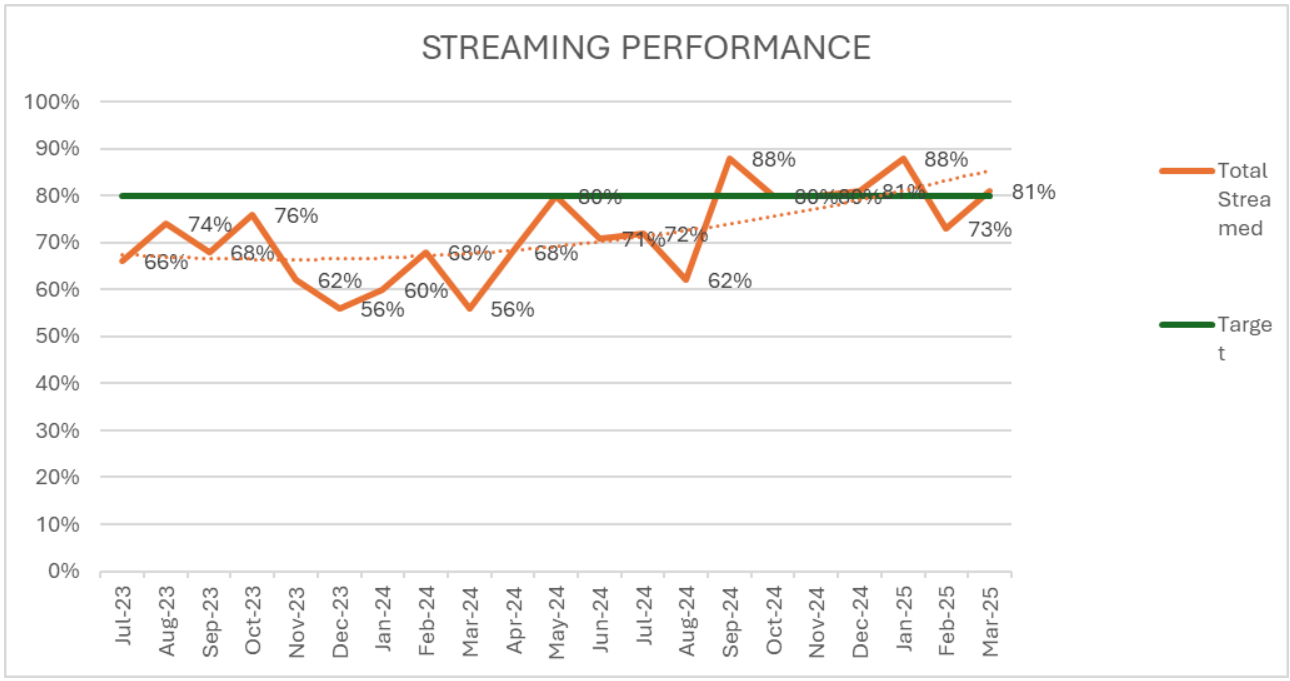
A range of data is now collected to determine the benefit and effectiveness of the service, the chart below demonstrates the number of hours that the suite is in use each month, this time would otherwise be spent by mental health service users in the ED department.



The number of patients streamed to the suite each month is demonstrated below:



A KPI of achieving 80% streaming of all mental health presentations to ED was established at the outset of the service and since September 2024 the streaming unit's performance has been maintained at an average of over 80% of referrals accepted.



Next steps

A number of key areas for further development in 2025 have been identified, including:

- Increasing the number of approved mental health practitioners based in the service to shorten wait times for Mental Health Act assessments which will improve the patient journey and ensure the patient reaches their next destination as quickly as possible.

- Further refining the mental health inpatient bed escalation protocol with the goal of minimising delays in transferring patients from ED to inpatient care when required.

- Staff skill development and training in physical health monitoring, with an emphasis on individuals going through alcohol withdrawal who are currently unable to be transferred to the Humber Suite because of their medical requirements.

- Considerations to improve access to prescribing within the Humber Suite, with the introduction of more Non-Medical Prescribers.

- Ongoing regular analysis and review of the streaming service data, identifying areas for further improvement.

3.2 Director of Nursing, Allied Health and Social Care Professionals

3.2.1 Leadership Visibility

The Director of Nursing, Allied health and Social Care Professionals has undertaken a number of visits to the various sites as part of her induction process. These have included:-

- Malton Community Hospital
- Townend Court
- Inspire
- Maister Court and Lodge
- PICU
- Avondale
- Newbridges
- Emergency Department Mental Health Streaming
- Miranda House
- Pine View

The Director of Nursing, Allied Health and Social Care Professionals has provided updates on each of the visits, and these have been shared with all staff through the Global update.

3.2.2 International Nurses Day 12th May

This year's theme for International Nurses' Day, announced by the International Council of Nurses (ICN), is: **"Caring for nurses strengthens economies."** At Humber, we have developed our own strapline this year which is: **'Better care for nurses, means better care for you.'** Nurses are at the very heart of patient care, providing not only clinical expertise but also compassion, leadership, and unwavering commitment every single day. This year's theme reminds us of the

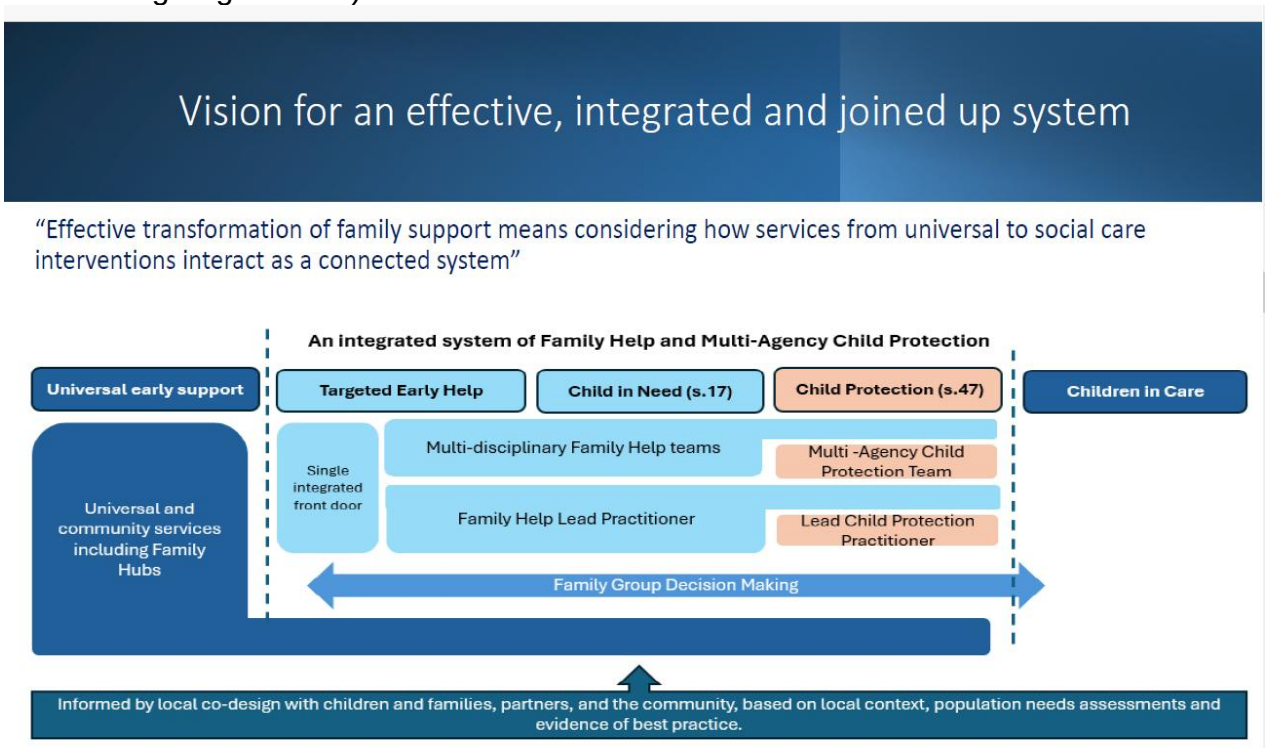
crucial role nurses play in shaping the future of healthcare and strengthening our communities. We have celebrated this though a number of roadshows at various sites, a virtual card designed by The Humber Centre Art Group and a personal message from the Chief Executive and the Director of Nursing, Allied Health and Social Care Professionals.

3.2.3 National Safeguarding Reforms- Families First Partnership Programme

The Government has set out its Plan for Change to rebalance the children's social care system through funding and rolling out the Families First Partnership programme. Although not statutory, this programme places expectations on safeguarding partners to implement reforms in family help, multi-agency child protection and family group decision making. The purpose is to rebalance the safeguarding system away from crisis to early intervention, to support children remaining at home/ within their communities and preventing them from entering care.

The programme is described as a national transformation and is underpinned by the following key factors:

- Children and young people should be the heart of the design of the transformation.
- Based on local need.
- Strong emphasis on early intervention to prevent crisis.
- Approaches to be tailored to diverse needs including domestic abuse, sexual abuse, disabilities, mental health issues, substance misuse and harm outside the home (exploitation and online).
- Adopt a whole family approach, including understanding the needs of adults in the household and diversity. Children to be supported to live within family network, whenever possible.
- Adopt principles for working in partnership with parents and carers (Chapter 1 – Working Together 23).



The programme requires a number of things to be put into place regarding structures and processes to underpin the transformation and the Government has produced a guidance document that outlines the requirements on all safeguarding partners. There is a national expectation that the transformation activity will run alongside business-as-usual activity from April 2025-March 2026. The programme is underpinned £500 million of funding in financial year 25/26, through the Local Government Finance Settlement.

Learning from pathfinders on effective implementation identifies the following is necessary:

This programme transforms how support, and services will be provided to children and young people through a new model of community based, multi-agency locally configured teams, providing wrap around support to the families earlier, based on a hub model as opposed to a threshold model.

An initial session was held by the Children's Safeguarding Partnership in Hull with partners in April to consider how a project team can be put together to steer the planning of the transformation. Key leads are identified to join the working group to ensure the Trust contributes to the development of the local crafting of this transformation and ensures the Trust contributes to the development of safeguarding services for children and young people in Hull and East Riding.

3.2.4 Big 5 Audits

The following audits have been agreed and will be undertaken by the divisions in 2025/26:

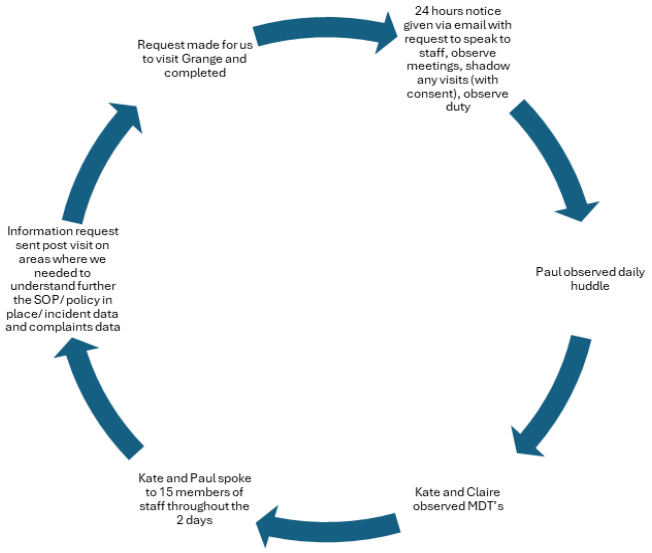
- patient and family engagement
- quality of care planning
- medication compliance and support
- clinical supervision of decision making under MHA
- quality of discharge arrangements

The Big 5 Audits will be launched as part of Clinical Audit Week 2nd to 6th June 2025 when the divisions will have access to the audits following approval.

3.2.5 CMHT Mock Inspection

As part of the Trusts journey toward outstanding, a series of Unannounced CQC Mock Inspections have been agreed to be undertaken by the Clinical Director, Deputy Director of Nursing, AHP and Social Work and Deputy Chief Operating Officer. A programme has been put together based on areas that were yet to be inspected by CQC, the Community Mental Health Teams East and West were subject to a mock inspection in March 2025.

The focus was on the safe and well led domains and assessment against the quality standards under these domains. The process is articulated below



A number of actions are required to be formulated into an improvement plan to be reported to Quality and Patient Safety Group in June 2025.

3.2.6 CQC Inspection of Inspire

In February 2025, the CQC undertook as assessment of the adolescent mental health ward in the Trust. The final report has now been published and the overall rating was Good.

3.3 Associate Director of People & Organisational Development (OD) Updates

3.3.1 Leadership Visibility and Visits

Inspire – 4th April 2025 – The Associate Director of People & OD was given a tour of Orion and Nova ward at Inspire gaining valuable insight into the work the teams undertake at this unit, as well as to understand the experience of young people accessing services as well as that of the staff. Huge thanks to Justine Rooke, Sam McKenzie and Karen Warwick for their time and attention on the day.

3.3.2 National Statutory and Mandatory Training MOU

NHSE launched its Statutory and Mandatory Training MOU on 1st May 2025, following 100% uptake at Trusts, following support from Humber's EMT in February 2025.

Lack of portability of training has been raised as an issue by staff and this MOU is a key part of the NHS' response to Improving Working Lives which will help to save up to 100,000 days of staff time.

Whilst this MOU is an interim solution, it lays foundations for digitalisation of the processes, to create a seamless and robust experience for staff and bank workers. Key features of the attached StatMand MOU are as follows:

- This MOU is supported by NHS England, CQC and NHS Resolution.
- It aligns with the NHS England Enabling Staff Movement Toolkit, which provides guidance for any staff movement MOUs/workforce sharing agreements.
- It sits alongside any other workforce sharing agreements or staff movement MOUs you may have in place, so these can continue to operate as they do now.
- It is for any staff movements (substantive or bank workers) between any of the 266 NHS organisations in England
- It is exclusively for the transfer of the 11 Core Skills Training Framework (CSTF) subjects plus learning disabilities and autism training (aka Oliver McGowan training). Employment checks require a higher legal threshold and will be covered by the digital staff passport.
- The MOU establishes an agreement that all organisations will accept prior training for the subjects listed, for at least the time periods set out in the appendix.
- Two mechanisms to receive records are acceptable; either via ESR IAT or new starters can present certificates of completion downloaded from ESR, e-learning for healthcare or a 3rd party LMS.
- Your onboarding team will simply ask for evidence and if within the expiry period, then add to the new starter's training record and they will be required to refresh on expiry.
- Local orientation will continue as required.

3.3.3 Off Framework Agency Use

There has been a strive to eradicate all off-framework agency usage by the organisation, supported by the efforts of the Flexible Workforce Team (FWT), in line with the NHS mandate. The FWT team have not booked any off-framework agency staff since June 2024. Since then, a reduction across general agency usage has been seen, whilst still maintaining safer staffing levels.

As of April 2025, the combined bank and framework agency fill rate was 97% (of which 94% was Bank). Since January 2025, the Trust has maintained zero HCA agency usage, however, there is still some reliance on framework agency usage for Nurses. With that said, the overall agency usage for Nurses has seen a reduction of 10% in 12 months.

In 2025/26, FWT have an objective to further reduce the use of framework usage in Nursing, in addition to maintaining the zero HCA framework agency usage. To support the reduction in framework agency use for Nursing, 13 Nurses have been recruited on bank since January 2025 (3 ahead of projected target).
There has been an increased focus around clearing bank staff for work by targeting those with less than 85% statutory mandatory compliance, therefore increasing the pool of active 'bank only' workers. In addition to the focus around clearing bank staff for work, FWT are progressing with a bank cleanse for those workers who do not engage after an 8 week-period. This will ensure the bank figures are reflective of those who are engaged and booking shifts.

3.3.4 Recruitment Statistics

Recruitment data from Trac is monitored on a monthly basis to ensure the service provision is robust and meeting the needs of both recruiting managers and candidates alike. The Recruitment team work alongside recruiting managers to ensure that they can recruit the right people as quickly and efficiently as possible to ensure as a Trust we continue to have a positive impact on patient care and experience by having the right people in posts at the right time.

In the month of April 2025, the following metrics were achieved:

- **'Conditional offer to checks ok'** was an average of 13.1 days, significantly below the 20-day target. This position has been maintained at around 13 days in both March and April.

- **'Closing date to start date'** was an average of 58.6 days, below the 65-day target. This figure has been consistently below target since April 2024 with the exception of September and January when the figure rose slightly to 69.5 days and 66.6 respectively.

Trac benchmarking data (for the previous quarter) places Humber in the top 25% across 204 NHS organisations for 'time to hire.'
The Recruitment team are working proactively with managers to address 'time to shortlist' metrics which have been consistently above the 2-day target since January 2025.

3.3.5 People Promise Exemplar Update

Since the launch of the 'Plus' initiatives in November 2024 showcasing what is available for our people in terms of our approach to flexible working and our extensive offer of health and wellbeing initiatives the Trust's People Promise Manager has now left the organisation as the funding for the role has ended (April 2025)
Prior to leaving, intranet pages were updated to ensure that all information in relation to the Plus initiatives can be accessed with ease.
The impact of the Your Health and Wellbeing Plus initiative will be measured via an annual paper presented to the Health and Wellbeing Committee.
The impact of Your Leave Plus and Your Flex Plus will also be measured on an annual basis through papers that will consider the offer within the initiative, uptake and overall feedback. This work will be undertaken by the People Experience team going forward to ensure that our offer remains exemplary.

3.3.6 Flexible Working Requests (2024-25)

The following data show the number of flexible working requests made by Trust colleagues, with highlighted months illustrating those from the point at which our offer was pro-actively discussed and shared around the Trust geography.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
No of Requests in Month	60	51	35	31	29	35	51	54	36	68	56	47	59
Rolling 12 Months	471	480	466	445	440	439	459	483	495	520	538	560	558

3.3.7 Workforce Wellbeing

The following data show the uptake of the Workforce Wellbeing Team's services, with data of physical and wellbeing MOTs for the last financial year (April 2024-March 2025). We can see a total of 730 new referrals for staff attending for a physical or wellbeing MOT and that figures have been consistent peaking in September 2024 with 88 staff and a gradual increase in monthly figures since the start of 2025.

	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total
Number of new referrals for MOT appointments – physical health and wellbeing	44	74	51	55	37	88	80	54	62	48	63	74	**730**
Number of new referrals for 121 appointments	17	18	12	14	6	14	8	9	14	17	17	11	**157**
Total number of physical health MOT appointments	60	49	44	41	29	62	60	62	52	48	63	76	**646**
Total number of wellbeing MOT appointments	3	3	9	5	2	9	3	3	3	8	2	0	**50**
Total number of 121 appointments	46	44	36	37	19	38	45	36	31	33	28	24	**417**

The number of wellbeing activity suppliers has been extended to include availability throughout the Trust. The Team continues to promote the Humber Recovery and Wellbeing College which also offers sessions and workshops to support the health and wellbeing our people.

Whilst not part of the core health and wellbeing activity programme other activities such as **Tai Chi** have also been offered during the wellbeing campaigns.

Participation/Booking requests (1 April 2024 - 31 March 2025):

Health and Wellbeing activity	Number of staff
Yoga / Pilates	191
Indoor climbing	26
Cookery classes	16
Dance classes / workshops	6
Massage / Reflexology	337
Tai Chi	56
Totals	**632**

Positive feedback has been received from staff who have attended the activities and improvements in staff wellbeing have been noted.

In the last 12 months the Workforce Wellbeing Team have conducted onsite MOT clinics or drop-in sessions at a number of Trust sites.

The wellbeing team continue to work alongside occupational health offering targeted support to departments or divisions within the Trust based upon need (for example high levels of sickness absence due to stress or musculoskeletal issues)

3.3.8 Flu Programme 2024/25

Seasonal flu vaccination remains a critical important public health intervention and a key priority for 2024/25 to reduce morbidity, mortality and hospitalisation associated with flu at a time when the NHS and social care will be managing winter pressures whilst continuing to recover from the impact of the coronavirus (COVID -19) pandemic.

The 2024/25 Flu campaign saw Humber achieve an overall uptake of 60.56%. 43.02% of this group were staff in patient facing or clinical roles with a total of 2752 patient facing and clinical staff presenting for flu vaccine this season. 12.61% of our bank staff had their flu vaccination.

In comparison to the previous year 2023/24 when there was the offer of flu and COVID vaccines being delivered by Humber at the same time we had 47.87% of frontline staff vaccinated. This shows a decrease in 20204/25 of 4.85%. As COVID was delivered at the same time this may have been a reason more clinical and patient facing staff presented for vaccination in 2023/24.

The occupational health and wellbeing department are currently planning for flu season 2025/26. Ideas for campaigns to raise awareness and increase uptake are being discussed with the support of the Health and Wellbeing Group committee meeting and the wider People & OD Directorate. We are currently speaking to staff who regret not having their vaccination and their reasons why. We are analysing sickness absence data for winter 2024/25 and we are also looking to improve comms and access to the flu vaccine during the next campaign.

3.3.9 Statutory and Mandatory Training Update

Our statutory and mandatory training compliance continues to demonstrate consistent high performance, with overall compliance steady at 94.09% at the end of March 2025, well above the Trust target of 85%. This strong position is reinforced by recent benchmarking data, which confirms Humber Teaching NHS Foundation Trust as one of the highest performing Trusts in the region and across the NHS. Key areas such as Basic Life Support (86.41%) are now surpassing target for the first time since May 2024, and DMI compliance remains above target for the sixth consecutive month. However, Paediatric ILS has dipped to 72% due to four staff becoming non-compliant, and Safeguarding Level 3 remains below target, prompting a review of classroom versus digital completion rates, with a proposal for increased classroom sessions submitted to the Head of Safeguarding.

We continue to monitor and respond to these variations, using our data to support meaningful adjustments and improvements. A key step taken in May was the streamlining of training requirements, removing recurring modules no longer deemed necessary, which is expected to release significant staff time and further clarify our compliance picture. Additionally, we are piloting a new, more compassionate reminder system for overdue training that overcomes ESR's current limitations and has already proven effective with medical colleagues. This approach is being extended to other areas, aiming to improve engagement by meeting staff where they are rather than relying solely on manager-issued compliance alerts.

We also acknowledge ongoing issues with accessing Safeguarding Level 3 training. A collaborative effort between the safeguarding team and the Learning Team is now improving clarity and accessibility, ensuring staff can meet their training obligations with ease and confidence.

While compliance has remained broadly stable year-on-year (94.71% in March 2024 vs. 94.09% in March 2025), the number of outstanding courses has increased slightly due to the introduction of new modules such as Clinical Risk, EPRR, and Freedom to Speak Up.

We remain committed to supporting our staff with relevant, accessible, and essential training, positioning Humber as a leader in both compliance and staff development.

3.3.10 Leadership and Talent Development Update

- **Humber Talent Programme Update**

In March 2025, the 10 delegates of the Humber Talent Programme spent the day developing an extensive 12-month Personal Development Plan, setting SMART objectives and a roadmap of what each participant wants to achieve during the programme. Attendees have since spent time forming mentoring or coaching relationships and mapping out their network of support.

In April, the group attended a workshop on Personal Growth and Presence discovering how to apply their strengths in their current roles. Since the programme began, 1 person has already progressed internally crediting the programme for

giving them the confidence to apply to a more senior role. All 10 participants have now received a Lumina portrait.

- **Alumni Programme**

Building on the success of the first Alumni Workshop, the team delivered the second PROUD Alumni workshop, *Compassionate Leadership*, which was again fully booked and received excellent feedback from participants.

> *"This learning allowed me to think differently about the ways in which I show up to lead, and what I should expect from others, those I can influence and inspire, to be more compassionate. This was such a thought-provoking session, and I'd recommend it to any leader, particularly those that have led for a long time in the NHS."*
>
> (Anonymous Participant, 2025)

Workshop number three, *Dealing with Dysfunction*, is currently in development and is scheduled for delivery in August. We have continued to enhance the Alumni offer by creating more focused, bite sized versions of the first two workshops to balance operational and development needs respectively and enable greater access to learning across the Trust. These sessions are condensed into half day slots and are available via teams or in-person. The bite sized Leading Change workshop is already available with 2 in-person sessions delivered to 19 senior leaders from Children's Services and further delivery dates to be promoted over the coming months.

The Alumni continues to grow with two new cohorts joining our illustrious group increasing the number of members to over 300. This month see's the launch of two further developments with the 2*nd* edition of the Alumni newsletter being released along with a new change adoption model designed by our very own alumni members.

3.3.11 Career Development Update

The Career Development Team continue to work hard to become an anchor employer in our region, by attending local school and college events engaging with young people and offering support. We play a leading role in developing local talent pipelines, strengthening the regional economy, and setting the standard for workforce development, while benefiting from a skilled, loyal, and future-ready workforce.

Three internal staff members have undertaken apprenticeships in April in Coaching, Senior Leadership, and Operations Management. This will help improve performance, and support succession planning. It will also help to develop future leaders, enhance operational efficiency, and foster a strong coaching culture, all while making the most of our apprenticeship levy contributions.
We have hosted 2 x work experience placements in our ISPHN and Children's physio teams at Walker Street.

In early May we were excited to be part of a Virtual Work Experience Programme as part of the Mental Health, Learning Disabilities and Autism Sector Collaborative. We

delivered google classroom sessions to young people regarding careers and next steps, together with some interactive activities. The virtual work experience focused on careers in the MH, LD & A sector, specifically Psychological Professions, MH & LD Nursing, and AHPs. It consisted of a mix of professional speakers and sessions on routes into careers, values, and general employability.

On 22nd May we will be attending the Inclusive Careers project held at the MKM Stadium, Hull in partnership with the Hull and East Yorkshire Business, Growth and Skills Hub (part of the Humber Local Enterprise Partnership). The inclusive careers project aims are to increase the number of people understanding and considering career routes and pathways within the health and care sector. The project has primarily focused efforts upon the most disadvantaged and vulnerable young people in schools (including those in SEND & AP settings) and those seeking to re-train, upskill or re-enter the labour market. This event will showcase some of the work that has been undertaken and we will be to speak to students about their learning and establish relationships with Careers Leaders.

3.3.12 Launch of the national consultation on manager regulation

The NHS wants to make sure that its current and future managers and leaders have the right skills and values to support colleagues to improve and deliver services, engendering a culture of openness and honesty in which all NHS staff are encouraged and supported to raise concerns. Managers and leaders need access to the right learning and training opportunities throughout their careers and patients and staff alike need to be confident that leadership in the NHS is effective and accountable.

That is why NHS England is developing a leadership and management framework, which will introduce a code of practice, a set of core standards and a development curriculum for managers. This will support managers and leaders to undertake further training to improve their effectiveness and to progress in their careers.
The development of the management regulation has been driven by the messenger review and by other reports that reference leadership and management effectiveness (Darzi, Berwick, Mid Staffs, Kark, Snowy White Peaks, People Plan etc).

What will be produced: consistent standards for all NHS leaders and managers. Developed in partnership with the CMI, social care and Professional standards authority (as well as in consultation with the HPMA/CIPD)
Framework will include:

- A code of practice (which is a step beyond the Messenger review recommendations)
- Standards and competencies with defined levels; entry to exec (consultation on these starting soon)
- Core Curriculum at every level from aspiring manager to Board level leaders.

How will it be produced:

- Co-designed with multi stakeholder involvement
- Will be heavily consulted upon
- Various surveys and feedback opportunities over the coming months

A comprehensive consultation document is now in circulation seeking feedback on the development of core competencies that are under development.
Whilst this is yet to conclude and with key stakeholders at the Trust providing feedback, we are making traction regardless on reflecting these competencies into our internal Leadership Development proposition.

3.3.13 Sexual Violence and Misconduct Update

Further to the Worker Protection (Amendment of Equality Act 2010) Act 2023 coming into force on 26th October 2024 which places a duty on employers to "take reasonable steps" to prevent sexual harassment of their employees, the Trust has appointed Karen Phillips, Associate Director of People and OD as Executive level sponsor for this programme of work. In addition, Rosie O Connell – Head of Safeguarding and Alison Meads – Head of People Experience have been appointed as the Trusts leads for Sexual Safety.

In addition, the following work is currently underway:

- A new Sexual Misconduct Policy has been drafted and consulted upon and is currently at the final stages of governance prior to launch.
- A training needs analysis has been carried out and agreed that it is highly recommended for all of our line managers to carry out the e-module that is available on ESR to raise awareness and gain basic knowledge about how to respond to a report.
- Risk assessments are currently underway across the Trust and a central risk register will be compiled by the Sexual Safety Group
- The sexual safety group will assess progress against the national assurance framework in 2025 and establish priority actions from the outcomes.
- A review of the data available has been carried out and a new Sexual Safety report will be compiled and submitted to QPAS and elements of it included in the People Insight report
- A launch plan is currently being developed for this programme of work to include provision of intranet pages and a summary of support available for employees. This will include presentations to raise awareness and open sessions with staff to ensure that they are aware of the policy, how to report incidents and what support is available. There will be a leaflet designed to summarise the key points and how to report incidents.

EMT are fully cited on the programme of work and the next steps are to plan for the launch of this work across the Trust.

3.3.14 Equality, Diversity and Inclusion

Supreme Court Judgment

Following the UK Supreme Court judgment in *For Women Scotland v The Scottish Ministers*, the Equality and Human Rights Commission (EHRC) provided interim guidance to clarify the judgment's main consequences on trans people. Employers and other Public Sector Equality Duty (PSED) duty-bearers must comply with the law and seek appropriate specialist legal advice when necessary.

The Trust reacted promptly, communicating a message of support and compassion to our trans colleagues across the organisation, and is currently developing an action plan to address policy reviews, training, estates, and interim guidance for managers.

The EHRC's stated aim is to deliver full statutory and non-statutory guidance by late June, following a public consultation in May.

3.3.15 Gender Pay Gap

Based on a snapshot date of 31 March 2024, the Trust has a mean gender pay gap of 9.84%. This represents a significant improvement from the previous year's figure of 12.4% and marks a year-on-year decrease since the first gender pay gap report in 2018.

The Trust compares favourably to the national mean pay gap figure for 2024, which stands at 18.1%, representing a 7.5% increase from the previous year.

3.3.16 Workforce Race Equality Standard (WRES)

The Trust has drafted its progress against the Workforce Race Equality Standard (WRES) indicators, emphasising efforts to address workplace inequality and demonstrating advancement in relation to the nine WRES indicators. This approach enables the Trust to fully comprehend local challenges, implement necessary changes, and also track our progress on a broader scale by comparing regional and national issues.

The Trust has improved in all nine Workforce Race Equality Standard (WRES) indicators compared to the previous year's figures. Seven of these indicators have surpassed national comparison figures, highlighting two focus areas moving forward.

Areas for Assurance

- 14.47% improvement in ethnically diverse staff working in clinical and non-clinical roles of band seven and above. Similarly, we have seen an improvement in ethnically diverse representation across the workforce, with year-on-year improvements since 2019, when the figure was 3.5%, rising to 8.99% in March 2025.

- We can be assured that our recruitment processes do not disadvantage ethnically diverse staff.

- The relative likelihood of staff entering a formal disciplinary investigation has fallen, and we have seen the gap narrow significantly between ethnically diverse and White staff.

- There is equality between ethnically diverse and White staff accessing non-mandatory training and CPD

- For WRES indicators 5 through 8, representing NSS responses, the Trust has improved on the previous year's figures in all four.

    - We have seen year-on-year improvement for three indicators since 2020.

    - In two of the four indicators, we have seen a significant narrowing of the gap between ethnically diverse and White staff and is the closest the figure has been to that of White colleagues since 2020.

    - We have observed an improvement in the number of ethnically diverse staff completing the NSS, increasing from 50 in 2020 to 152 in 2024.

- The percentage difference between the organisation's Board voting membership and its overall workforce. With a figure of 11.1%, surpassing our workforce and local demographic representation.

Areas for Focus

- The percentage of ethnically diverse staff experiencing harassment, bullying, or abuse from patients, relatives, or the public in the last 12 months has improved significantly. However, it remains slightly higher than the national figures.

- The percentage of ethnically diverse staff who have experienced discrimination from their manager, team leader, or colleagues in the last 12 months has improved, but remains significantly higher than it is for White staff.

3.3.17 Workforce Disability Equality Standard (WDES)

The Trust has drafted its progress against the Workforce Disability Equality Standard (WDES) indicators, emphasising efforts to address workplace inequality and demonstrating advancement in relation to a set of ten specific metrics used to compare the experiences of disabled and non-disabled staff.

The Trust has improved in seven out of ten Workforce Disability Equality Standard (WDES) indicators compared to the previous year's figures. Seven of these indicators have surpassed national comparison figures, highlighting areas of focus moving forward.

Areas for Assurance

- 20% improvement in disabled staff working in clinical and non-clinical roles of band 8c and above. Similarly, we have seen an improvement in disability representation across the workforce, with year-on-year increases since 2019, when the figure was 3.9%, rising to 10.05% as of March 2025.
- Disabled staff are not disadvantaged in our recruitment processes.
- For WDES indicators 4 through 10, representing 9 NSS responses, the Trust has improved on the previous year's figures in six.

    - We have seen a significant reduction in disabled staff experiencing bullying and harassment from patients.
    - A significant improvement in the percentage of disabled and non-disabled staff reporting incidents of bullying and harassment.
    - A continual improvement since 2020 for disabled staff who believe that their organisation provides equal opportunities for career progression or promotion.
    - A continual improvement since 2020 for disabled staff feeling pressure from their manager to come to work, despite not feeling well enough to perform their duties.
    - A continual improvement since 2020, with disabled staff reporting that their employers has made reasonable adjustments to enable them to carry out their work.
    - An improvement in the number of disabled staff completing the NSS, increasing from 286 in 2020 to 566 in 2024.
- The percentage difference between the organisation's Board voting membership and its overall workforce, 9.09%, closely matches our workforce and local demographic representation of 10%.

Areas for Focus

- Experiencing harassment, bullying or abuse from other colleagues. Slightly down on the national figure and an increase from the previous year.
- Experiencing harassment, bullying or abuse from managers. Better than the national figure, but an increase from the previous year.

3.3.18 Respect

The objective for the original respect campaign was in response to anecdotal feedback from our staff networks, with the key aim of driving up the reporting of bullying and harassment between staff. The most statistically significant improvement in the 2024 National Staff Survey is for the question 'the last time I or a colleague received bullying, harassment or discrimination, I or a colleague reported it'. If we look in more detail, we can also see that staff from ethnically diverse communities are reporting at higher rates of than their white peers. As such, we can see the impact of the Respect campaign in the staff survey, it has worked as intended, we have addressed under reporting and driven up the reporting of these incidents.

We are continuing to work on embedding Respect, working with the Trust's designer and commissioning four new Respect posters based on the protected characteristics, so there will be one for anti-racism, homophobia, disability discrimination and to support our new sexual misconduct polices a sexual harassment poster. These posters will then be consulted upon with the networks and EDI steering group with a relaunch of the Respect framework across the organisation in the Spring.

3.3.19 No Excuse for Abuse

No Excuse for Abuse was designed to support managers and staff when subjected to abuse by service users in their care. Since the December launch of the No Excuse for Abuse Toolkit, it was recognised as QI Charter of the Month in Dec 2024, it has subsequently been inspected and endorsed by UNISON who found it to be very comprehensive and proactive and we will be adding their logo to the posters and documentation. Also, NHS England are keen to include our work in an EDI Best Practice Case Study, alongside Respect and our approach to implementing the NHSE EDI Improvement Plan.

However, we have taken learning on board, and we know that No Excuse for Abuse is focused on post incident support for staff, and work is underway to better understand the Datix data, so we can see which areas have a higher prevalence of such incidents and look to work with colleagues such as the OD team to provide bespoke support for those areas.

Our Staff Networks have been active in supporting the organisation to be more inclusive, this includes:

1. Rainbow Alliance Network

- The network has contributed towards articles for the global email for LGBT+ History Month in February where information about becoming the new chair of the network has been shared.
- The network undertook a review of the Eliminating Mixed Sex Accommodation policy and supported the review of the PACE Supporting Trans Patients Policy review.

2. Disability Network

- The network piloted of out of hours meetings to reach a wider audience.
- New badges and posters were designed by the network, one for disability and the other for hidden disabilities.
- The network contributed towards articles in the global email for Disability History Month (Nov/ Dec) and International Day of Persons with Disabilities (December 3).

3. Race Equality Network

- Supported the EDI lead in the development of navigating racial microaggressions guidance.
- Held virtual Black History Month event in October with guest speakers from Show Racism the Red Card, the event was well attended.
- Added quarterly Race Equality Development session into their schedule to include guest speakers from around the Trust to share work on that includes race equality, such as Patients and Carer Race Equality Framework (PCREF), Trauma Informed Care, Culture of Care, Respect and No Excuse for Abuse.

3.3.20 Key areas of focus for Staff networks

Our Race Equality Staff Network is hosting a quarterly development session, where they plan to invite guest speakers from around the Trust to discuss their work on anti-racist practice, including the Culture of Care, Trauma-Informed Care, and the Patient and Carer Race Equality Framework (PCREF).

Our disability staff network has collaborated with its members to design and develop new badges and posters to raise awareness of hidden disabilities.

Our LGBTQ+ staff network is supporting the Trust in how it responds to the UK Supreme Court judgment in *For Women Scotland v The Scottish Ministers.*

3.3.21 Career Development

The number of staff from underrepresented communities who are developing their careers through the Trust's development Programmes includes:

Humber Talent Programme

- 20% of the cohort have a disability or long-term condition, significantly surpassing the workforce demographic.
- 10% of the cohort have a mixed ethnic heritage, matching the workforce demographic.
- 20% of candidates represent the LGBTQ+ community, significantly surpassing the Trust demographic.

3.4 Medical Director Updates

3.4.1 Leadership Viability

I conducted an unannounced visit to Newbridges alongside Dean Royle, Non-Executive Director on the 1 April 2025. Overall, it was a positive experience - the unit is well managed, and the staff demonstrate a strong commitment to patient care. Additionally, I spent extended time with the clinical leadership team, discussing the effective operation of the senior team and patient flow. I will continue to stay in touch to monitor progress in these areas.

3.4.2 Medical Education

- DME remains on long-term sick, ‘light touch’ Interim DME cover in place provided by Dr Doug Ma, Royal College Tutor.

- 2024 National Education & Training Survey (NETS) received and deep dive completed in liaison with NHS England, Quality Intelligence Manager. Results are positive, no concerns at an NHS England level with regards to the quality of our medical education and training provision at Humber.
    - 81% of respondents would recommend their placement for care or treatment when asked ‘How likely are you to recommend this practice placement or training post location to friends and family if they ever need the care or treatment provided there?’

- 81% of respondents would recommend their placement for training when asked 'How likely are you to recommend this practice placement or training post to friends and colleagues as a place to work or train?

Both scores are significantly higher than the national average.

- Overall experience indicator showed Humber scoring as 10th in the region.

- Nominations being received for Annual HFT Medical Education Awards in preparation for the ceremony in June, guest speaker is the Dean of the RCPsych.

- SAS Tutor post currently vacant due to retirement of previous post-holder.

- Planning to deliver a National CAMHS conference in October/November to help recruitment and showcase the Trust.

Medical Workforce/Staffing:

- Medical Workforce Team transferred from HR to the Medical Directorate on the 1st April 2025.
- Urgent piece of work to implement exception reporting reform by 12th September 2025, this will require system change and will increase the admin burden in Medical Staffing.

Medical Appraisal & Revalidation:

- 4th Appraisal Forum held on 27th March 2025 – high attendance and excellent feedback.

3.4.3 Pharmacy

Following the successful implementation of SystmOne Electronic Prescribing and Medicines Administration System (EPMA), Pharmacy is working with the Clinical Digital Team to create a series of clinical templates to capture consistent and accurate data in the monitoring of patients. The first set of templates which are being developed include Rapid Tranquilisation and Lithium monitoring.

The Rapid Tranquilisation template was an action from a recent national audit (POMH-UK) that the Trust participated in.

3.4.4 Quality Improvement

- Innovation Hub – the Innovation Hub interim SharePoint site and Ideas Capture Application (Aha) are currently being tested by the Task and Finish Group, The Communications team are developing branding options that will be shared with a number of groups for feedback. The SharePoint Site will enable the share of learning and build of materials for the website. Brief is drafted and with the Tasks and Finish Group for Comment.

- The inaugural QI Week of 2025/26 is scheduled for 16–20 June 2025. The week's events will focus on sharing insights and learnings from completed improvement work.

3.4.5 Mental Health Legislation

Appointments were approved at Board for the 4 new Associate Hospital Managers we interviewed. They are currently going through the recruitment process, and we will then proceed with the training programme.

We have also recently carried out a mock CQC visit to STaRS as they are likely to be high up on the list for next to receive an unannounced MHA visit from the CQC. Issues found have been shared with the ward and asked to complete an action plan

We are in the process of recruiting someone to cover an additional day in order to oversee some of the monitoring of restrictive practice such as rapid tranquilisation and LTS reviews.

3.4.5 Research and Development

We are delighted that Imperial College London is collaborating with our Trust and Hull City Council on the second phase of the Measuring Loneliness in the UK (INTERACT) Study. This is currently the largest global study looking to develop a 'heat map' of loneliness. By people participating in a short, anonymised survey, it will be possible to identify 'hot spots' of loneliness in cities and towns and subsequently develop targeted interventions to help identify and support people that are lonely or socially isolated and suffering in silence. 170,000 people nationally have already completed the survey. In this second phase the aim is to help make Hull and the Humber region the best place in the world for loneliness research. The idea is to get as many residents as possible in and around the Hull city area to respond to a brief anonymised survey (takes around 3-5 mins). Dr Austen El-Osta, Director of the Self-Care Academic Research Unit at Imperial College London, who is leading this research states "If more than 10% of the local population responds to the survey, we will for the first time have an international gold standard heat map that can be used by the local authority, NHS and voluntary organisations to deliver targeted interventions to tackle loneliness. One of the key benefits of bringing this study to Hull is 'making loneliness everybody's business' so that this wicked problem of society could be talked about and destigmatised. We are all prone to feeling lonely at times, but little is being done at the societal level to help support lonely people who are suffering in silence." This high profile research has already attracted media attention - Hull study to map 'silent epidemic' of loneliness - BBC News (19/03/25).

3.5 Director of Finance Updates

3.5.1 Leadership Visibility

Since the last board meeting a series of visits have been arranged for operational teams to meet with the senior Finance Directorate team to learn more about the work of the directorate and for any questions on our portfolio to be raised. Visits that have taken place include the Grange (Jon Duckles attended), College House (Rob Atkinson attended).

The Director of Finance was pleased to support the Health Stars Golf Day with the CEO and has also attended Bridlington Primary Care with Mathew Handley and Maktin and Norton Lions Club with the Charity Team to discuss fundraising ambitions for the Malton Services Dream.

The Director of Finance has also been appointed as the Deputy Chair of the Healthcare Finance Managers Association (HFMA) Mental Health and Learning Disability Steering Group.

3.5.2 Cyber Security Updates

NHS England's Cyber Security teams release several alerts each month. These are (currently) referred to as CareCERT advisories and the trust must ensure that action is taken to deploy the remediation for each.

There are two types of CareCert notifications,

High priority notifications - cover the most serious cyber security threats, these notifications are sent to the IT Service desk with requirements for acknowledgement to NHS digital within 48 hours and remediation applied within 14 days.

Any high priority notifications that cannot be resolved within 14 days require a signed acceptance of the risk by the CEO and SIRO to be submitted to the NHS Digital portal.

Other CareCert notifications - are part of a general weekly bulletin and these are general awareness items with most issues identified requiring no action as the Trusts patching process has normally already deployed the updates required

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

- CareCERT notices issued during 2025: 51 (*Incl 8 in April*)
- High Priority CareCERT notices Issued during 2025: 7 (Incl 1 *in April*)

There were no Distributed Denial of Service (DDoS) attacks against the Trusts internet connections during March or April 2025.

3.5.3 Facilities Management Update:

- Work at Whitby Hospital for repointing and external penetrations repair commenced on 19 May, this work requires a scaffold to be erected around the perimeter of the building on a running basis (A communications plan is in place).
- Board has approved the tenders for the works at Granville Court and County Hall Beverley, we are in the process of appointing Contractors.
- Design Team has been appointed for the first phase of the adult inpatient project.
- Nominated building managers have been appointed for East Riding Community Hospital and Alfred Bean Hospital to coordinate evacuation exercises and building user groups.
- Risk assessments for Fire and H&S completed with all Trust buildings being deemed compliant, this now forms part of a monthly report to EMT.
- PLACE Lite and Cleaning Efficacy audits have started
- The catering teams at Miranda, Newbridges and Humber Centre prepared a special lunchtime buffet to recognise the 80th anniversary of VE Day.
- 5* food safety rating maintained at Newbridges.

- The National Healthcare Estates and Facilities day take place this year on Wednesday the 18th of June, the team are working on plans to celebrate this day.

3.5.4 Partnerships and Strategy Update:

- The Team are working closely with ICB colleagues and our primary care practice teams to ensure the next steps in relation to the Transfer of Primary Care Practices are managed carefully with patients' needs at the forefront. The decision to transfer Primary Care practices was a collaborative decision made with representatives from the ICB linked to alignment with the ICB strategy to support integrated neighbourhood care development, reflecting a shared commitment to commissioning services that are sustainable, future-focused, and able to meet population health needs over the long term.

- The LD Cancer Screening project has secured funding from both Health Stars and the Cancer Alliance to extend the project by 3 weeks to co-produce a Lung Cancer Screening video with experts by experience. The Cancer Innovation funding is open for submissions again and another bid is being drafted to focus on capacity and consent for people with LD in Goole and Bridlington around cancer screening and treatment.

- Internal capital funding has been approved for 3 years to introduce the "Do-It Profiler" tool within the Neurodiversity service. The "Do-It" profiler will enable the service productivity by supporting service users and staff to undertake assessments in a more timely and efficient way. This is now being operationalised within the neurodiversity services.

- A £1.8 million capital programme application has been successful to support the creation of separate male and female PICU units. These units will support the wider ICB and will support patient care closer to home. Work is currently being undertaken with Estates colleagues to scope the work required to deliver this project.

- Work using SDF to reduce OOA older people's placements is continuing. A list of suitable properties has been identified and an options paper will be produced to identify a preferred way forward

- The Trust are supporting the development of HNY Inclusion Health Strategic Approach. The plan is required to draw down national funding for inclusion health. The priorities in the draft plan are: Understanding the characteristics and needs of inclusion health groups, enhancing prevention and early intervention, develop a confident and competent workforce, delivering integrated, accessible and high-quality services.

3.5.5 Digital Update:

- All Trust divisions have successfully migrated from the legacy Lorenzo system to the new SystmOne Electronic Patient Record (EPR).

- The EPR programme is now focusing on post-go-live stability, system optimisation, and addressing outstanding data migration and quality issues.

- The rollout of clinical efficiency tools, including Lexacom voice recognition and Accurx patient communication, is progressing across the Trust.

- The second phase of the EPR extension, which includes comprehensive medication management functionality, is currently in development.

- Preparation for the full data repatriation from the legacy Lorenzo system is underway.

- The Electronic Transmission of Prescriptions (EPS) rollout commenced on 5th May 2025.

- The Information Governance Group (IGG) has approved key Data Protection Impact Assessments (DPIAs), including updates for SystmOne addressing consent changes.

- The Digital & Data Group (DDG) has approved the Lone Working Business Case, noting that funding is required for implementation.

- The Windows 11 deployment commenced in April 2025 and is on schedule for completion before the Windows 10 end-of-support date.

- The BeDigital governance structure has been updated and approved by the Executive Management Team to support ongoing optimisation and future digital developments.

4 Communications Update

Progress against strategic objectives over period.

Theme 1: Promoting people, communities, and social values

Aims	Activity over period	KPI	April Position
Uphold our strong and distinctive brand to create greater awareness, confidence, and relationship with stakeholders	New process to manage digital screens at inpatient units established and working (with estates, IT and comms) New brand plan developed and new easier to use templates in use. Photoshoot at Newbridges at new images added to photo library	Increase visits to online brand portal by 20% demonstrating staff engagement and usage of brand. Benchmark 556.	+38.5% or 770 sessions
Protect and promote the Trust's external reputation	Media highlights • Loneliness Research Study on BBC Radio Humberside • Recovery College on Hull Daily Mail	Track and manage positive V negative messaging and ensure balance of coverage is in Trust favour	15 Positive and 3 Neutral 0 Negative

	• NHS England – our nurses on Nurses Day	Establish in house media training	41 staff now trained.
Share and celebrate our successes to inspire confidence raise our profile	New content planner reducing single use content and maximising impact of our stories. Excellent coverage and engagement with Inspire CQC 'good' story FFT feedback for GP services shared on social media International Nurses' Day had excellent engagement on social media (Facebook and LinkedIn) and the Global with Sarah Smyth's VLOG.	Social media engagement +4% Linked in channel growth - 2872 followers 100 engagements across the awareness date on all channels and for all 'Red' awareness dates.	All channels 5.24% Linkedin - 6,184 +136 new followers in month 317 total engagements – 100 on social media, 217 in the Global
Ensure that patients, the public and their representatives know what to expect from us and have high levels of confidence in our service	Communications Champions Forum established with Hull and East Yorkshire 0-19 Services and Mental Health Support Teams (MHSTs). Aims to share intelligence, insights, and expertise to develop reactive campaigns addressing health concerns affecting children, young people and families. Management of GP transition announcement ensuring reasons for transition are clear.	Meet individual campaign objectives.	Accessing clinical impact with services

Theme 2: Enhancing prevention, wellbeing and recovery

Aims	Activity over period	KPI	April Position
Ensure that patients and service users have accurate information that meets their needs	Connect Website - now live and fully operational. Planning hard launch of Help Hub tool SOP established to ensure updates keep content accurate and up to date. Trust website content changed to direct to it. Stakeholder newsletters continue to be sent to audiences monthly	TBC after 6 months live Newsletter open rate +30% Newsletter subscribers – up 40% (from 141) Increase subscribers by 50%	22,000 active users 32,000 sessions 28% Email and linked in combined subscribers – 3,028 Newsletter subscribers – up 10% (from 233)

Develop and participate in campaigns that support the prevention agenda	Time to Talk Day, 6 February – Social media promoting NHS Talking Therapies MHST social media paid campaigns – May campaigns include domestic abuse and exam stress	Engagement with social media Grow social media accounts	103 engagements 31 new followers, 63 engagements
Support national NHS communications campaigns aimed at illness prevention, demand reduction and self-care, personalising them for our audiences.	Bank holiday communications re opening hours	No measures set for national messaging. Reported as part of overall social media KPI's	

Theme 3: Developing an effective and empowered workforce

Aims	Activity over period	KPI	April Position
Attract excellent candidates	Humbelievable - Spring Clean Your Career campaign now complete. This concludes 24/25 activity. Report in appendix. Planning for experimental summer campaign under way Work on improving job vacancy templates at consultant level New animations including members of staff in development	New campaign Annual campaign target to improve on previous years visits to Join Humber website Launch jobs email newsletter	Sending 600 visits per day to the Join Humber website +30% on 2023/4 campaign, 39,000 website sessions on the Join Humber +2600 subscribers
Be the employer of choice for professionals pursuing a rewarding career.	Staff survey results communications – creating range of designs and communications to not only promote the survey and and results but to continue sharing the message about how the NHS Staff Survey influences changes throughout the year. 100k Your Way launched early April, with this year's focus on 'moving more'.	Staff survey completion to increase each year – from 53% in 24/25 10% staff engaged Post event survey	Improved position on 24/25 97 staff members and 74 teams signed up for the challenge. 518 staff members. 14.3% of staff engaged. Feedback will be

		Net Promoter Score in top quartile +73%	conducted post May 2025.
Have easy to access, high quality digital internal communications that our teams can access how, when and wherever they are.	We continue to get good click throughs on the newly designed Global as well as positive feedback on the new layout. The design has now been applied to our Monthly Divisional Local newsletters. Intranet – Following previous supplier going into liquidation emideial work has taken place to ensure no break in service. This will be complete by end May. We are now moving on the establish important new developments around site navigation and AI search functionality to help support staff.	Global Click Through Rate (CTR) - + 7% Intranet visits - +77101 p/m Bounce rate < 50%	CTR – 17.11% 84,552 17.49% (excludes homepage)
Promote internal messages to enable shared understanding, inspire commitment to their achievement, and support the achievement of Trust priorities	We continue to support the Staff Governor Election process during the current voting phase. Report it and No Excuse for Abuse campaign refresh with EDI team. Extended to includes patients and service user target messaging. Work progressing well on this, with poster designs being created in collaboration with HR/EDI Lead	Help to ensure all Staff Governor roles are filled. Staff survey result - The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it.'	TBC 2024 result +6.89%

Theme 4: Innovating for quality and patient safety

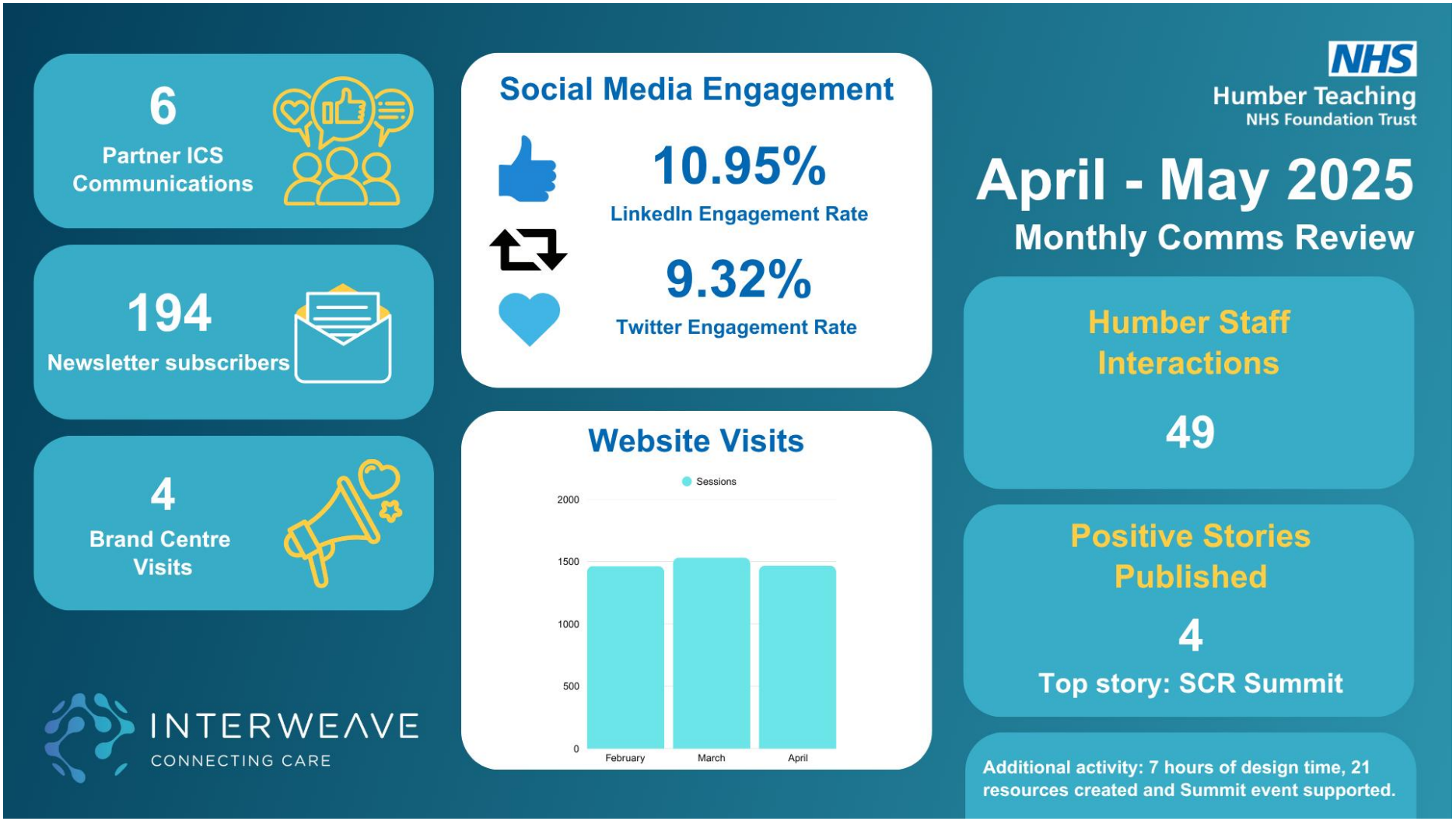
Aims	Activity over period	KPI	April Position
Promote excellence, innovation and where early adoption is taking place	2025 Awards nominations have begun Our Interweave team has already been shortlisted in the HSJ Digital Awards. We are currently supporting a number of entries across the Trust for the HSJ Patient Safety Awards and preparing ahead of the HSJ awards.	4 national/2 local shortlists annually per year	HSJ Digital – 1 shortlisted HSJ Patient Safety – awaiting shortlist – 12 June HSJ Awards – deadline 30.05.25
Demonstrate how supporting, enabling and participating in the	Loneliness study in partnership with Imperial College London	1 story p/m	BBC national news coverage and BBC Radio Humberside

development of the health research evidence base benefits the health and wellbeing of the people we serve, and the services we provide			coverage. That's TV Humber in process of being planned.

Theme 5: Optimising an efficient and sustainable organisation

Aims	Activity over period	KPI	April Position
Use digital communications to enhance patient care, health management and patient experience.	An independent accessibility audit will be run w/c 12th May on the Trust website to ensure we meet and exceed all current guidelines, and the report will be delivered w/c 19th May. An audit has also been done by the accessibility Monitoring Team at the Government Digital Service. Development work has been completed to address areas of noncompliance and reassess the site.	Reduce bounce rate – whole site <50% Average page visits/views per session < 3	49.8% 1.9
Support the Trust's Business Development, Projects & Innovation strategies.	EPR Optimisation phase is in motion with an enhanced focus on the launch of Accurx (SMS messaging), Lexacom (voice recognition) and EPS (electronic prescribing) across our divisional teams. Interweave Communications Strategy 2025-27 and full website content refresh is in motion. Planning Shared Care Record Summit event Innovation Hub involvement and brand development.	New communications plan in progress. Strategy KPIs Sponsorship and attendee numbers Measures TBC by QI team	See Digital Dashboard in appendix See Interweave Dashboard in appendix All sponsorship opportunities filled – 1 x partner, 4 x Gold, 7 x Silver and 1x registration desk sponsors. Registration page has opened recently – we will monitor numbers from next month.

Appendix - Digital Dashboards



NHS
Humber Teaching
NHS Foundation Trust

April - May 2025

Monthly Comms Review

5
EPR Optimisation Projects Supported

11
Campaign emails sent to staff

15
Brand Centre Visits

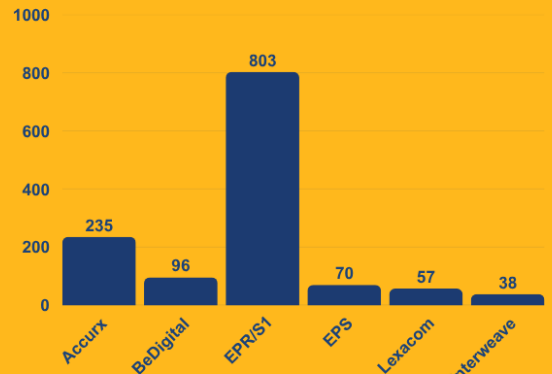
BeDigital
DISCOVER, DESIGN, DEVELOP, DEPLOY

Staff Engagement

59%

or 13,754 of campaign emails opened

Intranet Page Visits



Global And Local Newsletter Interactions

207
in the Digital section

Positive Stories Published

4
Top story: ShCR Summit

Additional activity: 7.5 hours of design time and four resources created.

5 Health Stars Update

See Appendix 1

6 Humbelievable Campaign Report

See Appendix 2

Finance & Fundraising Report

Including update on Wishes and Dreams

May 2025

Reporting on April 2025

Anita Green – Charity Manager
Jess Spicer – Senior Finance Officer

Health Stars

Better Healthcare, Brighter Futures

Highlights Dashboard

1. Delivering Outstanding Care

554 visits to website

£7000 raised through events

£2000 donation to Better Days

2. Enhance Healthcare experiences and outcomes

Wish of the month
Vouchers for Research Team

100% wishes approved
Target = 75%

Launched appeal

3. Improve staff health, wellbeing and development

HYAG / Ryedale Hub / STaRS

3

Water bottles for staff
2 x Team Days

3/33
Charity Champions

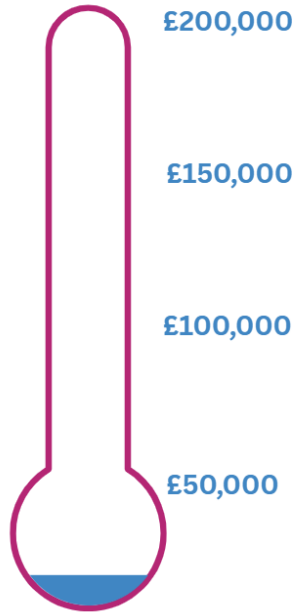
4. Improve health and wellbeing of communities

24,322 views

Views on socials

Top social story:
Golf Trophy

142 views
125 reach



£12,455
Total raised YTD

KPI update

Trust Strategic Goals: Enhancing prevention, wellbeing and recovery

Charity Goal: Support the delivery of outstanding patient care

GOAL / KPI	Measure of success	Success to date
Be in the upper quartile of Community/Mental Health Trust charities by year 3. 2025/26 Target = £200,000	Grants: £50,000 Events/Community: £30,000 Individual: £15,000 Corporate: £5000 Other: £100,000	TOTAL: £12,455 Grants: £2000 Events/Community: £6944 Individual: £1874 Corporate: £0 Other: £1637
Be the charity of choice for people taking part in events or organising their own fundraising	20 people signed up to Health Stars events 10 people/groups organising their own fundraising	7 1
Promote fundraising to all staff, visitors and, where appropriate, patients	Fundraising posters/resources visible on every unit/service	
Share good news across all platforms	25 stories on Health Stars website 4 stories shared to external media	1 story uploaded Better Days shared and picked up by several outlets
Increase visits to website	Increase visits to website by 5%: - Total visits - Visits to 'Access Funding' page	

KPI update

Trust Strategic Goals: Innovating for quality and patient safety / Optimising an efficient and sustainable organisation

Charity Goal: Enhance healthcare experiences and outcomes

GOAL / KPI	Measure of success	Success to date
Increase the percentage of wishes that are approved	75% of wishes approved	100% approval
Launch and complete 4 Dreams	4 Dreams completed	Better Days Appeal launched Flojac mattress – funding application submitted 5 other wishes in initial stages
Focus on staff submitting wishes that address Health Inequalities	10 wishes addressing Health Inequalities	

KPI update

Trust Strategic Goals: Developing an effective and empowered workforce

Charity Goal: Improve staff health, wellbeing and development

GOAL / KPI	Measure of success	Success to date
Recruit Charity Champions within each service to increase knowledge and understanding of the charity	50% of services have a charity champion (33)	3
Increase understanding amongst staff of need for fundraising	Health Stars team to speak at 20 meetings / events	3
Increase wishes specifically for wellbeing of staff	Approve 5 wishes specifically to improve staff wellbeing	3

KPI update

Trust Strategic Goals: Fostering integration, partnerships and alliances / Promoting people, communities and social values

Charity Goal: Improve the health and wellbeing of our communities

GOAL / KPI	Measure of success	Success to date
Increase social media presence across all platforms	Increase Facebook followers by 15% to 1000 Launch a LinkedIn page – 200 followers	899 followers
Develop corporate relationships	Work with 5 corporate partners	1
Launch and maintain Small Community Grants Scheme	Allocate 35 small grants	Awaiting launch
Launch external supporter newsletters Establish CRM to manage donor relationships	Launch an external supporter newsletter with 100 people on mailing list.	CRM currently being populated

CHARITY OPERATIONS

- ★ Create Operational Plan for 2025/26 with a Fundraising First focus
- ★ Set up a LinkedIn page for the charity to better engage with local businesses.
- ★ CRM Live (Donorfy)
- ★ Launch charity dashboard for reports

FUNDRAISING AND EVENTS

- ★ 1st May = Golf Day - £8,000 income
- ★ Easter Raffle (£80)
- ★ East Yorkshire Half Marathon and 10K
- ★ London Marathon (£550)
- ★ £5000 from Earl Fitzwilliam Charitable Trust

SUPPORTER ENGAGEMENT

- ★ Launch Charity Champions
- ★ Re-launch Health Stars workshops for staff

WISHES AND DREAMS

- ★ Launch Better Days Appeal
- ★ Flojac mattress application submitted

CHARITY OPERATIONS

- ★ Launch Small Community Grants Scheme
- ★ Develop Fundraising Complaints policy (Fundraising Regulator Code of Practice)
- ★ Finance / Reserves policy
- ★ Launch Annual Report
- ★ Launch Impact Report

FUNDRAISING AND EVENTS

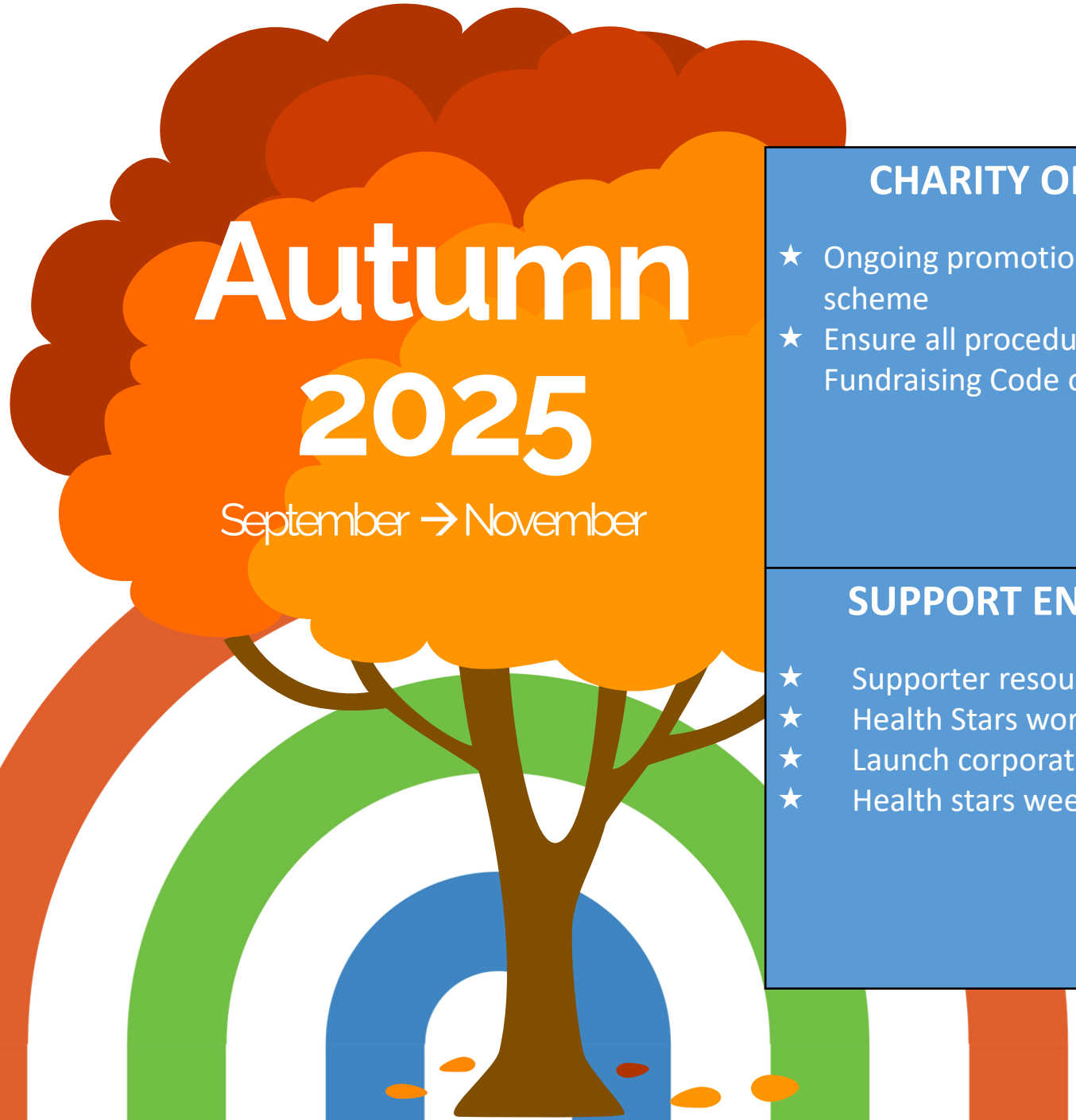
- ★ Hull 10K
- ★ CEO Challenge
- ★ Yorkshire 3 Peaks

SUPPORTER ENGAGEMENT

- ★ Supporter resources on all inpatient units
- ★ Health Stars workshops for staff
- ★ Develop corporate partnerships package
- ★ Launch mailing list and newsletter
- ★ Promo Microhive – save your pennies for something special

WISHES AND DREAMS

- ★ Launch Whitby campaign
- ★ Jack Braunton Trust application submitted (Better Days)
- ★ Capital application – Inspire Garden
- ★ Eyegaze machine appeal live



CHARITY OPERATIONS

- ★ Ongoing promotion of small grants scheme
- ★ Ensure all procedures match the new Fundraising Code of Conduct

FUNDRAISING AND EVENTS

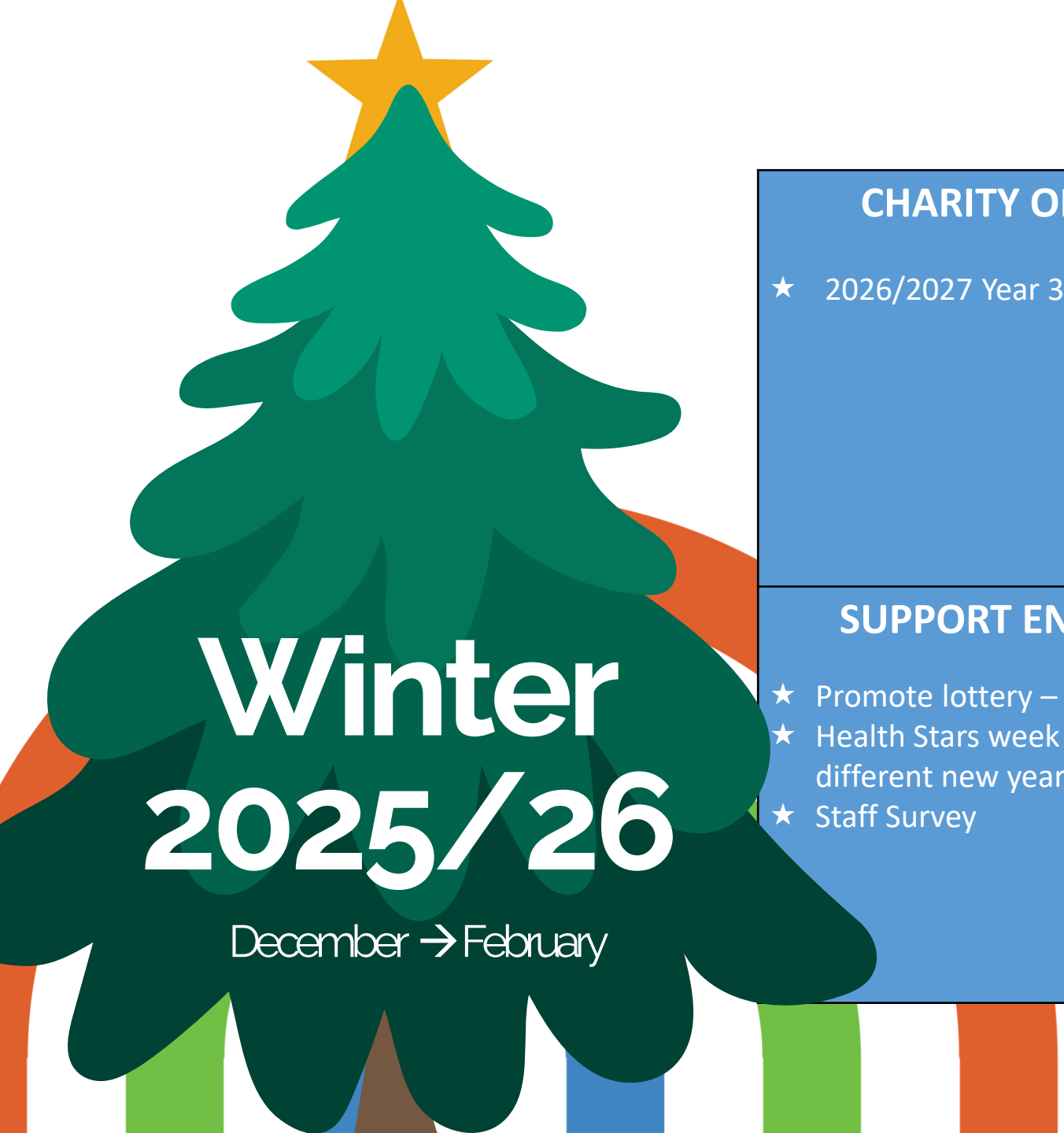
- ★ Yorkshire Marathon
- ★ Haltemprice 10K
- ★ Malton 10K
- ★ Skydive
- ★ Eyeweb challenge (corporate fundraising)
- ★ Volunteer Awards
- ★ Staff Awards

SUPPORT ENGAGEMENT

- ★ Supporter resources in all services
- ★ Health Stars workshops for staff
- ★ Launch corporate package
- ★ Health stars week (1 – 7 September)

WISHES AND DREAMS

- ★ Workforce Wellbeing Grant from NHS CT application submitted



CHARITY OPERATIONS

- ★ 2026/2027 Year 3 Plan

FUNDRAISING AND EVENTS

- ★ Christmas Gift appeal
- ★ Christmas raffle

SUPPORT ENGAGEMENT

- ★ Promote lottery – Christmas winnings!
- ★ Health Stars week – each day a different new year's resolution
- ★ Staff Survey

WISHES AND DREAMS

- ★ Granville Court transformation complete
- ★ Potential launch of 0-19 mobile clinic dream

Financial position as at: 30th April 2025

*For information – not yet transacted

Balance Sheet Reconciliation

The following table provides a reconciliation of fund balances to resources

As per trial balance at 30/04/2025	£
Bank account balance NHS Foundation Trust	10,000
Bank account balance NHS FT Fund Deposit	366,824.64
Charities Investment Fund (CIOF)	355,000
Investment – H Butler Shares	9,556
Total resources held	**741,380.64**
Accrual (to be reviewed)	(1,200)
Debtors	2,600
Gifts In Kind (Inventory)	12,844
Other liabilities - Humber Teaching NHS FT (Wish recharges)	(204,791)
Current commitments	(28,072.34)
Net funds at DATE	**522,761.30**

Aged Receivables Summary

As at 8 May 2025
Ageing by due date

		< 1 Month	1 Month	2 Months	3 Months	Older	Total
Citycare	Golf Day 25/26	335.00	0.00	0.00	0.00	0.00	335.00
Sensia	Golf Day 25/26	0.00	200.00	0.00	0.00	0.00	200.00
Vic Coupland Ltd	Golf Day 25/26	0.00	75.00	0.00	0.00	0.00	75.00
The One Point	Golf Day 23/24	0.00	0.00	0.00	0.00	250.00	250.00
Total		**335**	**275**	**0**	**0**	**250**	**860**

Fund Zone Restructure

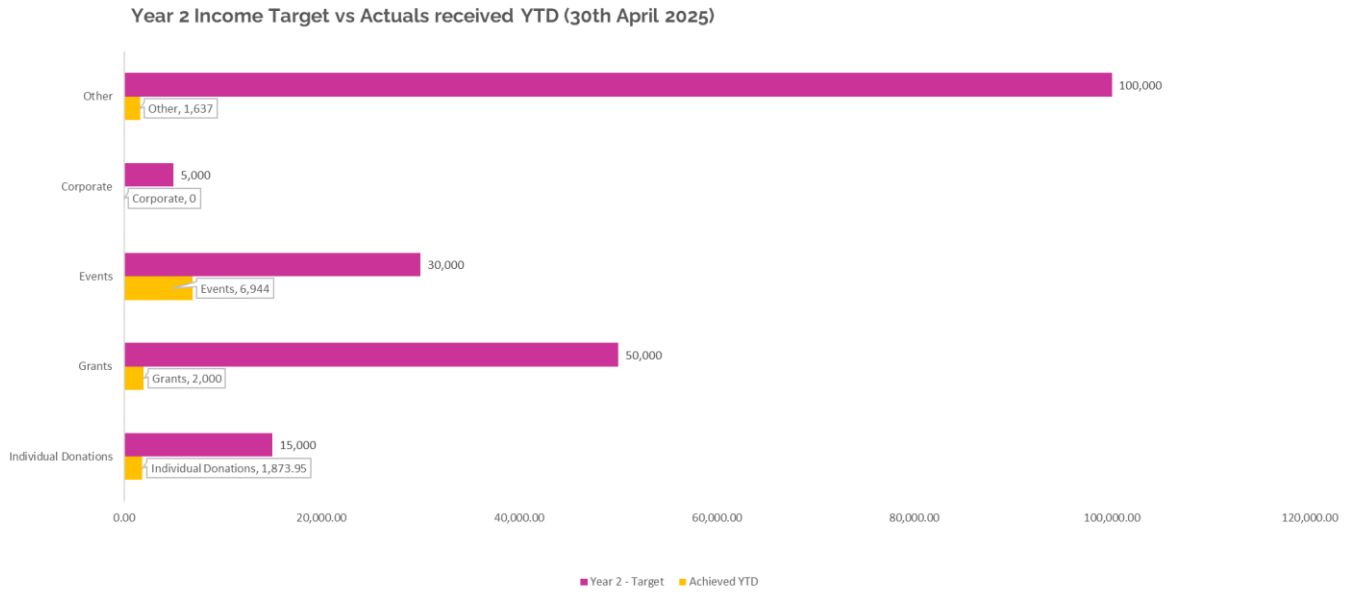
Figures based on balances as at 31-03-25

Fund Zones	Sub Fund	25/26 Opening Balance (FOT)
Community & Primary Care	General	93,618
	Malton	1,450
	Whitby	29,859
	Betty Whatling Legacy	39,513
	Bridlington	25,885
		190,325
Children, Young People & Families	General	327
	Inspire	31,475
	Learning Disabilities	346
		32,148
Mental Health and Wellbeing	General	7,288
	Westlands	505
	Maister Lodge	759
	Newbridges	59
	Mill View Court	278
	Mill View Lodge	18
	Avondale	1,552
	Forensics	13
		10,471
Neurodiversity	General	0
		0
Health Stars – Central Fund	General	94,882
	Volunteers	4,690
	Recovery College	348
	DBT	79
	Grimsby Fishermen's Grant	15,000
	Small Community Grants Scheme	200,000
		314,999
Total:		**547,944**

In Year Financial Performance: Year 2 income target £200,000

Grants: £50,000	Events/Community: £30,000	Individual donations: £15,000	Corporate: £5,000	Other: £100,000
NHS Charities Together Grants, Trusts and Foundations	Health Stars own events or hosted by third parties Seasonal campaigns and appeals	Individual fundraising Major gifts Corporate sponsorships Planned giving (in memory, celebration General donations	Charity of the Year Fundraising within businesses (not connected to an event)	Investment income Legacies / gifts in wills

As at the end of April 2025 actual year to date income of £12,5k had been received.
The following graph shows the year to date performance against the annual target for the four fundraising pillars.



Fundraising: Grants

Grants: £50,000
NHS Charities Together Grants, Trusts and Foundations
Total raised to date: £2000

Fundraising: Events and Community

Events: £30,000
Health Stars own events or hosted by third parties Seasonal campaigns and appeals
Total raised to date: 6,944

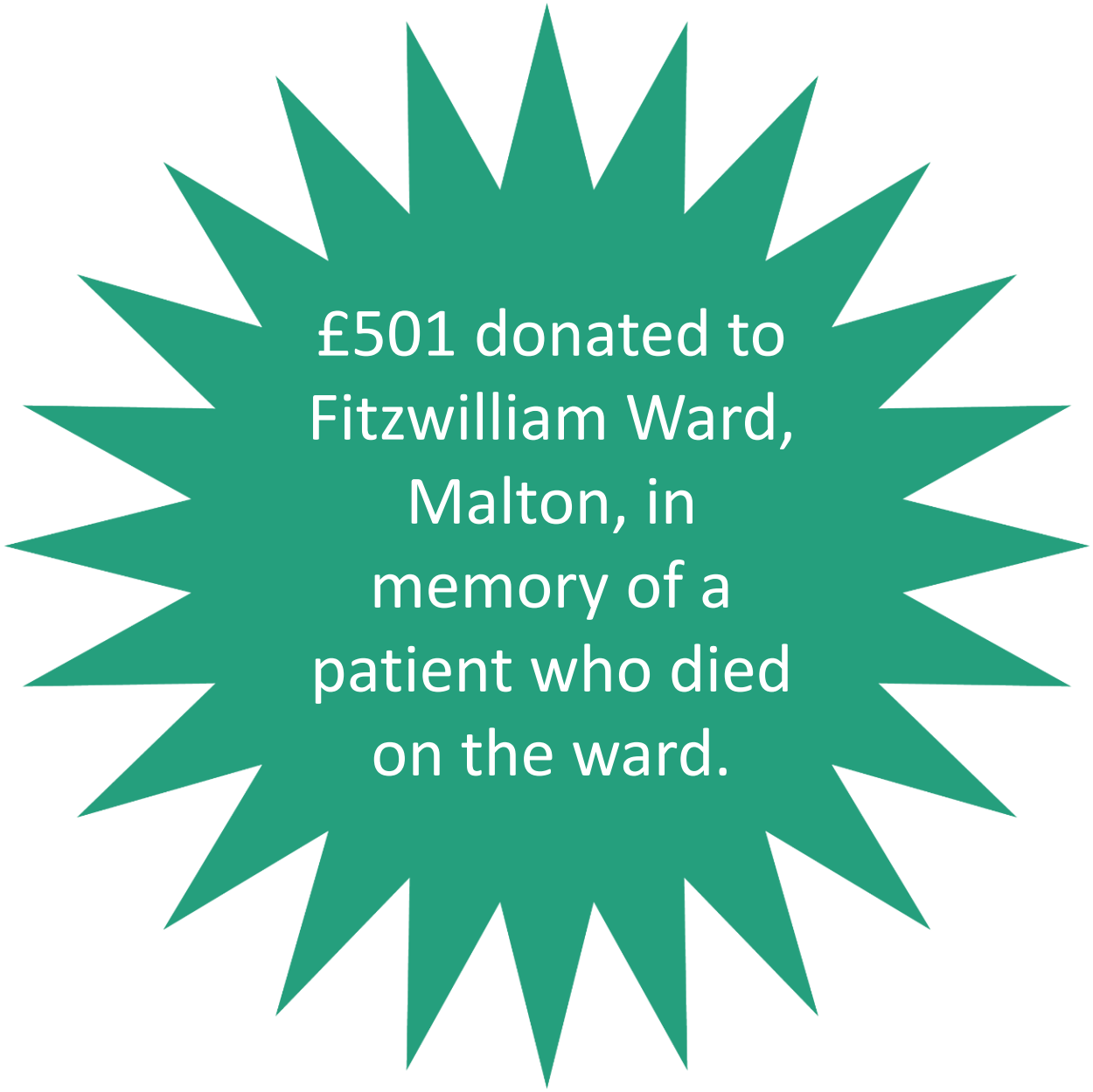
£78 raised through an Easter Egg raffle across Willerby sites

£100 raised on the 9 Miles for 9 Steps Safer Sleep walk

£317 raised by people taking part in the Night Walk

Fundraising: Individuals

Individual donations: £15,000
Individual fundraising
Major gifts
Corporate sponsorships
Planned giving (in memory, celebration)
General donations
Total to date: £1,874



Fundraising: Corporate

Individual donations: £5,000
Charity of the Year Fundraising within businesses (not connected to an event)
Total to date: £0

Fundraising: Other

Other: £100,000
Investment income Legacies / gifts in wills
Total to date: £1,637

Fundraising Events

Event	Date	Participants	Minimum income
East Yorkshire 10K	25 May	1	£100
East Yorkshire Half Marathon	25 May	1	£100
Hull 10K	8 June	3	£300
Yorkshire 3 Peaks	14 June	2	£400
Skydive	September		

3 July	Driving Treasure Hunt

Fundraising: Golf Day

£8000!!!!

Small Community Grants Scheme

- £200,000 transferred to Health Stars to administer a Small Community Grants Scheme
- Similar scheme took place in 2023/2024 and gave grants to around 35 local grassroots organisations who were working with people in the community to improve their mental health.
- Money came from Humber, was administered by Smile. We've taken it in-house.
- An online form will sit on Health Stars website for organisations to apply for the money (up to £5000).
- Waiting for the group to confirm they are happy with the questions on the form, T&Cs and criteria etc.
- Online form – with automation to the 'panel' – can be developed as soon as questions are confirmed.
- 'Go live' in Summer 2025.

Wishes 2024/2025

87 wishes received

Month	Wishes submitted
May 2024	5
June	4
July	8
August	8
September	11
October	7

Month	Wishes submitted
November	9
December	8
January	5
February	9
March	9

56 complete

20 declined

4 in process

7 closed

Wishes 2024/2025

20 declined

10 declined as no quotes provided despite chasing wish maker.

4 wishes should have come out of core budget.

Humber Centre – TV in Multi Faith Room – declined by Estates are part of a larger project

Scarborough Community Services – Water butt declined due to Estates Water Policy.

4 on hold

HYAG polo shirts – awaiting artwork for new logo

Mouth muscle trainer – discussions between medical devices / SALT team / procurement

Lung cancer video – awaiting confirmation of who to pay the invoice

Summerhouse at Rosedale – discussion later in this meeting – is it a Dream?

Wishes 2024/2025

Division	Number of wishes granted	£ Amount granted
Children and LD	14	£6051
Community & Primary	8	£3817
Corporate	8	£2808
Forensics	2	£473
Mental Health	22	£6059

Wishes 2025/2026

9 wishes received

Month	Wishes submitted
April 2025	9
May 2024	
June	
July	
August	
September	

Month	Wishes submitted
October	
November	
December	
January 2026	
February	
March	

9
complete

0
declined

0
in process

0
closed

APRIL 2025

Division	Team	Item	Amount	Fund zone	Status
Corporate	Research and Development	Vouchers for public engagement workshop	£200	THKY1	Complete
Mental Health	Haltemprice CMHT	Polytunnel Thermal Anti Drip Cover	£135	THKY1	Complete
Mental Health	STaRS	Health Stars Water Bottles	£45	THKY1	Complete
Mental Health	Your Health Goole Shop	Room Furnishings	£198	THKY1	Complete
Mental Health	Bridlington and Driffield CMHT	Gardening / Planting Supplies	£119	B1 R	Complete
Mental Health	HICTOP	Team Day - Sewerby Hall and Zoo tickets	£270	THKY1	Complete
Mental Health	Westlands	Team Day - Catering	£360	THKY1	Complete
Mental Health	STaRS	Health Stars Water Bottles	£60	THKY1	Complete
Mental Health	STaRS	Health Stars Water Bottles	£60	THKY1	Complete

Wishes

Our favourite wish of the month

£200 Love to Shop vouchers

“The Research Team don’t get any funding for lived experience activity at the pre-grant application stage and there is no internal allocated budget for this in services. But it is really important for meaningful research that when we’re developing potential future research we make sure those with lived experience help us shape research ideas before we even apply for external research grants to run the actual research study in the future.”

Actions

Regular Health Stars workshops

KPI to visit and speak to at least 20 staff groups throughout the year

Current dreams

	**Malton Day Room**	Creating a dementia friendly day room on the Fitzwilliam Ward	£50,000	Launch appeal: Better Days £10,000 income	Community and Primary
	**Whitby Hospital Children's Area**	Creating a fun and child-friendly space within the waiting area	£30,000 in fund	Dan and Rob visited, working on new ideas	Community and Primary
	**0-19 Mobile Clinic**	To provide services within communities	Unknown cost	Bethia has sent out a survey to relevant teams asking for feedback. Main decision = who should have the van?	Children and LD
	**People Promise**	To provide a psychologist for staff as part of the Workforce Wellbeing Team	Unknown cost	NHS CT Workforce Wellbeing Grants open, apply for round 2 in Autumn	Corporate

Current dreams

	**Flojac - Scarborough**	An inflatable bed which could be used to assist in palliative care. A lot of patients when nearing the end of life need to have a mattress upgrade but due to their condition it is difficult to move them. This often includes having to use the fire brigade and as many staff as possible, which can be difficult to organise and can cause a delay.		An application has gone to The Saturday Hospital Fund	Community and Primary
	**Granville Court**	Huge transformation of Granville Court – Anita finding out how Health Stars can be involved	Anita visited and spoke to Activity Coordinators. Will be attending Project Group meetings going forward.		Children and LD
	**Granville Court Eyegaze machine**	Purchase of 2 Eyegaze machines to support patients who communicate through their eyes	Approx £8000	First Dream Team meeting coming up!	Children and LD

Current dreams

	**Inspire Courtyard Garden**	Transform the courtyard garden at Inspire	Unknown	Initial meetings and engagement with HYAG and patients	Children and LD

Actions

Keep momentum up with Better Days
Appeal, shopping list of items

Launch Whitby Hospital Appeal
- Work with Dan re applications to: Capital/Estates Board
- Appeal name: TBC
- Health Stars for Whitby Hospital

Manage expectations – we have 8
Dreams in progress

Good News

Check out our latest news stories:

healthstars.org/news

Fundraising for our Better Days Appeal has been kicked-off with a donation from the Earl Fitzwilliam Charitable Trust.

The Trust granted us a fantastic £2,000 for our appeal to create a dementia friendly dayroom on the Fitzwilliam Ward at Malton Community Hospital.

The Fitzwilliam Ward, part of Humber Teaching NHS Foundation Trust, helps patients regain independence after being poorly or having treatment like an operation. The ward also provides compassionate palliative care, ensuring comfort and dignity for those in their final days.

Staff from the ward came up with the idea for the appeal after recognising the lack of space on the ward where patients could spend quality time with loved ones or take part in activities and therapy.

Rachel Laud, Service Manager said, "A new day room will create a welcoming space where patients can connect with their visitors, enjoy a change of environment away from their beds and take part in therapeutic activities. We are looking forward to creating a community of donors that will get behind the appeal and help us make our first steps towards our goal. We hope that the community come out in force for this appeal that could have such a positive impact on anyone that needs our service"

We are looking for ideas for events we can attend and to meet with groups who may consider supporting the appeal with their own events or activities. We are also inviting anyone who wants to support the appeal to take part in a local event to raise funds for the appeal.

The appeal is live on Just Giving and anyone who wants to donate can visit the page to help kick start the fundraising.

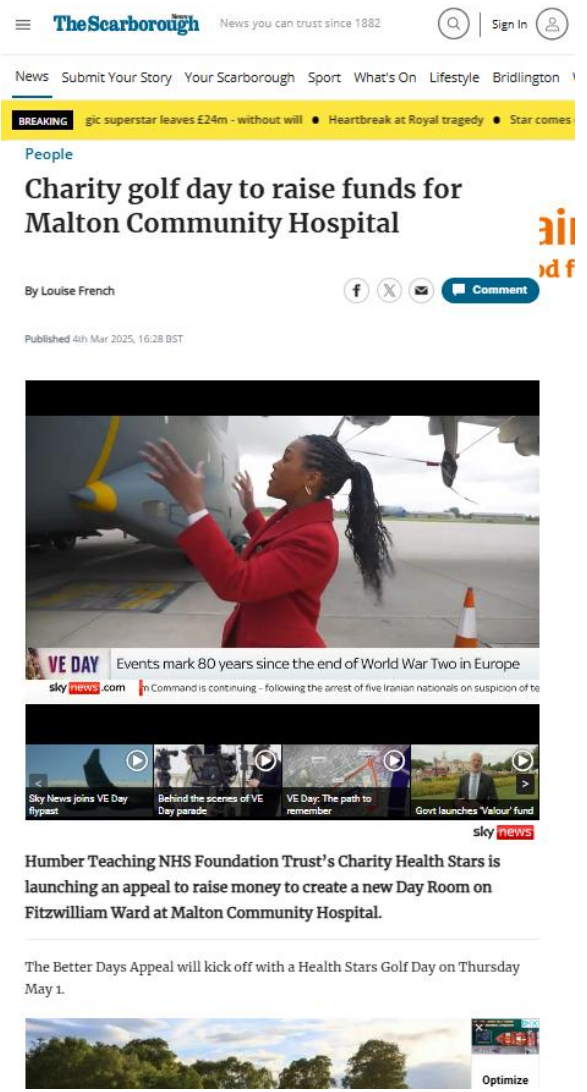
Rebecca Wilkin from the estate said "The Fitzwilliam Malton Estate is delighted to be associated with improvements to the Fitzwilliam Ward at Malton Hospital through a grant from the Earl Fitzwilliam Charitable Trust. Helping to ensure that local residents benefit from modern healthcare facilities very much fits with the Fitzwilliam Malton Estate's aspirations for the town."

To launch the appeal, nurses and healthcare workers from the ward have starred in a short film talking about what the appeal means to them.

Anita Green, Health Stars Charity Manager said, "We are thrilled to launch the Better Days Appeal and hope to hear from the community with ideas for how they can get involved. Every donation, no matter the size, will help us enhance the hospital experience for patients, families, and staff."

Better Days and Golf Day in the news

COAST & COUNTY RADIO



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BREAKING gic superstar leaves £24m - without will • Heartbreak at Royal tragedy • Star comes

People

Charity golf day to raise funds for Malton Community Hospital

By Louise French Comment

Published 4th Mar 2025, 16:28 BST

VE DAY Events mark 80 years since the end of World War Two in Europe

skynews.com

Sky News joins VE Day flypast | Behind the scenes of VE Day parade | VE Day: The path to remember | Govt launches 'Valour' fund

sky news

Humber Teaching NHS Foundation Trust's Charity Health Stars is launching an appeal to raise money to create a new Day Room on Fitzwilliam Ward at Malton Community Hospital.

The Better Days Appeal will kick off with a Health Stars Golf Day on Thursday May 1.

Optimize

Humbelievable Campaign Report

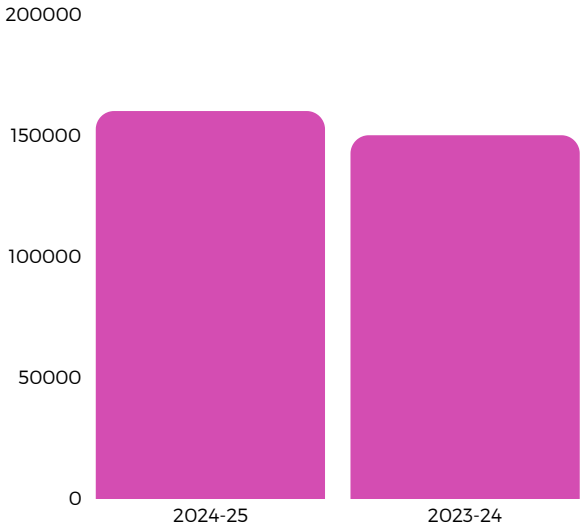
2024/25

NHS Humber Teaching NHS Foundation Trust

KEY STATS

160,000 VISITS
TO JOIN.HUMBER.NHS.UK

OVER 1.5 MILLION AD VIEWS



6% INCREASE
IN SITE VISITS, YEAR-ON-YEAR (+10,000)

ZERO
ADDITIONAL SPEND FROM 23/24

15 PENCE
AVG COST PER VISIT

REDUCTION OF 25%

72% INCREASE
IN SEARCH TRAFFIC, YEAR ON YEAR

Humbelievable Campaign Report

2024/25

NHS Humber Teaching NHS Foundation Trust

CAMPAIGN ACTIVITY VISUALS

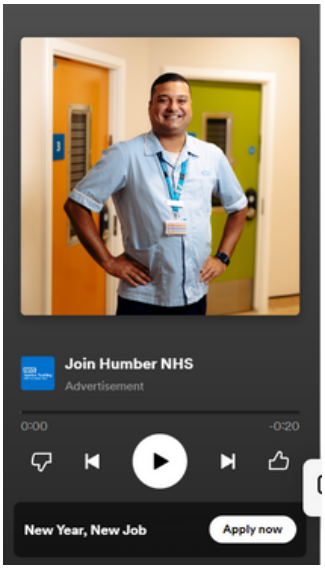
Humbelievable Campaign Report

2024/25

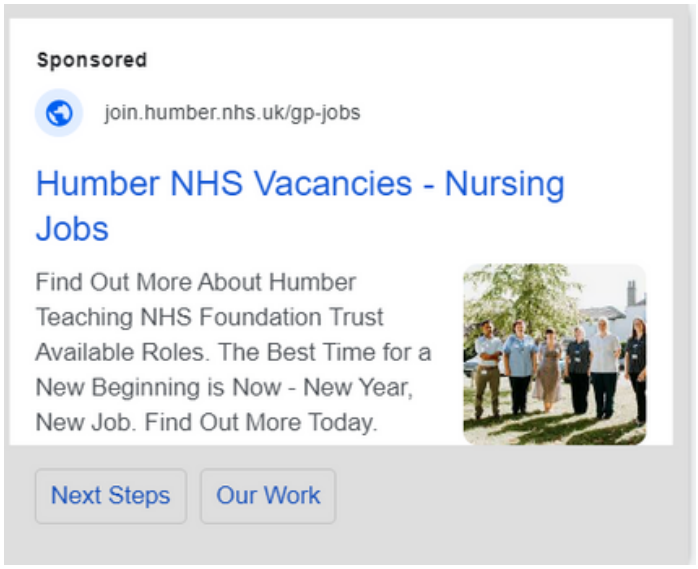
NHS Humber Teaching NHS Foundation Trust

AD AND MEDIA VISUALS

Billboard ads on Anlaby Road and Clough Road.



Spotify Ad.



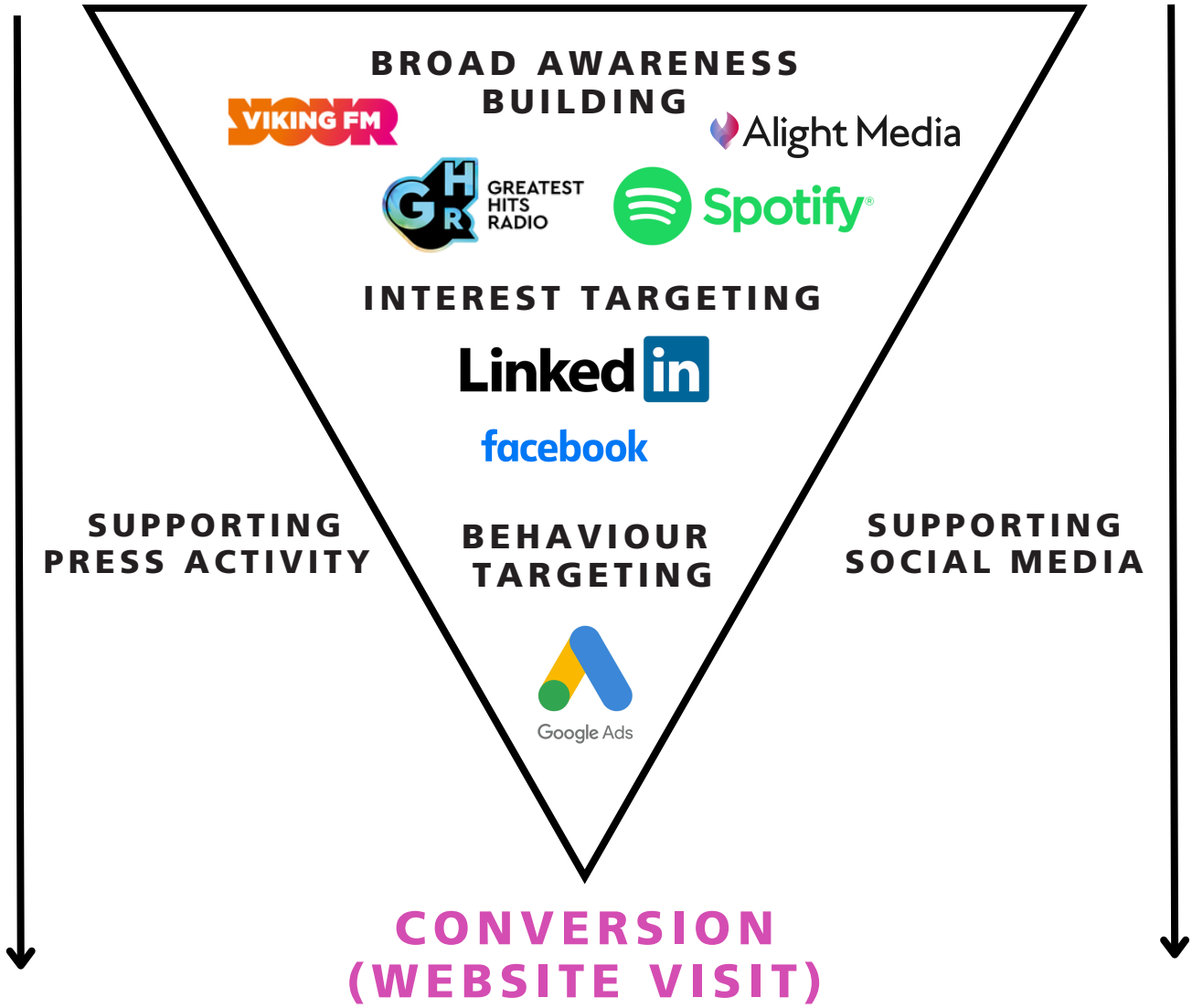
Google Search Ad

New Year, New Job Campaign Report

DECEMBER 2023 - JANUARY 2024

NHS Humber Teaching NHS Foundation Trust

TARGETING APPROACH
PAID ADVERTISING-LED



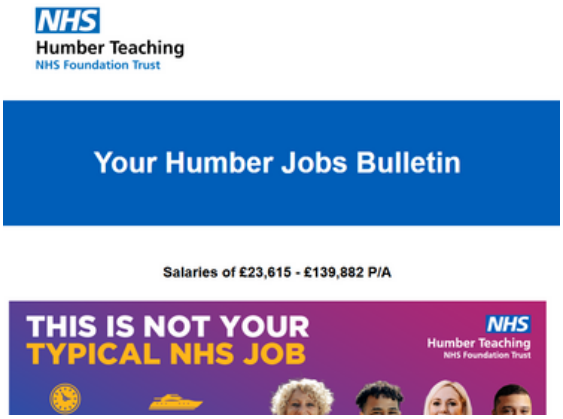
- Increase in video content
- Additional spring and back to school campaigns based on audience insight
- Benefits led
- Increased focus on re-capturing those who didn't apply first time around
- 5 campaigns, year round
- Supporting content improved
- Additional supporting PR activity throughout the year. More output caries a recruitment message

Humbelievable Campaign Report

2024/25

NHS Humber Teaching NHS Foundation Trust

JOBS BULLETIN

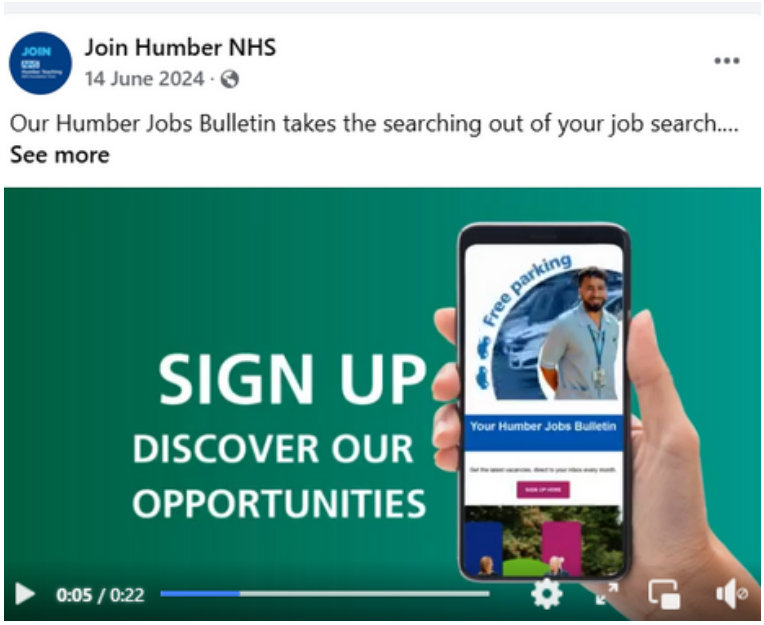


OVER 2,500 SUBSCRIBERS

BUILT UP FROM 0 IN 2024

50% OPEN RATE (40% ABOVE INDUSTRY STANDARD)

AVG 150 CLICKS PER SEND



Humbelievable Campaign Report

2024/25

NHS
Humber Teaching
NHS Foundation Trust

GROWTH OPPORTUNITIES

JOBS BULLETIN
FASTEST-GROWING OUTPUT

MORE PR
CARRYING RECRUITMENT MESSAGE

FREE OUTPUT, SUPPORTS PAID CAMPAIGNS

EXPERIMENTAL CAMPAIGNS

TEST NEW APPROACHES NOW SEASONAL CAMPAIGNS ARE WELL-ESTABLISHED

DIFFERENTIATE FROM COMPETITION - THEY ARE BEGINNING TO EMULATE OUR CONTENT

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 8

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Publications and Policy Highlights
Author/s:	Name: Michele Moran Title: Chief Executive
Recommendation:	

To approve		To discuss	
To note	✓	To ratify	
For assurance			

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	To inform and update the Trust Board on recent publications and policy since the March 2025 Board meeting (as detailed below): • *The Impact of Staff Fatigue on Patient Safety* • *Impacts and Benefits of Provider Collaboratives at Scale* • *Board Member Appraisal Guidance* • *Department for Science, Innovation and Technology - Digital inclusion action plan: first steps* • *National Induction Framework* • *Care Quality Commission (CQC) Monitoring the Mental Health Act in 2023/24* • *How Racism Affects Health* • *NHS Performance Assessment Framework* • *Delivery of patient letters: an opportunity to improve patient access and productivity* • *The Capital Needs of Community Services* • *CQC: Identifying Red Flags and Harmful Patterns of Behaviour in Healthcare* • *Guidance for Developing a Healthy Nursing Staff Bank*

Key Issues within the report:

Positive Assurances to Provide: • n/a	**Key Actions Commissioned/Work Underway:** • n/a
Key Risks/Areas of Focus: • n/a	**Decisions Made:** • n/a

Governance: *Please indicate which committee or group this paper has previously been presented to:*				
		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership and alliances
	Developing an effective and empowered workforce
	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Publications and Policy Highlights

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

1. The Impact of Staff Fatigue on Patient Safety

The Health Services Safety Investigations Body (HSSIB) has published a report which outlines the impact that fatigue has on patient safety in acute NHS hospitals. The report pulls together findings from staff interviews, discussions and observational visits to several acute hospital trusts, combined with evidence from national bodies, forums and networks with insight on this topic.

Whilst the report focusses on staff working in acute hospitals, HSSIB said the findings will be relevant to providers and staff in other health and care settings.

Link to the report: HSSIB Investigation report: The impact of staff fatigue on patient safety (24 April 2025) - HSSIB investigations - Patient Safety Learning - the hub

Lead: Associate Director of People and OD

- The key findings of this report will be considered by the P&OD team and the Staff Health and Wellbeing Group.
- We can consider this in light of our ongoing focus on continuing to build on our broad and good offer to support staff health and wellbeing.
- Our safer staffing report provides good assurance that our staffing levels are good overall
- That we have strong oversight of e-roster "rule breaks" especially staff working on annual leave, not taking breaks, working overtime and excessive hours.
- The Trust will also begin to consider this as part of our risk management approach, specifically seeking to understand if this is a risk for us locally.

2. Impacts and Benefits of Provider Collaboratives at Scale

Across the country, provider collaboration is showing how working at scale can deliver efficiencies, support staff, and improve care – even in tough conditions.

A new case study report, published by NHS Providers, contains examples of what provider collaboratives across all sectors are achieving together, from reducing waiting lists to creating shared services

Lead: Chief Executive

A separate paper is on the agenda reflecting the current model developments. A paper has been sent to the NHSE CEO about our work on collaboratives and the benefits.

3. Board Member Appraisal Guidance

On 1 April 2025 NHS England (NHSE) published new board member appraisal guidance. Intended to set clear expectations and enhance consistency in board member appraisals, the guidance applies to chairs, chief executives, non-executive directors (NEDs) and executive directors (EDs) in trusts, foundation trusts (FTs) and integrated care boards (ICBs).

The guidance is part of a suite of tools to support leadership and management development following the recommendations of the independent review on *Leadership for a collaborative and*

inclusive future undertaken by General Sir Gordon Messenger and Dame Linda Pollard in 2021. It supersedes the Framework for conducting annual appraisals of NHS chairs published in February 2024 and incorporates the NHS leadership competency framework (LCF) domains and Fit and proper persons test framework for board members requirements.

The guidance can be accessed via this link: NHS England » Board member appraisal guidance

Lead: Associate Director of People and Organisational Development & Head of Corporate Affairs
The guidance has been shared with Board members ahead of this year's round of appraisals. The Board appraisal documentation reflects the published guidance requirements.

4. Department for Science, Innovation and Technology - Digital inclusion action plan: first steps

This plan aims to close the digital divide in the UK, ensuring that everyone has the access, skills, support and confidence to engage in our modern digital society and economy, whatever their circumstances. The first five actions look at local level support, skills, devices, accessible government services and evidence around health outcomes and health inequalities. It focuses on young people, older people, people with disabilities, people currently out of work, and low-income households.

The plan can be accessed via this link: Digital Inclusion Action Plan: First Steps - GOV.UK

Lead: Director of Finance
'To effectively implement the Digital Inclusion Action Plan the Trust will need to must integrate its objectives with existing digital and health inequalities strategies – this work will be taken through the appropriate internal governance routes to enable plans to be updated'

5. National Induction Framework

NHS England's National Induction Framework is designed to inform, guide and navigate new colleagues working in health and social care - across organisations and systems. The content can be used by all NHS and social care employers and includes guides and templates for recruiting managers to support new joiners.
.
Link: NHS England » National Induction Framework

Lead: Associate Director of People and Organisational Development
At Humber are using the NHSE National Induction Framework as a core foundation for our induction revision project. This work, outlined in the paper presented to EMT on 8 April, applies national guidance in conjunction with our local workforce needs and broader evidence-based research. By triangulating these inputs, we are developing a fit-for-purpose, inclusive, and sustainable induction offer for the people of Humber, ensuring it is both nationally aligned and locally relevant.

6. Care Quality Commission (CQC) Monitoring the Mental Health Act in 2023/24

The Mental Health Act 1983 (MHA) is the legal framework that provides authority for hospitals to detain and treat people who have a mental illness and need protection for their own health or safety, or the safety of other people. This report sets out the CQC's activity and findings during

2023/24 from engagement with people who are subject to the MHA as well as a review of services registered to assess, treat and care for people detained using the MHA.

Link: https://www.cqc.org.uk/publications/monitoring-mental-health-act/2023-2024

Lead: Medical Director
The CQC publication raised significant concerns about mental health services, including system pressures, workforce shortages, health inequalities, poor interpretation service use, access challenges for children and young people, blanket restrictions, and the impact of poor environments.

These issues were discussed at the Mental Health Legislation Committee via an Insight Report, which provided the Trust's perspective and several positive assurances. Example of actions noted included divisional responses, implementation of the Trust's autism strategy, Trust's Health Inequalities plans, a robust system for monitoring DoLS in inpatient units, the use of ReachDeck to support non-native English speakers, and strong oversight of restrictive interventions aimed at reducing their use.

There were outlines of steps in the trust to improve care quality, equity, and patient experience.

7. How Racism Affects Health

This report examines the relationship between racism and health outcomes. It shows how people of colour experience three building blocks of good health – employment, income, and where people live – and finds large, unacceptable variations according to ethnicity.

Link to the report: https://www.health.org.uk/reports-and-analysis/reports/how-racism-affects-health

Lead: Medical Director
Workforce Actions
The Trust has implemented both Respect and the No Excuse for Absence Framework to address discrimination. Outcomes from our national staff survey demonstrate that the aims of the Respect Campaign have tangible results, with a 7% increase in staff reporting incidents of bullying, harassment and discrimination. Statistically, this is the most improved outcome in the survey. No Excuse for Abuse was launched to address abuse towards staff from patients, being recognised as QI Charter of the Month in December 2024. Subsequently, the framework was endorsed by UNISON, which found it comprehensive and supported its implementation, and their logo was applied to the documentation. The framework has been well received by wards and clinical divisions.

Patient Actions
The Trust is actively implementing the Patient and Carer Race Equality Framework (PCREF) to address racism and reduce inequalities. As part of this effort, Black Thrive Global conducted race equity training in March for ward staff and executives. This training supports the integration of the Culture of Care's (CofC) Antiracism Guiding Principle and strengthens service accessibility and outcomes for diverse users and staff. More training sessions are planned for May, with a particular focus on senior leaders, ensuring compliance with PCREF standards while advancing race equity within the organization.
The Trust has implemented the requirements of the Patient and Carer Race Equality Framework (PCREF) that explicitly addresses racism and supports efforts to reduce inequalities.

Health Inequalities
The Trust has consulted on and implemented a comprehensive Health Inequalities Work Plan to tackle disparities in healthcare access and outcomes. This initiative was recognised with the QI Charter of the Month award in June 2024. Health inequalities refer to unjust and preventable differences in health across various populations and social groups, affecting life expectancy, prevalent health conditions, and the quality of care available.

8. NHS Performance Assessment Framework

On 27 March, a substantially revised regulatory oversight framework for 2025/26 was approved for consultation by NHS England's (NHSE's) board.

Now called the NHS performance assessment framework, this iteration reflects feedback from engagement with trusts and integrated care boards (ICBs) about the previous draft, as well as the changing external context.

It will go out for testing and engagement in April with a short period of consultation in May 2025, and will be published at the end of Q1 with the first segmentation of trusts and ICBs happening in July.

Further details are available via this link: NHS performance assessment framework consultation - NHS Providers

Lead: Director of Finance
A paper on the current consulted version of the performance assessment framework is on the agenda today, once the final framework is published this will be brought to board to determine the appropriate assurance route.

9. Delivery of patient letters: an opportunity to improve patient access and productivity

NHS Providers has published a briefing on the role of patient letters in enabling patients to access healthcare, and how timely delivery offers opportunities to improve patient access and experience.

The briefing is designed to help NHS trusts to understand upcoming reforms, consider improvements to patient communications and optimise their use of available postal services.

Lead: Chief Operating Officer

This briefing is set out in the context of the NHS shift from analogue to digital, and the considerations that Trusts will be taking where technology can improve their processes alongside avoiding digital exclusion. It acknowledges that letters can play an essential role in enabling patients to access healthcare, and there will still be cohorts of patients who rely on receiving physical letters.

As a Trust we continue to focus on improving patient access and experience and actively want to work to reduce digital exclusion and health inequalities for our patients. To do this we are ensuring that our patients are supported to access new technology where this is applicable and are planning to increase our offer through our Recovery College to help with this as an example. This briefing will be considered by the operational divisions and through our Bedigital programme.

10. The Capital Needs of Community Services

Community services are grappling with the repercussions of years of capital underinvestment.

Nearly 9 in 10 NHS leaders who responded to a survey by NHS Providers reported they were unable to secure adequate funding.

The latest report from the Community Network, published with NHS Confederation, underscores the need for increased capital funding in community services.

Lead: Director of Finance
Across the NHS Capital is currently in demand, and this publication is not dissimilar to previous documents highlighting the need for capital investment into the NHS. A multi-year settlement for capital is expected as part of the budget, however details at this stage are unknown.

11. CQC: Identifying Red Flags and Harmful Patterns of Behaviour in Healthcare

The CQC commissioned the Patient Experience Library to analyse warning signals from avoidable harm inquiries in health and social care. The report finds harmful patterns in behaviour and cultures, and the red flags that can help to identify them.

The CQC commissioned the report to draw out the patterns of harm in organisational and professional behaviour. An evidence-based approach was used to help develop a common language and identify red flags that can be used to:

- recognise avoidable harm
- break harmful patterns
- understand what poor and harmful cultures look like
- open up evidence-based conversations
- support organisational learning and training.

The report found that where there is a problem, it usually involves multiple people who have failed to spot or deal with avoidable harm. It identifies 3 states in which problem cultures can give rise to failures and identifies six different organisational subcultures that feed into an overall harmful culture where failures happen.

Link to the report: Patient Experience Library

Lead: Director of Nursing, Allied Health and Social Care Professionals
This report aligns with Part C of the Thirlwall Inquiry and the work being undertaken by the avoidable harm group. The avoidable harm group will consider the evidence-based approach and will develop recommendations for EMT to consider. This will involve patient safety, safeguarding and Human Resources.

12. Guidance for Developing a Healthy Nursing Staff Bank

NHS England has published guidance which is designed to support NHS trusts to develop and refine their nursing bank offer as one measure to reduce nurse agency use. It sets out the core elements they should consider in ensuring their bank provides high quality temporary staffing solutions in a timely fashion to support safe, effective care, and identifies resources to help them do so.

Link to the guidance: https://www.england.nhs.uk/publication/guidance-for-developing-a-healthy-nursing-staff-bank/

Lead: Associate Director of People and Organisational Development
Humber NHS Teaching Foundation Trust prides itself on the robust management of its bank, which supports the organisations' ability to *'deliver the right staff, with the right skills, in the right place at the right time.'*

This position statement is with regards to the 'Developing a Healthy Nursing Staff Bank' national guidance published on 9th April 2025. The national guidance is broken down into 3 key areas:

1. Bank strategy
Humber have developed a strategy and action plan to reduce overall reliance on agency usage. The Flexible Workforce Team (FWT) have adopted a 'bank first' approach to filling shifts and as such have eradicated all off-framework agency usage since June 2024.

To support this reduction, the bank recruitment trajectory for 2025 has been exceeded, recruiting more Nurses than planned, in order to meet demand which will naturally occur as framework usage further decreases.

In April 2025, there has been a change to the annual appraisal process, which has already seen an increase to the amount of bank workers engaging with this. Historically, bank worker engagement with the appraisal process had been low, with less than 10% of the bank workforce completing an appraisal or annual review. In 6 weeks, there has already been a 42% uptake regarding the annual review.

2. Governance and deployment

Robust processes are in place to ensure off-framework agency usage is maintained and there are assurances that any framework agency staff adhere to the same NHS employment check standards, as internal bank recruitment.

The following governance systems are in place:
- centralised booking to ensure consistency across departments or sites
- regular agency reviews to ensure quality and value
- Pre-employment Check (PEC) forms are required ahead of booking framework agency staff
- monthly KPI monitoring – shared with senior members of People & OD for oversight and assurance
- internal use of Trac for bank staff recruitment, ensuring all NHS employment check standards are in place ahead of clearing for work – subsequent to this, all bank staff must adhere to the same Statutory Mandatory Training Policy as all substantive staff.

The following deployment approaches are currently being used:
- effective e-rostering embedded across the organisation
- regular safer staffing reviews – FWT join a weekly meeting to discuss, in collaboration with clinical and operational colleagues across all settings
- staff upskilling to ensure effective skill mix. The Trust has a robust workforce planning process which supports the use of skill mixing. This will indirectly have an impact on the bank workforce.

3. Flexible staff offer

As part of the Trust's bank strategy, there has been a strive to further improve the overall bank offer to ensure bank workers feel valued.

Upskilling bank staff and continuing professional development

- The ‘Humber welcome’ booklet and introductory calls have been introduced since April 2025;
- All bank staff are subject to the same Statutory Mandatory Policy as substantive staff to support patient safety but also support CPD;
- FWT work proactively to convert bank staff to substantive appointments wherever possible;
- The Trust has a robust in-house training & development offer, with access to additional opportunities such as coaching and mentoring.
- Annual appraisal / review is open to all bank staff, in line with their bank anniversary date.

Health & wellbeing support

The Trust has an internal Occupational Health and wellbeing support provision, which is available to all staff (including bank). This includes:

- Access to counselling via Occupational Health;
- Access to MSK service provision and direct support from Trust’s Occupational Therapist;
- Access to health & wellbeing MOT (including physical and mental wellbeing checks).
  The Trust is further expanding their provision, for all staff, to include access to psychological support.

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 9

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Emergency Preparedness, Resilience and Response (EPRR) Annual Report
Author/s:	Name: Lynn Parkinson/Lisa James Title: Accountable Emergency Officer/EPRR and Business Continuity Manager
Recommendation:	

To approve	✓	To discuss	
To note		To ratify	
For assurance			

Purpose of Paper:	To provide an overview of the EPRR programme and activities over the last 12 months and demonstrate the Trusts compliance with the NHSE EPRR core standards.

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	13.05.25
Mental Health Legislation Committee		Operational Delivery Group	28.04.25
Other (please detail)			

Key Issues within the report:	The attached annual report provides the Trust with assurance that the Trust has met the EPRR duties and obligations as set out in the Health and Care Act (2022) during the period 1st April 2024 to 31st March 2025. The report provides an overview of EPRR activities during the last 12 months including its continued response to GP Collective Action and the outcome of the EPRR annual assurance assessment. This report also sets out EPRR priorities for 2025/26.

Positive Assurances to Provide:

- That we continue to meet the standards set by the EPRR national teams and obligations under the Health and Care Act (2022)
- That we continue to improve care and service safety, resilience and response through a programme of EPRR training, testing and learning from incidents internally and through networks and partners.

Key Actions Commissioned/Work Underway:

- Continue the work to improve on the EPRR core standards compliance rating for 2025-26.
- To ensure audit recommendations are actioned.

Matters of Concern or Key Risks:	**Decisions Made:**
• Continue to identify key risks for the Trust and work with community and national risk registers.	• To raise the level of compliance against the NHS England Core Standards through work programmes that address the Trust's improvement requirements and continue to strive to improve on those areas.

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
√	Innovating Quality and Patient Safety
√	Enhancing prevention, wellbeing and recovery
√	Fostering integration, partnership and alliances
	Developing an effective and empowered workforce
√	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	✓			
Quality Impact	✓			
Risk	✓			To be advised of any future implications as and when required by the author
Legal	✓			
Compliance	✓			
Communication	✓			
Financial	✓			
Human Resources	✓			
IM&T	✓			
Users and Carers	✓			
Inequalities	✓			
Collaboration (system working)	✓			
Equality and Diversity	✓			
Report Exempt from Public Disclosure?			No	

Humber Teaching
NHS Foundation Trust

Emergency Preparedness, Resilience and Response

Annual Report

1st April 2024 – 31st March 2025

Caring, Learning
& Growing Together

FOREWORD

Throughout the year the Emergency Planning Team has assessed risk, developed plans, delivered a range of scenario-based training and exercising, and worked collaboratively with key stakeholders, partners, managers and clinicians. The work has enabled the Trust to provide an effective, resilient and coordinated response to the demands that continue to present. GP Collective Action has been a large part of the Trusts response during 2024/25 with the Command-and-control arrangements being stood up to manage potential disruptions to service due to actions being taken.

The annual EPRR core standards self-assessment for 2024-25 was again undertaken by the Trust using the new process and compliance requirements previously introduced in 2023-24.

NHS organisations and providers of NHS funded care must evidence that they can plan for and deal with a wide range of incidents and emergencies that could affect health or patient care. All NHS funded organisations must meet the requirements of the Civil Contingencies Act (2004), Health and Care Act (2022), NHS England Command and Control Framework, NHS Business Continuity Management Framework and the NHS Emergency Preparedness Resilience and Response Framework. It is for these reasons that Humber Teaching NHS Foundation Trust continues to drive improvement within its EPRR agenda.

I am pleased to present the EPRR 2024-25 Annual Report which identifies the work undertaken to address key priorities, identifies Trust compliance with statutory duties and acknowledges its achievements over the last twelve months.

Lynn Parkinson
Chief Operating Officer/Deputy Chief Executive and Accountable Emergency Officer

1. Background

NHS Organisations and providers of NHS Funded care must evidence that they can deal with major incidents or emergency disruptions whilst maintaining services to patients. This is commonly known within the NHS as Emergency Preparedness, Resilience and Response (EPRR).

Humber Teaching NHS Foundation Trust must ensure consistent delivery of high-quality safe care to patients through resilience, planning and preparation. Robust arrangements must also be in place to continue to deliver this level of care when unexpected incidents occur or at times of great pressure.

The Trusts response to situations has continued over the last 12 months in managing GP collective action.

2. Purpose

This Annual Report provides the Trust Board with assurance that the Trust has met the EPRR duties and obligations as set out in the Health and Care Act (2022) during the period 1st April 2024 to 31st March 2025. This report provides an overview of EPRR activities over the last 12 months and has set out EPRR priorities for the next 12 months

3. Statutory Framework and National Policy Drivers

Under the Civil Contingencies Act (2004) the Trust is not categorised as a responder, it does not have an Emergency Department and is therefore not subject to the Act; however, there is an expectation under the Health and Care Act (2022) that the Trust prepares and responds as though it were.

The Acts are accompanied by other requirements such as the NHS Standard Contract, NHS England Core Standards for EPRR, the national EPRR Framework (2022) and NHS Business Continuity Management Framework.

The strategic national EPRR Framework contains principles for health emergency planning for the NHS in England at all levels including NHS provider organisations, providers of NHS funded care, Integrated Care Boards, general practices and other primary/community care organisations.

The NHS England Core Standards for EPRR requires an annual report to the Trust Board and provides the minimum standards which NHS organisations and providers of NHS funded care must meet. The Trust undertakes an annual self-assessment against the core standards relating to its services and provides assurance to the ICB and NHS England that robust and resilient EPRR arrangements are established and maintained within the Trust.

4. Accountable Emergency Officer

The Chief Operating Officer is the designated Accountable Emergency Officer with responsibility for EPRR in the Trust. The Chief Operating Officer delegates responsibility to the Deputy Chief Operating Officer/Head of EPRR to ensure that all legislative requirements and responsibilities are delivered with the support of the EPRR Team.

5. Emergency Preparedness, Resilience and Response Discharge of Responsibilities in 2024/25

5.1 EPRR Assurance Process

Each year Trusts are asked to assess overall whether it they are ***'full'***, ***'substantial'***, ***'partial'*** **or** ***'non-compliant'*** with the core standards and an additional deep dive element.

The NHS EPRR Core Standards were introduced to clearly set out the minimum standards expected of NHS organisations and providers of NHS funded care with respect to emergency preparedness, resilience, and response.

The NHSE EPRR Core Standards enable agencies across the country to share a common purpose and to coordinate EPRR activities in proportion to the organisation's size and scope. In addition, they provide a consistent cohesive framework for self-assessment, peer review and assurance processes.

The annual EPRR core standards self-assessment for 2024-25 was again undertaken by the Trust using the new process and compliance requirements previously introduced in 2023-24.

The Trust had to self-assess against each core standard using the compliance levels defined below:

Compliance Level	Definition
Fully Compliant	Fully compliant with the core standard
Partially Compliant	Not compliant with the core standard The organisation EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months
Non-Compliant	Not compliant with the core standard In line with the organisation EPRR work programme, compliance will not be reached within the next 12 months

Deep Dive

Following key themes and common health risks raised as part of last year's annual assurance process, the 2024/25 EPRR annual deep dive focussed on cyber this year and these have been included in the team's action plan. To note, however, the overall Trust assessment excludes the deep dive element and does not contribute to the overall compliance level.

Assurance rating principle

The number of core standards applicable to each organisation type is different however, Humber Teaching NHS Foundation Trust had 58 applicable core standards to self-assess against. The overall final EPRR assurance rating is based on the percentage of core standards the organisation is compliant with outlined in the table below:

Compliance Level	Definition
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards

Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partially	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-Compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

These standards were reviewed and updated as lessons were identified from testing, national legislation, and guidance changes and/or as part of the rolling NHSE EPRR governance programme.

Humber Teaching NHS Foundation Trust completed its self-assessment against this year's applicable core standards and deep dive standards uploading evidence as required, the timeline for the 2024/25 process is outlined below:

- It self-assessed itself as non-compliant at 67% and provided evidence to underpin each core standard for review by the Humber and North Yorkshire Integrated Care Board (HNY ICB) by the 31st of October 2024, signed off by the Trusts Accountable Emergency Officer. This is a significant improvement on last years position, where the compliance level was at 24%. The Humber and North Yorkshire ICB position was 60% compliance.

- On receipt of this evidence HNY ICB carried out the evidence check and identified five standards that they did not consider the Trust to be fully compliant on. A follow up meeting with the ICB and the Trust including the Trust AEO was held on 8th November 2024. This session discussed the submission content and the areas of challenge following the review by the ICB.

- It was agreed after discussion that 4 out of 5 of the standards would revert to non-compliant and the fifth (Risk Management) would remain compliant as the Trust had provided additional evidence. The outcome of the meeting was confirmed in writing by the ICB, and the compliance rating would reduce from 67% to 60%. This was accepted by the Trust.

- The Local Health Resilience Partnership (LHRP) meeting took place on 19th November 2024 with a confirm and challenge by each organisation with attendance required by all Accountable Emergency Officers.

- All organisations were expected to provide updated action plans and an outcome report to their Trust Boards by 31st December 2024 to complete the assurance cycle.

The table below illustrates the final overall compliance of 60% within each domain.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	9	2	0
Command and control	2	2	0	0

Training and exercising	4	1	3	0
Response	5	4	1	0
Warning and informing	4	4	0	0
Cooperation	4	3	1	0
Business Continuity	10	5	5	0
Hazmat/CBRN	10	0	10	0
Total	58	35	23	0

Although NHSE recognise the significance of taking this evidence-based approach and the additional demands and challenges it places across organisations, given the competing pressures and that Trust Boards may be concerned by the reduction in compliance ratings. It is important to note that they consider this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness.

As a result of the outcome of non-compliance the EPRR team have developed a comprehensive action plan to focus their efforts over the next 12 months to increase the percentage compliance for the next submission later in 2025, this action plan is due for completion in September 2024. It is anticipated that assessment for 2025/26 will take a similar timeline, and the first submission will be around September 2025, it is expected that on completion of the current actions the Trust will be in a much stronger position and compliance will be much higher in 2025 aiming for partial compliance at a minimum.

6.0 Risk Assessment

The Trust has an EPRR risk register which is reviewed quarterly with the Trust risk manager; entries onto the EPRR risk register are aligned to the Humber Local Resilience Forum community risk register and these are reported monthly to the Trust Operational Delivery Group via the Risk Managers report.

Assessing the potential risk of emergencies occurring and using this knowledge to inform contingency planning is a key duty and therefore the Trust must have suitable plans which set out how it intends to respond to and recover from major incidents and emergencies as identified in the local and community risk registers.

7.0 Partnership Working

The Trust is represented at both health and multi-agency emergency preparedness groups within the Yorkshire and Humber area. The Trust works collaboratively with these agencies throughout the year to support coordination and information sharing. There has been a significant demand on organisations to attend frequent national and local calls during times of pressure and we have ensured that appropriate representation from the Trust has been available. We have senior representation and input into the Local Resilience Forum (LRF) Strategic Coordination Group and LRF Health Cell as well as daily and weekend system calls. We have ensured EPRR representation into Tactical Coordination Groups as these groups provide a valuable platform in terms of communication, planning and sharing learning from events and incidents.

Groups attended over the last year include:

- Humber Local Resilience Forum and general working group (multi-agency)

- North of England Mental Health Forum EPRR Leads
- Humber and North Yorkshire ICB system calls
- Humber and North Yorkshire ICB Local Health Resilience Operational Subgroup
- Quarterly Local Health Resilience Partnership
- Vulnerable Persons working group
- Power Outage working group
- Humber and North Yorkshire ICB Industrial Action system calls
- Yorkshire and Humber Mental Health and Community EPRR Group

8.0 Training, Exercising and Testing

8.1 Training

A key element of EPRR is the ability for the organisation and its staff to respond positively to incidents and emergencies. The Programme of Health Command training delivered by NHSE has been rolled out to all our directors and managers on call for Strategic and Tactical Command and continues to be delivered to new staff as they become eligible to join the rota. The undertaking of this training deems the individual competent to undertake on call duties and manage an incident should this arise. To support all our Strategic and Tactical commanders with their EPRR knowledge and competency the Health Command Portfolios have also been rolled out with specific training identified for individuals at each level. This has been recorded on an EPRR training needs analysis.

An EPRR all staff awareness e-learning package has also been created by the team with the Trusts instructional designer and rolled out as part of the Trust's mandatory training in the last 12 months, this is a requirement of the EPRR core standards and gives all staff in the Trust a basic understanding of EPRR, the current compliancy for this E-learning training is standing at 87.11%. This will be reported to the Board from the end of April 2025.

One member of the EPRR team has also been accepted onto the NHSE funded Diploma in Health Emergency Planning which will contribute to their own portfolio, starting in July 2025.

8.2 Exercises

There have been several exercises that the team and other individuals from the Trust has attended in the last 12 months, these are:

Multi-Agency/Internal	Scenario	Date
Internal – Business Continuity	Humber Centre Live Exercise	3rd January 2024
Internal – Business Continuity	Pine View Live Exercise	31st January 2024
Internal – Business Continuity	Community Forensic BC Exercise	21st February 2024
Multi-Agency	ICB Vulnerable persons data pull exercise	29th April 2024
Internal – Business Continuity	Humber Centre Power Outage Live Exercise	13th June 2024
Multi-Agency	Nitazene Preparedness	9th September 2024

	Workshop	
Multi-Agency	Test of the Low & Medium Secure Evacuation Plan	December 2024
Multi-Agency	Mass casualties incident	December 2024

All these exercises had debriefs completed and work is ongoing with recommendations from these. The EPRR team are part of this process.

Planned exercises for 2025 are:

	Exercising	
	Internal	**Multi-agency**
April	Communication Test	
May	Forensic BC exercise	NHSE Business Continuity workshops
July	Mental Health BC exercise	
September	Evacuation Exercise	Exercise Pegasus
October	Communication Test	

8.3. Testing

Communication tests to on call teams have also continued to take place every six months in line with current requirements. This tests their ability to respond to an incident in the out of hours period and is becoming an embedded process for those who provide on call cover across all areas of the Trust particularly in the out of hours period. This includes managers, directors, estates, communications, loggists and medical teams on call

Communications Tests were held on:

8th October 2024
10th April 2025

Areas of learning resulted in:

- Communication to on-call managers that unknown phone numbers should be responded to when on call.
- Advised on-call managers that work commitments whilst on-call should be managed to enable calls to be taken or alternative contact provided.

9.0 Responding to external influences

NHS Alert Levels

We continue to be responsive to any changes to NHS alert levels (below) and the Trust has a robust process for stepping up its command-and-control arrangements in support.

Alert Level	Description	Responding Organisation
1	An incident of event which impacts on a single provider, and which can be managed within place or with ICB support	Led by affected provider organisation with support from their ICB (place)
2	An incident of event which impacts multiple providers	Led by the ICB with support of

	within an ICB footprint or requires mutual aid between providers within a single ICB.	the regional EPRR team
3	An incident of event which impacts multiple providers within an ICB footprint or of such a magnitude/specialism that it requires regional coordination. May require national support.	Led by NHSE regional team
4	An incident of event affecting multiple regions or of such a magnitude that it requires national involvement to lead the NHS response.	Led by NHSE national team

GP Collective Action

Planned GP collection action over the last 12 months meant that our Tactical command and control arrangements have been stood up to coordinate the Trusts preparedness and plan for any impacts as a result on a weekly basis. Although the impact to the Trust was minimal there were some issues encountered by services that were raised and escalated to the ICB for resolution. This was also overseen by the HNY ICB GP coordination group with weekly meetings taking place to update all partners as to current progress and impacts. After agreements talks with the LMC this was stepped down by the ICB ahead of the new financial year.

10.0 Incidents

Incident Management is a fundamental part of the EPRR team's requirement, and they have managed several incidents which also warranted the stepping up of the Trusts control and command arrangements, these are: -

- PICU Fire - 21st May 2024
- Crowdstrike which affected 'Allocate' the bank workforce system - 19th July 2024
- GP Systems Outage - 30th Sept – 2nd Oct 2024

All the above had a debrief held either as a formal session or via questionnaire to identify learning and outcomes. The actions are monitored by the EPRR team and are reported through the EPRR quarterly report to ODG.

11.0 Business Continuity Management System

The Business Continuity Management System supports the Trust in its obligations to have robust processes in place for risk identification, creation of dedicated business continuity plans, testing & exercising arrangements and continuous improvement.

The team are currently working on a process for undertaking a Strategic Business Impact Analysis across the Trust and the introduction of a formal process for teams to identify when to trigger the implementation of their Business Continuity Plans.

The EPRR team continue to support in all elements of this system through working with divisions and directorates through Single Point of Contacts (SPOC's) and Operational Delivery Groups.

12.0 Emergency Preparedness Plans

The EPRR Team continues to develop, update and improve trust-wide resilience plans in alignment with updated risk registers, national guidance, and learning. As a result of the core standards recommendations some of the plans currently being updated are:

- The Incident Response Plan
- The Trust Business Continuity Policy
- The CBRN Plan
- Outbreak of Communicable Infection Policy

13.0 Operational Support

The Trust continues to work closely with the ICB leads for winter and surge planning and regularly responds to requests for assurance on its ability to deliver operationally during times of increasing pressure in the health system, supporting patient flow and the planning for bank holidays/events.

The UEC RaidR digital reporting system has now been rolled out across Community and Mental Health Trust's. This was a national requirement, and Trusts were supported by NHSE to work through and develop their internal processes to enable this to be implemented by February 19th, 2025. This system captures the Trust's OPEL (Operational Pressures Escalation Levels) score through several data parameters, narrative and OPEL actions taken. The UEC RaidR submission is completed by the EPRR team during weekdays and the bed management team, community band 7's and on-call managers during the weekends.

The Trust maintains a robust on-call manager and director rota system as well as a well-established evening duty manager rota which is managed by the EPRR team.

The EPRR team continues to collate and publish several plans including the weekend clinical capacity and contingency plan and bank holiday plan that incorporates key service information from all areas of the Trust which support the on-call staff with any issues that may arise during their out of hours duties.

Comprehensive and up to date on-call packs also provide a range of information, policies, maps and procedures to support the on-call teams.

14.0 Assurance and Governance Arrangements

14.1 Internal Audit

A Business Continuity and Resilience Audit carried out by Audit Yorkshire concluded in December 2024 with the final report being published in January 2025. The resulting outcome of 'significant assurance' was achieved with 4 moderate recommendations and 2 minors, the majority were completed by March 2025 and the final to be completed by June 2025.

14.2 Operational Delivery Group

This remains the group for oversight of all EPRR related plans, policies and reports and the EPRR team continue to provide quarterly updates of progress in relation to the EPRR core standards and the EPRR work programme.

14.3 Local Health Resilience Partnership (LHRP) and Local Resilience Forums (LRF)

The LHRP for the NHS Humber and North Yorkshire Integrated Care Board provides additional governance and oversight in terms of reviewing the Trusts submission of its EPRR core standards and its self-assessment. The LHRP is chaired by the ICB EPRR lead and attended by Accountable Emergency Officers or director equivalent from each organisation including Humber Teaching NHS Foundation Trust.

The LRF is a multi-agency partnership made up of representatives from local category 1 and 2 responder organisations including the NHS. They work collaboratively with the LHRP for their respective areas. We continue to be made welcome and maintain a presence at the Humber LRF meetings where possible and the ICB represents health at the North Yorkshire LRF.

15 .0 Summary

2024/25 has been another busy and challenging year for Humber Teaching NHS Foundation Trust in terms of its EPRR response. The EPRR team has been dedicated to meeting the demands faced in terms of responding to the GP collective action whilst continuing to ensure the out of hours rotas have been managed, weekend and bank holiday plans have been distributed and ensuring system assurance deadlines have been met. Testing of plans has been undertaken, flooding and severe weather has been accounted for, training has continued and a programme of work for 2025/26 has been planned.

16.0 EPRR Priorities for Emergency Planning, Response and Resilience

As new guidance is developed, introduced and learning from each response is collated the teams' key priorities for the 2025/26 are as detailed below:

- Raise the level of compliance against the NHS England Core Standards to at least Partial through work programmes that address the Trust's improvement requirements and continue to strive to improve on those areas currently achieving partial or non-compliance.

- Updating of the Trust's suite of plans, including the Incident Response Plan, policies and procedures to ensure that they reflect national guidance; best practice and learning from live and test situations.

- Improve care and service safety, resilience and response through a programme of EPRR training, testing and learning from incidents internally and through networks and partners.

- Further embed the importance of Business Continuity Management with operational services by delivering support and training and ensure an evidence-based approach is taken.

- Continue to improve on the system and monitoring mechanisms with our Mental Health and community partners and stakeholders.

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Agenda Item 10

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	CQC Monitoring the Mental Health Act in 2023 – 2024
Author/s:	Kwame Opoku-Fofie, Medical Director
Recommendation:	

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

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The paper covers key highlights and summaries of the CQC Monitoring the Mental Health Act in 2023 – 2024. The perspective from Humber has been added for assurance where appropriate.

Key Issues within the report:

Positive Assurances to Provide:

- The perspective from Humber has been added
- Our Trust's website has an accessibility tool called ReachDeck which supports individuals who use English as a second language
- Trust has a robust monitoring system in place to ensure there are no delays in providing patients with their rights.

Key Actions Commissioned/Work Underway:

- There have been several focussed pieces of work around improving staff knowledge of blanket restrictions.
- Humber have a trust autism strategy in place which includes training goals for all staff.
- implementation of the Patient and Carer Race Equality Framework (PCREF)

Matters of Concern or Key Risks:

- Increasing demand in especially in children services
- Increasing demand in neurodiversity assessment and management.

Decisions Made:

- Mental Health Legislation Committee receives a quarterly report on the use of restrictive interventions

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	
Mental Health Legislation Committee	01.05.2025	Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
√	Innovating Quality and Patient Safety
√	Enhancing prevention, wellbeing and recovery
√	Fostering integration, partnership and alliances
√	Developing an effective and empowered workforce
	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

CQC Monitoring the Mental Health Act in 2023 – 2024

The report highlights the ongoing challenges in mental health care that are compounding the pressures on mental health inpatient services.

Key points:

System pressures and the MHA - concerns that the high demand for mental health services, without the capacity to meet it, means people cannot always get the right care at the right time. CQC highlighted the recent introduction of NHS England statutory guidance on Discharge from mental health inpatient settings, which outlines how organisations should work together to ensure effective discharge planning and the best outcomes for people when they are discharged from hospital.

From a Humber perspective this document went to the January Mental Health Legislation Steering Group for discussion with an action for each division's discharge SOP to be reviewed against this document. There was agreement that the document should be presented in each divisional clinical governance meeting for consideration to use it in the SOP review.

Workforce – concerns re shortages in both medical and support roles continue to have a negative impact on patient care.

Issues included:

- Wards without a permanent Responsible Clinician. As a result, in one instance, doctors from another hospital over 40 miles away were covering the ward, and there was not always a doctor available on-site within normal working hours.
- Multiple wards with no occupational therapists available for their patients.
- Instances where services were without a physiotherapist or reported difficulties recruiting tutors for young people of compulsory school age.

The trust vacancy rate remains below 10%, currently at 6.67%. The nursing vacancy rate stands at 6.40%. While the consultant vacancy rate remains high, it has been improving month by month. Where necessary, vacancies are filled by qualified locum consultants from agencies, ensuring that all wards are covered by a named Responsible Clinician. The trust continues to implement the safer wards model to maintain appropriate staffing levels.

Continued evidence of staff **not having the specialist training required** to care for people, particularly autistic people and people with a learning disability.

Humber have a trust autism strategy in place which includes training goals for all staff. Our neurodiversity services have produced a training package for all staff to access, which covers awareness of sensory needs, and autism awareness. For Neurodiversity celebration week Humber put on teams' sessions for all staff to attend to gain a better understand how we can support our patients and carers and to develop awareness of what Neurodiversity is and to celebrate the strengths and differences of the Neurodiversity world. Our Autism diagnostic service provides a consultation service to other services to support a better understanding of a person with autism. Our Intensive support service also provide a consultation and works alongside mental health services to support understanding of a person with a learning disability presentation and needs. This has seen an increase in understanding of knowledge in these service areas. We have a steering group being established to support the implementation of reasonable adjustments across all services and a health inequalities strategy across all divisions.

CQC remain concerned that clinicians may not always be considering where the MHA can be used when the DoLS framework is not appropriate and where the patient is objecting to their placement.

From a Humber perspective there is a robust system of monitoring all patients placed on a DoLS in any of our inpatient units. Responsible Clinicians are always advised to use the MHA where the criteria is met as this provides more robust safeguards for the patient. We also now have agreement from Hull City Council that patients subject to DoLS from Hull in our inpatient units will be prioritised by them, and best interest assessments will be carried out prior to the end date of the urgent DoLS (7 days with a 7-day extension option). ERYC have been advised to liaise with Hull CC in order to establish robust processes and pathways in DoLS to help ensure consistent practise across the Local authorities.

Inequalities
concerns that some of the key issues raised in this report, including access to mental health support, are particularly challenging for certain groups of people, such as people from ethnic minority groups and those living in areas of deprivation.

In our last Monitoring the Mental Health Act report, we reported on positive initial findings of PCREF pilots and early adopter sites. Since then, these trusts have continued to report positive progress, including:

- focusing on data held in their trust and establishing workstreams to enhance data collection and better understand their populations and where discrimination may be happening
- engaging with a range of local groups and forming local partnerships, including with a local police force, to hear from different groups and develop training
- ensuring that the Board PCREF lead is well-established, and the Board are engaged with the framework
- using tools such as Dialog+ to facilitate better co-produced care plans and recruiting community support experts to work with care co-ordinators to bridge the gap between trusts and people who use services.
- updating websites and intranet pages with information on PCREF, explaining its governance structure and opportunities to get involved.

Humber Teaching NHS Foundation Trust (HTFT) is actively involved in national efforts to reduce health inequalities, particularly in mental health services. Key initiatives include:

Culture of Care Standards Programme:
- HTFT is one of 60 organisations in a national NHSE programme focusing on inpatient services for mental health, learning disability, and autism.
- Anti-racist practice is a core principle, with training provided to both ward staff and executive leaders.
- Quality improvement projects are co-produced on selected wards.
- The programme is delivered in partnership with Black Thrive Global and includes collaboration with the PCREF framework.
- The initiative will be implemented over two years, with shared learning across the Trust.

Patient and Carer Race Equality Framework (PCREF):
- HTFT is preparing to implement PCREF, which addresses racial disparities in mental health services (e.g., higher rates of detentions and restrictive interventions in Black communities).
- A PCREF Working Group will be established and co-production with community groups and Experts by Experience is a key element.
- HTFT is learning from early implementers like Sheffield Health & Social Care NHS Foundation Trust.

Workforce Development and Anti-Discrimination:
- The Trust is contributing to a national competency framework for social workers focused on equality, diversity, and inclusion.
- Two workshops in April 2024 identified learning needs regarding racialised communities.
- Insights from a “world café” event are feeding into a new workforce capabilities framework, led by Lancashire and South Cumbria NHS Foundation Trust.
- Anti-racist and allyship training has been delivered to system leaders in Hull and East Riding.

Concerns around people not understanding their rights.
In our Trust there is a robust monitoring system in place to ensure there are no delays in providing patients with their rights on admission or when their section has changed. MHL Team plan to consider some focussed work on ensuring rights are being repeated regularly as this is identified as an issue in the monthly MHA audits and CQC MHA visits. All detained patients are referred to the IMHA service on admission unless they opt out and have capacity to do so; all detained patients who do not have capacity to make this decision are automatically referred to the advocacy service by the MHL Team.

Concerns around poor use of interpretation services.
Our Trust’s website has an accessibility tool called ReachDeck which supports individuals who use English as a second language. It offers a text-to-speech feature, which reads text aloud with synchronized highlighting, and translation capabilities for over 100 languages. These tools help non-English speakers

better understand and engage with online content. As part of the Trust's EDI priorities for April 2023 to March 2025 we have continued to engage with community groups and are currently in the process of identifying Experts by Experience to support with the Patient and Carer Race Equality Framework (PCREF) where we will be working together to understand their specific needs to help to address areas where improvements can be made.

Children and young people - children and young people continue to face challenges in accessing mental health care.

Environment - concerns about the impact of poor-quality environments on patients and how ageing and poorly designed facilities affect people's care. Some concerns around locked kitchens and patients having to ask staff for access.

From a Humber perspective access to food and drink is currently being addressed via a small task and finish group specifically looking at developing some guidance to aid a consistent approach across the Trust to avoid restricting food and snacks. This includes representatives from each division, Trust catering dietician, and involvement from inpatients.

Blanket restrictions - Sometimes, issues with ward environments can increase the risk of blanket restrictions, meaning that access to areas is restricted for all patients, despite not all patients needing this level of restriction to keep them safe.

In 2023/24, we found blanket restrictions were uncommon. Staff at most services reviewed restrictions regularly to ensure they remained proportionate. In many cases, services were able to give us a clear rationale for the restrictions they impose. However, we continue to find examples of unnecessary restrictions and measures that did not support patients to be independent, such as locking doors to certain rooms.

Humber Approach to Blanket Restrictions – Summary of Activity

From a Humber perspective, several focused initiatives have been undertaken to improve staff understanding of blanket restrictions and how to avoid them. The Restraint Reduction Network (RRN) Blanket Restrictions Toolkit was initially piloted on the Newbridges and Inspire units at the end of 2023. This pilot facilitated meaningful collaboration with patients, allowing them to help adapt the questions and format of the restrictive interventions questionnaire. No blanket restrictions were identified during this process, and patients valued the opportunity to be involved. It was agreed that the questionnaire would be repeated every three months.

To support this work, Newbridges staff developed a handout guide incorporating relevant policy information, along with "bitesize learning" sessions for staff. The pilot was discussed in both the Acute Care Forum and the RRI Group, with a view to wider rollout across other areas.

In late 2024, a Practice Note (PN) was issued in response to themes emerging from recent CQC Mental Health Act (MHA) visits. The PN clarified when blanket restrictions may be justified, emphasising that all other alternatives must first be considered and that the correct procedures must be followed if any restriction is implemented.

A Trust-wide Blanket Restriction Register is in place, supported by a robust reporting system and a requirement for the regular review of all restrictions. Additionally, a Blanket Restriction Audit has been developed on InPhase, which all units are required to complete monthly.

Mental Health Bill – considerations from the CQC Monitoring the MHA in 2023 – 2024 report

While the Bill is introducing many significant and long-awaited amendments, we will be monitoring a number of areas closely to ensure they translate into positive changes for people:

Over-representation of Black people detained under the Mental Health Act and placed on community treatment orders (CTOs).

This is a longstanding inequality, and everyone involved in the delivery and oversight of mental health services must put measures in place to address it. We welcome the ambitions in the Bill to decrease the overall use of

community treatment orders and the racial disparity in their application, but it will be important to keep these reforms under review following implementation to measure their true impact.

Ongoing problems with care pathways and a lack of community provision for autistic people and people with a learning disability.

This can lead to them being inappropriately detained in hospital, which can have a devastating impact. We are pleased to see important amendments to the MHA included in this Bill, which will increase the safeguards for people who are detained. However, we are concerned that, even with the changes, there may still be a risk that people may be detained in suboptimal hospital placements. It will therefore be important to monitor implementation to ensure people are safeguarded from unintended consequences.

Persisting abusive and closed cultures in too many mental health services.

The likelihood that a service might develop a 'closed culture' is higher if an inherent risk factor is present. There are many inherent risk factors such as workforce retention and staffing shortages, which remain one of the greatest challenges for the mental health sector. While we have seen many services challenge and reduce the use of restrictive practices, there is still significant work to be done.

Impact on our second opinion appointed doctor (SOAD) service.

The SOAD service is an important safeguard for people who are detained under the MHA. While we welcome the increased safeguards included in the Mental Health Bill, we remain concerned about our ability to deliver the service in the longer term. Proposals in the Bill will result in a substantial increase the numbers of second opinions required while reducing the timeframes for delivery of some second opinions. Additional funding is needed to deliver the future second opinion service, which the Department of Health and Social Care (DHSC) has accepted in its impact assessment for the Mental Health Bill. However, as we highlight in the section on workforce, ongoing challenges with workforce availability means that additional funding alone will not be enough to address the issues facing the service.

Protecting patients' rights.

Our power to investigate MHA complaints complements our monitoring and regulatory role, as we use the intelligence from MHA complaints to inform wider work and to uphold the rights of people subject to the MHA. Measures in the Bill to improve how providers tell people how to complain will be beneficial to patients in ensuring their rights are protected. We will ensure our MHA complaints process is aligned with the Mental Health Bill in its final and published form after it gains Royal Assent. We commit to working with the Parliamentary and Health Service Ombudsman to direct complainants correctly and consistently to the appropriate oversight body, and ensure our process is accessible and responsive for people using services and their representatives.

As highlighted in our 2022/23 report, legislation alone won't bring the changes needed. Better funding, improved community support and investment in workforce are essential to improving mental health care and providing better outcomes for patients.

Conclusion

The *CQC Monitoring the Mental Health Act 2023–2024* report reinforces the significant and persistent pressures on mental health services nationally, particularly in inpatient care. It highlights key areas of concern—workforce shortages, discharge planning, restrictive practices, patient rights, and health inequalities—that directly impact the quality and safety of care. Humber Teaching NHS Foundation Trust has taken a proactive and responsive approach to these challenges, ensuring that national guidance and regulatory findings are carefully reviewed and embedded into local governance structures. This includes aligning divisional discharge procedures with national standards, implementing blanket restriction audits, and strengthening autism and neurodiversity training across the workforce.

The Trust's engagement with national frameworks such as PCREF and the Culture of Care Standards Programme reflects our strategic commitment to tackling inequalities and fostering inclusive, rights-based care.

While many of the CQC's concerns remain relevant, including risks of inappropriate detention, suboptimal environments, and variability in interpreting the Mental Health Act and DoLS frameworks, assurance can be taken from the systems Humber has in place to monitor and respond to these risks.

As the Mental Health Bill progresses, the Board's oversight will be critical in ensuring that implementation is underpinned by sound governance, effective workforce planning, and a continued focus on co-produced, patient-centred care.

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Agenda Item 11

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Freedom to Speak Up - Reflection and Planning Improvement
Author/s:	Michele Moran, Chief Executive and Executive Lead for Speaking Up Alison Flack, Freedom to Speak Up Guardian
Recommendation:	

To approve	X	To discuss	X
To note		To ratify	
For assurance	X		

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	To update the Trust Board on the completion of the Freedom to Speak Up Reflection and Planning Tool developed by the National Guardian's Office (NGO). The full reflection tool and agreed actions have been approved by the Workforce and Organisational Development Committee. This was discussed at the Trust Board development session and has been completed by the relevant leads. The noted actions will form an improvement plan to align with the Trust's speak up strategy.

Key Issues within the report:

Positive Assurances to Provide: • FTSU Strategy and Policy • Staff Survey Results • Completion of the NGO's reflection and planning tool. • Internal audit of FTSU – significant assurance received (subject to validation).	**Key Actions Commissioned/Work Underway:** • Development of an FTSU Improvement Plan for 25/26.
Key Risks/Areas of Focus: • Review of the ring fenced resources for speaking up. Further information will be shared with the Executive Management Team. • Review uptake up of Level 2 and 3 speak up training for managers and improve completion. • Review of the barriers in place to stop people raising concerns.	**Decisions Made:** • N/A

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	12/02/25
Finance Committee		Executive Management Team	28/01/25
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
Yes	Innovating Quality and Patient Safety
Yes	Enhancing prevention, wellbeing and recovery
Yes	Fostering integration, partnership and alliances
Yes	Developing an effective and empowered workforce
Yes	Maximising an efficient and sustainable organisation
Yes	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Humber Teaching
NHS Foundation Trust

Freedom to Speak Up – Reflection and Planning Tool and Development Plan

The Freedom to Speak Up reflection and planning tool, developed by the National Guardian's Office is designed help identify the strengths in key individuals with responsibility for speaking up, the leadership team and the organisation. This has now been completed and approved by the Workforce and Organisational Development Committee on 12th February 2025. The Board Development Session considered the full document on 30th October 2024 and agreed the necessary development areas.

An audit of Freedom to Speak Up processes and procedures undertaken by the internal audit team has recently been completed and has indicated "significant assurance" (subject to ratification) of the Trust's speak up processes.

The objective of this audit was to confirm that the Trust provides an environment where people feel safe to speak up with confidence and that Trust Leaders are listening to the concerns of workers and follow whistleblowing procedures.

The audit reported that the Trust can demonstrate that it has strong processes in place to ensure staff are aware of how to raise concerns and the ongoing Ambassador Programme supports this.

The development areas have been agreed as follows:-

Development areas to address in the next 6–12 months	Target date	Action owner
1. Develop a FTSU Improvement Plan for 25/26 to align with the Speak Up Strategy.	June 2025	Alison Flack
2. The Executive Management Team to discuss the amount of ringfenced time for the Guardian and the resources available on an annual basis.	June 2025	Michele Moran
3. To review the numbers of managers and senior leaders completing Level 2 and 3 NGO speak up training. To promote the training through the Trust's communication networks.	April 2025 Completed	Alison Flack
4. Review engagement with managers and the role they play in speak up.	June 2025	Alison Flack
5. Annual review of speak up arrangements.	June 2025	Michele Moran
6. Non-Executive Director for speak up to oversee allegations of staff feeling they have suffered a detriment from speaking up.	March 2025 Completed	Dean Royles

7. Identify any barriers that prevent staff from speaking up.	June 2025	Alison Flack
8. Identify areas where staff are not speaking up and the reasons why.	June 2025	Alison Flack
9. The Guardian to contact the Chairs of the networks to discuss attendance and raising awareness of the Guardian role.	June 2025	Alison Flack
10. Continue to recruit more ambassadors.	Ongoing	Alison Flack
11. To complete the recommended actions from the recent internal audit.	June 2025	Alison Flack

Humber Teaching NHS Foundation Trust

Agenda Item 12

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Emerging NHS England and ICB Developments
Author/s:	Michele Moran Chief Executive
Recommendation:	

To approve		To discuss	✓
To note		To ratify	
For assurance			

Purpose of Paper:	The Board is asked to note this report which highlights developments underway following the announcement by the Secretary of State that NHS England would be abolished and the running costs of ICBs would need to reduce by 50%.

Key Issues within the report:

Positive Assurances to Provide: • The Trust will continue to support the ICB during the transition period.	**Key Actions Commissioned/Work Underway:** • ICB transformation plans are developing
Key Risks/Areas of Focus: • We are assessing any implications for Humber as the work progresses	**Decisions Made:** • N/A

Governance:

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

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership and alliances
	Developing an effective and empowered workforce
√	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

NHS England and ICB Developments

1. Introduction

Since the Secretary of State for Health and Social Care announced that NHS England would be abolished in two years' time and that Integrated Care Boards would need to reduce their running costs by 50% by quarter 3 of this financial year, work has begun on progressing this agenda.

This paper provides an update on emerging developments.

2. Abolishment of NHS England

At an NHS Leadership event held on 29 April 2025, Sir Jim Mackey highlighted that work has begun to drive the cultures and behaviours required from senior leaders to deliver the change required across the NHS, whilst leading and managing the risks and transition.

3. Refocussing the Role of Integrated Care Boards

3.1 The Model ICB Blueprint

The Model ICB Blueprint has been developed by a group of ICB leaders from across the country, representing all regions and from systems of varying size, demographics, maturity and performance. It is a joint leadership product, developed and written by ICBs in partnership with NHS England. The group has worked together at pace to develop a shared vision of the future with a view to providing clarity on the direction of travel and a consistent understanding of the future role and functions of ICBs.

The Model ICB Blueprint builds on NHS England's letter to trust and system leaders issued at the start of the financial year. The letter set out two key expectations for ICBs: a 50% reduction in their running costs, and a shift towards positioning ICBs as strategic commissioners, central to delivering the ambitions of the 10 Year Health Plan. This vision, which is shaped by the government's three shifts – from hospital to community, treatment to prevention, and analogue to digital – are all set out as the central drivers for how ICBs will be expected to work within their systems.

The blueprint provides an additional level of detail on how ICBs are expected to evolve and sets out which of their functions may in future be transferred to providers. It defines the system leadership role of ICBs in improving population health, reducing inequalities, and ensuring access to high-quality care. ICBs will have a clear role as strategic commissioners. Some of their existing roles will transfer to regions, some to providers and some duplicative work will cease.

The blueprint reframes the core purpose, role and functions of ICBs in line with the government's three shifts and the forthcoming 10 Year Health Plan, and a refreshed

system architecture. ICBs are tasked with improving population health and ensuring access to consistently high-quality services. They will be accountable for ensuring the best use of their available resources, which should be used strategically with long-term population health outcomes in mind. Overall, the blueprint positions ICBs as system leaders, responsible for setting a population health strategy and acting as "healthcare payers" to maximise value from available resources.

The refreshed role for ICBs is set out as part of a refreshed system architecture in which:

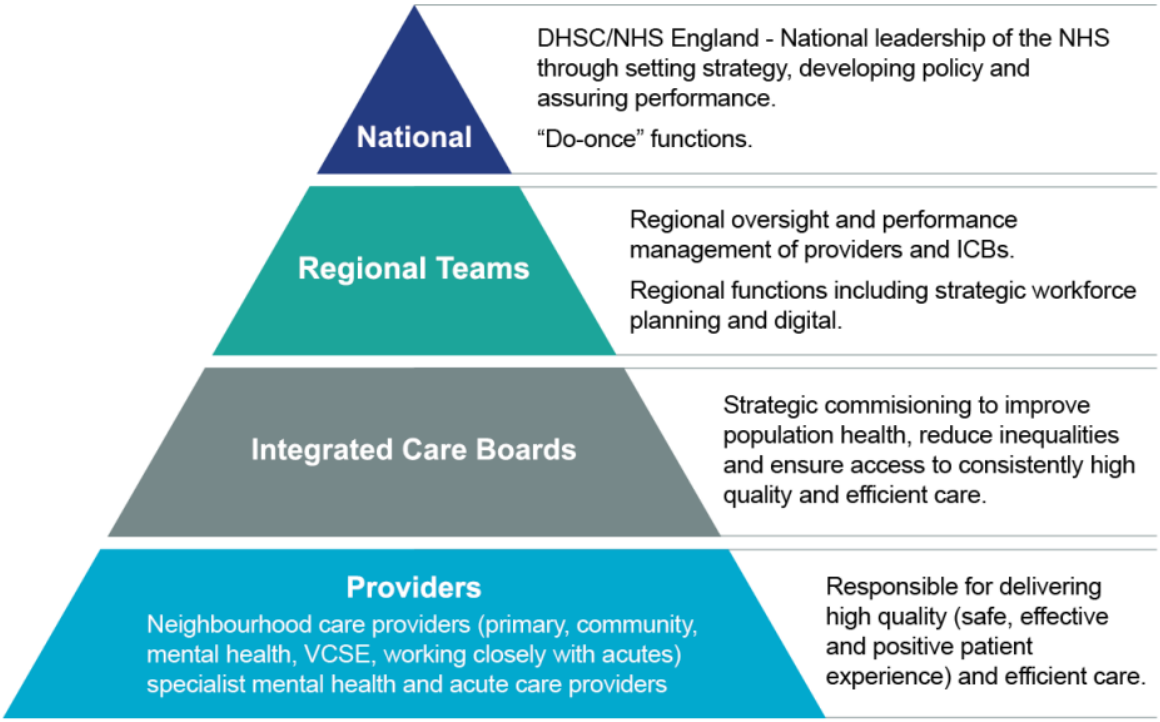
- DHSC/NHS England provide national leadership and "do once" functions
- Regional teams provide oversight and performance management of ICBs and providers and take on functions such as strategic workforce planning and digital provision;
- ICBs become strategic commissioners; and
- Providers are responsible for the delivery of care.

As strategic commissioners ICBs are expected to fulfil four core functions:

1. Understanding the local context.
2. Developing a long-term population health strategy.
3. Delivering the strategy through payer functions and resource allocation.
4. Evaluating impact.

The blueprint does not set out a specific role for providers in carrying out these functions.

The refreshed role of ICBs has been developed through a set of assumptions about a refreshed system landscape, along the lines set out below:



The core functions of ICBs is described below

3.2 The split of functions between ICBs, providers and regions

To support changes, the blueprint sets out which existing functions should be further developed to support a more focused role for ICBs, and which should be transferred to other parts of the system including providers.

It recommends that ICBs keep, and grow functions such as population health management, strategic planning and commissioning, maintenance of governance and quality management.

Functions which could be transferred to regional teams include oversight of provider performance under the NHS performance assessment framework, strategic workforce planning and research development and innovation.

Functions which could be transferred to providers are detailed below:

- local workforce development and training;
- green plans and sustainability;
- digital leadership (enabled by national data and digital infrastructure);
- development of neighbourhood and place-based partnerships (with ICBs retaining their commissioning role for neighbourhood health services);
- medicines optimisation (with ICBs retaining overview as part of their commissioning role);
- pathway and service development programmes (ICBs retaining strategic overview); and
- estates and infrastructure strategy.

Infection prevention and control, safeguarding, SEND, NHS Continuing Healthcare and General Practice IT will also be considered for transfer, although detail about where these will go are not clear at this point.

3.3 ICB Cost Reduction

NHS England has asked all ICBs to submit cost reduction plans by the end of May 2025, based on a revised running cost envelope of £18.76 per head of population. These reductions must be delivered by the end of Q3 2025/26 and maintained on a recurrent basis into 2026/27. Local variation is acknowledged, but regional aggregate plans must remain within that envelope. The ICB blueprint makes clear that savings cannot be achieved by shifting costs to providers unless this results in a genuine net saving.

3.4 Roles and responsibilities of ICBs

- Responsible for achieving the 4 principal Integrated Care System (ICS) purposes:
    - improving population health and healthcare;
    - tackling inequalities in outcomes, experience and access;
    - enhancing productivity and value for money; and
    - supporting social and economic development
- Statutory responsibility for arranging local services through effective strategic commissioning
- Hold their partners in the ICS to account using the system levers that bind them together, such as their joint system plans, partnership agreements, joint committees and collaboratives Providers (NHS trusts and foundation trusts):
- Provide high quality and safe services as contracted
- Comply with the requirements of the NHS Provider Licence, including in relation to quality governance NHS England:
- Statutory responsibility for overseeing overall delivery, performance and improvement of ICBs and providers
- Conduct an ICB performance assessment each financial year 2 using the ICB's segment and capability assessment
- Determine the segment for each organisation
- Determine how to support and drive improvement in each organisation. NHS England uses the assessment process to measure delivery against an agreed set of measures and identify where improvement is required. This determines a segment for each organisation. The appropriate response to secure improvement is then informed by the organisation's capability assessment. The approach to capability assessment is currently being finalised and the intention is to align the approach with the CQC.

4. All organisations

Every ICB and provider will be allocated a segment. This indicates its level of delivery from 1 (high performing) to 4 (low performing), and informs its support or intervention needs. A diagnostic will be performed on all segment 4 organisations to

identify those with the most intense support needs, these organisations will enter the recovery support programme and allocated a segment of 5

Each organisation will receive an individual organisational delivery score derived from performance against a set of metrics. Metrics are combined into the assessment domains and consolidated into short and medium-term scores. These are then combined to make the overall score.

For ICBs, an additional system adjustment may be applied where performance against the system-level metrics (system considerations), that align to system-wide delivery of major national priorities, is challenged. The system adjustment is combined with the organisational delivery score to give a picture of how the commissioning organisation is performing together with its delivery system.

4. Recommendation

The Board is asked to note the emerging developments across NHS England, the ICB and NHS provider trusts.

Humber Teaching NHS Foundation Trust

Agenda Item 13

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	National Staff Survey Results 2024 – IQVIA Presentation
Author/s:	Vickie Murray – Deputy Associate Director of People & OD
Recommendation:	To approve: ; To discuss: ✓ To note: ✓ ; To ratify: For assurance:
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The Survey administrator for the Trust, IQVIA will be attending to deliver the Trust National Staff Survey 2024 results. The results presented are representative of the sector scores for the Trust's who commission IQVIA as their survey administrator and therefore there are some variations compared to the final national results published on 13th March 2025, which the Board have already

Key Issues within the report:

Positive Assurances to Provide:

- The Trust improved upon its response rate compared to 2023 and reported a better response rate compared to benchmark and national figures.
- The Trust reports better than average scores across all people promise theme areas and sub themes compared to benchmark and national results and an improved position across our own scores of 2023 across each core people promise area.
- We are in the top three in our region for the themes, we are safe and healthy, we are a team and morale.
- 10 out of the 14 divisions and the directorates within the Trust improved on their response rate when comparing 2023 with 2024.
- The number of staff positively reporting that we *'act on concerns raised by patients and service users*' has also risen from 66% in 2019 to 79% in 2024. This is significantly better than our benchmark group and national averages.
- The statistically most significant improvement in

Key Actions Commissioned/Work Underway:

Wider Actions

- A NSS developing plan has been created and presented to EMT and POD Committee.
- Work has been undertaken to analyse each people promise area, with leads from the people team consulting on actions with wider stakeholders.

Equality, Diversity and Inclusion

- No Excuse for Abuse framework is now live and being operationalised
- Respect campaign to be reviewed and refreshed with guidance video and new posters. Target of the posters and campaign still remains around racism, homophobia, disability discrimination and sexual harassment.
- Implementation of the NHS England EDI Improvement Plan
- Implementation of the Equality Delivery System 22 (EDS22)
- Signed the Sexual Safety Charter with a full programme of activity in progress, including the launch of the Nationally led Sexual Misconduct Policy.

the survey by 6.6% was for the question '*The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it*,' which would correlate with the Trust efforts launching the Respect campaign. • We have demonstrated a positive improvement in 8 out of the 9 line management questions and above average benchmark scores on all questions. • The greatest improvements were in *We are Safe and Healthy* and *We Work Flexibly*, with the associated sub scores for those themes also showing the most significant improvements. • Four out of the five key questions have improved scores when comparing 2023 to 2024, with the question 25c *'I would recommend my organisation as a place to work'* having increased by nearly 2% when compared to 2023 results. • Q9. *We are a Team* - subtheme - *Line Management* saw a positive improvement in all of the questions. The Trust also scored above the average benchmark on all questions. • Q9h *My immediate manager cares about my concerns* improved on 2023 scores by 1.75% and scored better than the benchmark group by 1.57%. Q9i *My immediate manager takes effective action to help me with any problems I face* improved on 2023 scores by 1.93% and scored better than the benchmark by 1.98%. **National Results** • For IQVIA sector responses for Q7d *Team members understand each other's roles' the Trust positions* 'significantly worse' than sector scores, but this does not present an issue with national scores • Q7i *I feel a strong personal attachment to my team* scored 'significantly worse' in accordance with IQVIA results but again, when national results were published, this position showed an insignificant change.	
Key Risks/Areas of Focus: Specific areas of focus from the survey. • **Service User impact** – Specific question area 6a '*I feel my role makes a difference to service users'* • **Health and Wellbeing** – Specific focus on stress and psychological support – Q11c *'During the last 12 months have you felt unwell as a result of work-related stress?* ' • **Team Working** –focus on all relevant questions with specific focus on *Q7c 'I*	**Decisions Made:** • N/A.

receive the respect I deserve from my colleagues at work and Q7d *Team members understand each other's roles'* • **We are compassionate & Inclusive** – Improving experience of those from underrepresented groups. **National Results** • The Trust responses to Q10c. *on average how many UNPAID hours do you work per week for this organisation* both IQVIA sector scores and national scores place this as a significantly worse position	

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	13/05/25
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail) Board	28/05/25

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership and alliances
x	Developing an effective and empowered workforce
	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Humber Teaching NHS Foundation Trust

Agenda Item 14

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Trust Board Effectiveness and Terms of Reference Review 2025
Author/s:	Name: Rt Hon Caroline Flint FRCGP (Hon) Title: Trust Chair
Recommendation:	

To approve	✓	To discuss	
To note		To ratify	
For assurance			

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	Trust Board is asked to: • Note the Board effectiveness review report for 2024/25 • Approve the proposed amendments to the Trust Board Terms of Reference (attached at Appendix 1) as detailed in the effectiveness review report.

Key Issues within the report:

Positive Assurances to Provide: • The effectiveness review demonstrates good governance with the Board effectively meeting the requirements of the terms of reference throughout the year. • All committees have also undertaken an annual effectiveness review, and the results are contained in a separate paper. • The Executive Management Team has undertaken an effectiveness review, and no key areas of development were identified.	**Key Actions Commissioned/Work Underway:** • No actions identified
Matters of Concern or Key Risks: • No issues raised.	**Decisions Made:** N/A

Caring, Learning & Growing Together

Governance: *Please indicate which committee or group this paper has previously been presented to:*		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership and alliances
	Developing an effective and empowered workforce
√	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Trust Board
Annual Review of Trust Board Effectiveness and Terms of Reference
1 April 2024 to 31 March 2025

The Board's purpose, described in full in its Terms of Reference, is to: -

- Set and oversee the strategic direction of the Trust
- Ensure accountability for delivery of the strategy
- Ensuring compliance with statutory requirements and duties
- Shaping a positive culture for the Trust
- Taking decisions that it has reserved to itself.

The Chief Executive is the Accountable Officer for the Trust.

1. Executive Summary

Chair to provide a brief written overview of the Board's work during the year and whether she believes that the Board has operated effectively and added value

The Board holds formal meetings on a bi-monthly basis, with Strategic Board Development meetings occurring during the months when the Board does not meet.

Formal Board meetings are held virtually and live streamed which gives members of the public an opportunity to join the meeting on the day (without having to travel to venues) or to watch it later if they so wish. These meetings are held in public or private, depending on the business to be discussed. The Trust Board has a forward-looking annual work plan which outlines mandatory and regular reports required for the meeting and a copy of this is included with formal Board meeting papers.

Strategic Board Development sessions enable the Board to have detailed in-depth discussions about key strategic matters facing the Trust. A work programme has been produced to capture items to be considered at the Strategic Development meetings and the notes from the Strategic Development meetings are forwarded to Board meetings in private. In October 2024, the Board reviewed the items discussed at these meetings, the outcomes and action taken to progress each key area of work. The Board has also reflected on the effectiveness of these meetings and agreed they were working well and should continue.

The minutes of Board meetings clearly demonstrate debate, decision making and adherence to our Standing Orders, Scheme of Delegation and Standing Financial Instructions.
There were no instances that required a report to the Board on non-compliance with these documents in year.

In 2022, Grant Thornton undertook an external review of governance. The requirement for an externally facilitated review is stipulated in the Code of Governance for NHS provider trusts. A number of recommendations were made, and an action plan was produced in response. All recommendations have been implemented and annual effectiveness reviews have been undertaken since then.

In summary it has been another year as an effective and engaged Board with:

- good attendance at meetings
- good discussion, challenge and contributions by members of the Board
- effective relationships, skills and experience of all Board members
- Board members being involved in system level discussions and meetings

- the promotion of the Trust's reputation in the system
- continued delegation of governance issues to sub committees which enables more focussed Board meetings, with appropriate time to discuss more strategic issues at Strategic Board Development meetings. At the March 2025 Board meeting, the Board agreed that those operational groups which report into Committees should report into the Executive Management Team in future, with any exceptions highlighted through those groups escalated to the relevant committee in the usual way.
- the quality of papers presented to Board continued to be good resulting in the Board focussing on and being clear about the key issues it needed to discuss
- In addition, half of the Non-Executive Directors trained to become Associate Hospital Managers.

2. Delivery of functions delegated by Board

Several functions are delegated to sub committees and assurance is provided at each Board.

3. Attendance

3.1 The Board met on six occasions during 2024/25 and attendance is detailed below:

Members:	No of meetings attended
Chair, Caroline Flint	6/6
Chief Executive, Michele Moran	*6/6*
Francis Patton, Non-Executive Director	*2/2*
Mike Smith, Non-Executive Director	*2/2*
Dean Royles, Non-Executive Director	*5/6*
Stuart McKinnon-Evans, Non-Executive Director	*5/6*
Phillip Earnshaw, Non-Executive Director	*6/6*
Keith Nurcombe, Non-Executive Director	*4/4*
Stephanie Poole, Non-Executive Director	*4/4*
Director of Finance, Peter Beckwith	*6/6*
Medical Director, Kwame Fofie	*6/6*
Director of Nursing, Allied Health and Social Care Professionals Hilary Gledhill	*6/6*
Chief Operating Officer, Lynn Parkinson	*6/6*
Associate Director of People and Organisation Development (non-voting)	*5/6*

3.2 Chair (and Executive lead) to provide a view on whether the membership composition is effective and the extent to which members have contributed.

Membership is standard for Trust Boards and deputies attend for executives as required. Invitations are extended to others throughout the year as appropriate. Good contributions were provided from members throughout the year.

3.3 Include any recommendation for change to membership & reasons why

There are no recommendations to change the composition of the Board for the year ahead.

4. Quoracy

The Board meetings were quorate on all occasions.

5. Reporting Committees to Board

The following committees reported to the Board during 2024/25: -

- Quality Committee
- Audit Committee
- People and Organisation Development Committee
- Mental Health Legislation Committee
- Finance and Investment Committee
- Charitable Funds Committee
- Remuneration and Nomination Committee
- Collaborative Committee

Has the Board approved the Terms of Reference for each of these sub committees?

Yes.

The annual review of committee effectiveness and terms of reference for these committees for 2024/25 will be presented to the Board in May 2025 for approval. It should be noted that the Charitable Funds Committee was stood down in 2024 (with alternative governance arrangements established). Consequently, an effectiveness and terms of reference review will not be presented for this Committee.

Has the Board received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports received from the reporting groups/committees provided the required level of assurance?

Yes, assurance reports from each committee are prepared and presented by the non-executive chair of each committee to the Board following each meeting.

Has the Board requested / received an annual assurance report or effectiveness review from each of the reporting groups for 2024/25?

Yes – assurance reports are provided to the Board by the Committee Chair. A report regarding the outcomes of the effectiveness reviews will be forwarded to the May 2025 Board meeting.

6. Conduct of meetings

Chair to consider the following questions

- *Was a workplan agreed at the start of the year and have meetings and agendas been appropriately scheduled to meet the work plan?*

Yes, a workplan was agreed and forms the basis of monthly agendas. Any change to the workplan is highlighted when papers are despatched to Board members.

- *Are the reports and papers presented of a high quality and prepared in time for issue five working days ahead of the meeting?*

Yes.

However, to ensure committee assurance reports provide up to date assurance after a sub-committee meeting (which can sometimes occur around meeting paper distribution day) these may follow a day or two after papers have been distributed to ensure the most up to date assurance is provided to Board. Any committee assurance reports to follow are clearly stated on the email when papers are sent to Board members.

- *Is the quality and timeliness of the minutes satisfactory?*

Yes

- *Is an action log maintained and are actions clearly recorded, assigned to individuals with timelines and followed through?*

Yes

7. Review of Terms of Reference

Chair to summarise any recommended changes to its terms of reference in light of the annual evaluation.

Amendments are proposed as detailed below and highlighted in the terms of reference (ToR) attached at Appendix 1:

- Change of job title from Director of Workforce & OD to Associate Director of People and OD
- Removal of reference to the provision of Council of Governor meeting minutes to the Board as this practice does not occur (minutes are available on the website or from the Board Support Unit)
- Replacement of the reference to `NHS Improvement' to `NHS England'
- Removal of the reference to the Charitable Funds Committee as this Committee has been stood down.
- Reference to the number of Associate Non-Executive Directors on the Board updated to reflect current arrangements and the inclusion of the Associate Director of People and OD under the membership section
- Reference to the Trust Secretary replaced with the PA to the Chair and Chief Executive

8. Workplan for 2024/25

Has a workplan for the year ahead, 2024/25 been prepared?

Yes.

The workplans are included in the monthly Board papers.

9. Any Actions Arising from this Effectiveness Review? YES [ ] NO [x]

Trust Board members completed an effectiveness questionnaire inviting comments regarding the: focus of the Board; team working; Board meetings; and Board leadership. The findings revealed the Board is working effectively.

Humber Teaching NHS Foundation Trust

Terms of Reference

Board of Directors

Authority	The Trust is required to establish a Board of Directors in accordance with the requirements of the NHS Act 2006 (as may be amended by the Health & Social Care Act 2012), and the Trust's Constitution. All members of the Board shall act collectively as a unitary Board with each member having equal liability**.** The Trust has Standing Orders for the practice and procedures of the Board of Directors (Annex 8 of the Constitution). For the avoidance of doubt, those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.
Role / Purpose	The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England. The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes. The Trust may provide goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health. The Trust may also carry out activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose. The Trust has a Board which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a sub-committee of the Board or to an Executive Director. Arrangements for the reservation and delegation of powers are set out in the Standing Orders, Scheme of Delegation and Standing Financial Instructions. The Board will ensure regular reviews of its effectiveness and that of its sub committees that have been delegated powers by the Board via annual committee effectiveness reviews and as part of an established ongoing Board development programme. The Board will achieve its purpose by: • Setting and overseeing the strategic direction of the organisation within the overall policies and priorities of the Government, the Trust's

	regulators, and its commissioners, having taken account of the views of the Trust's members and public at large • Ensuring accountability by holding the organisation to account for the delivery of the strategy; and through seeking assurance that systems of control are robust and reliable • Ensuring compliance with statutory requirements of the Trust and the statutory duties are effectively discharged including the Provider License conditions and the Care Quality Commission registration and appropriate returns and disclosures are made to the regulators • Shaping a positive culture for the organisation • Monitoring the work of the Executive Directors • Taking those decisions that it has reserved to itself. The general duty of the Board of Directors and each Director individually, is to act with a view to promoting the success of the Trust to maximise the benefits for the members of the Trust as a whole and for the public**.** In carrying out their duties, members of the Board of Directors and any attendees must ensure that they act in accordance with the values of the Trust which are: • **Caring –** our shared commitment to patient centred care, providing dignity and respect through our high quality and patient safety culture. • **Learning –** our shared commitment to actively engage, listen and learn from our people and empower them to use evidence-based teaching approaches. • **Growing Together –** our shared commitment to be an Accountable organisation, seeking collaborations with other to support and grow health and social care systems. In addition, members of the Board must ensure compliance with NHS England's Fit and Proper Person Test Framework requirements, which takes account of the requirements of the Care Quality Commission in relation to directors being fit and proper for their roles.
Duties	The duties set out below shall not preclude the Board of Directors from reserving powers and duties to itself. These powers and duties shall be set out in the Standing Orders, Scheme of Delegation and Standing Financial Instructions and for the avoidance of doubt where there is a conflict, Standing Orders, Scheme of Delegation and Standing Financial Instructions will take precedence over these Terms of Reference. The duties of the Board of Directors are to: • Set the values and strategic direction of the Trust; and ensure the Trust's Strategy is reviewed as necessary.

	• Provide leadership to the Trust to promote the achievement of the Trust's Principal Purpose' as set out in the Constitution (i.e. the provision of goods and services for the purposes of health services in England), ensuring at all times that it operates in accordance with the Constitution and the terms of the license as issued by Monitor (now part of NHS ~~Improvement~~England) • Promote teaching, research and innovation in healthcare to a degree commensurate with the Trust's "teaching hospital" status • Engage as appropriate with the Trust's membership and Council of Governors. • Promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction. • Oversee the implementation of the Trust's strategic goals and monitor the executive team's delivery of the strategic objectives ensuring consistency with the role/purpose of the Board of Directors • Agree the Trust's financial and strategic objectives, including approval of the Strategic Plan. • Ensure that the Trust has adequate and effective governance and risk management systems in place • Monitor the performance of the Trust and ensure that the Executive Directors manage the Trust within the resources available in such a way as to: ▪ Ensure the safety of service users and the delivery of ~~high quality~~high-quality care. ▪ Protect the health and safety of Trust employees and all others to whom the Trust owes a duty of care. ▪ Make effective and efficient use of Trust resources. ▪ Promote the prevention and control of healthcare associated infection. ▪ Comply with all relevant regulatory and legal requirements. ▪ Maintain high standards of ethical behaviour, corporate governance and personal conduct in the business of the Trust. ▪ Maintain the high reputation of the Trust both with reference to local stakeholders and the wider community. • Receive and consider high level reports on matters material to the Trust detailing information and action with respect to: ▪ Service User and Carer experience. ▪ Human resource matters. ▪ Operational performance, including performance against targets and contracts ▪ Clinical quality and safety, including infection prevention and control ▪ The identification and management of risk ▪ Financial performance. ▪ Matters pertaining to the reputation of the Trust

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	▪ Mental Health Act Legislation duty • Review and approve any declarations/compliance statements to regulatory bodies prior to their submission. • Review and adopt the Trust's Annual Report and Accounts. • Act as corporate trustee for the Trust's Charitable Funds. The Board may hold delegated responsibility to provide commissioning leadership and monitoring functions within the Humber and North Yorkshire (HNY) Integrated Care System and will sub-contract with a range of healthcare providers in the delivery of: • Child and Adolescent Mental Health In-Patient services • Adult Low and Medium Secure services • Adult Eating Disorder Services. The Board of Directors may delegate powers to formally constituted Committees. The Board of Directors shall determine the membership and terms of reference of Committees and Sub-Committees and shall if it requires, receive and consider reports of such Committees. Minutes or reports from the Committees below, and any others that the Board so requests, shall be presented to the next scheduled meeting of the Board of Directors following the Committee meeting. • Audit Committee • ~~Charitable Funds Committee~~ • Finance & Investment Committee • Mental Health Legislation Committee • Quality Committee • Remuneration and Nomination Committee • ~~Workforce &~~People and Organisational Development Committee • Commissioning Committee Members of the Board of Directors must ensure that wherever possible they attend every Board meeting (including additional Board meetings when convened). An explanation of non-attendance should be made to the Chair. Attendance at meetings will be monitored by the Head of Corporate Affairs and shall be reported to the Chair on a regular basis and shall also be reported annually in the Annual Report. Where, exceptionally, a director is absent from a meeting they may not normally send a deputy in their place, although attendance in these circumstances will be at the discretion of the Chair. Where there are formal acting up arrangements in place the person acting up may attend and will

	assume the voting rights of the Director they are acting up for. If no formal acting up arrangements are in place the person attending may not assume the voting rights of the Director, they are attending for. The Board may invite non-members to attend its meetings on an ad hoc basis, as it considers necessary and appropriate, and this will be at the discretion of the Chair. ~~Minutes of the Council of Governors meetings shall be presented at a meeting of the Board of Directors for information.~~ The Executive Team will support the Chief Executive in the implementation of the Board's decisions and will facilitate the efficient and effective working of the Board of Directors by considering and responding to those matters referred to it. Detail of the sub-committee structure is appended to this document. The Chair of the Board of Directors shall be the Chair of the Trust. In the absence of the Chair of the Trust, (or in the event of him/her declaring a conflict of interest in an agenda item) the Deputy Chair, if one is appointed, shall chair the meeting. Should there be no Deputy Chair, or one is not available (or where they too have also declared a conflict of interest in an agenda item), the meeting shall be chaired by one of the other independent Non-Executive Directors. The Chair of the Trust will: • Provide leadership to the Board of Directors • Enable Directors to make a full contribution to the affairs of the Board of Directors ensuring that the Board acts as a cohesive team • Ensure the key, appropriate issues, which place emphasis on service user and carers, services, policy issues and statutory requirements are discussed by the Board of Directors in a timely manner • Ensure the Board of Directors has adequate support and necessary data on which to base informed decisions and monitor that such decisions are implemented. • Provide a conduit between the Council of Governors and the Board of Directors. The Senior Independent Director (SID) is appointed by the Board of Directors as an alternative point of contact for Governors (and Directors) when: • They have concerns that have not been resolved through normal channels • Contact with the Chair, Director of Finance or Chief Executive is inappropriate

	• Discussing the Chair's performance appraisal, remuneration or allowances The SID is also a contact point for staff who wish to raise concerns under the Freedom to Speak Up process. The Non-Executive Directors are accountable to the Council of Governors for the performance of the Board of Directors. To exercise this accountability effectively, the Non-Executive Directors will need the support of their Executive Director colleagues. A properly functioning accountability relationship will require the Non-Executive Directors to provide Governors with a range of information on how the Board of Directors has assured itself on key areas of quality, operational and financial performance; to give an account of the performance of the Trust. The Non-Executive Directors will need to encourage questioning and be open to challenge as part of this relationship.
Membership	The membership of the Board of Directors, is determined in accordance with the Trust's Constitution and, shall comprise both executive and Non-Executive Directors. Membership shall be as follows: • A Non-Executive Chair • Up to 6 other Non-Executive Directors • Up to 6 Executive Directors • Associate Director of People and Organisational Development (non-voting) * • Up to 2 Associate Non-Executive Directors (non-voting) * *Associate Non-Executive and Executive Director appointments will be non-voting and not count towards the ~~6~~ other Non-Executive or Executive Director positions. At all times at least half of the Board of Directors, excluding the Chair shall be Non-Executive Directors. For clarity the Executive Directors who are members of Board of Directors are: • Chief Executive (voting) • Director of Finance (voting) • Medical Director (voting) • Director of Nursing, Allied Health and Social Care Professionals & Caldicott Guardian (voting) • Chief Operating Officer (voting) • Associate Director of ~~Workforce &~~People and Organisational Development (non-voting)

	All full members of the Board of Directors shall have one full vote each, with the Chair having a second or casting vote should the need arise. The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be the Senior Independent Director. In consultation with the Chair of the Trust, the Council of Governors may also appoint one of the Non-Executive Directors as a Deputy Chair.
Quorum	No business shall be transacted at a meeting unless at least one third of the whole number of the Chair and Board members (including at least one Executive Director and one Non-Executive Director) is present.
Chair	Chair of the Board of Directors
Frequency	Board meetings will take place bi-monthly. Strategic Development meetings will occur during the months when the Board is not meeting.
Agenda and Papers	An agenda for each meeting, together with relevant papers, will be forwarded to members to arrive 5 working days before the meeting.
Minutes and Reporting	The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it. Meetings of the Board of Directors shall be held at such times and places as the Board may determine. The frequency of meetings shall be agreed by the Board of Directors and will normally be held bi-monthly. The Board may agree to vary the frequency; however, this shall not preclude meetings being convened in accordance with Standing Orders and the Constitution. All meetings shall be held in public, at which members of the public and representatives of the press shall be permitted to attend. Members of the public are not permitted to ask questions during the meeting as it is a meeting held in public, not a public meeting. However, questions can be submitted to the Chair at the end of a meeting. Responses to the questions may be given at that time or in writing within 5 days of the meeting. Members of the public may be excluded from a part II meeting for special reasons and having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest. Such matters will be discussed in a separate closed session which will not be attended by members of the public. The public may attend each meeting of the Board of Directors, but shall be required to withdraw upon the Board of Directors resolving: - *'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'*

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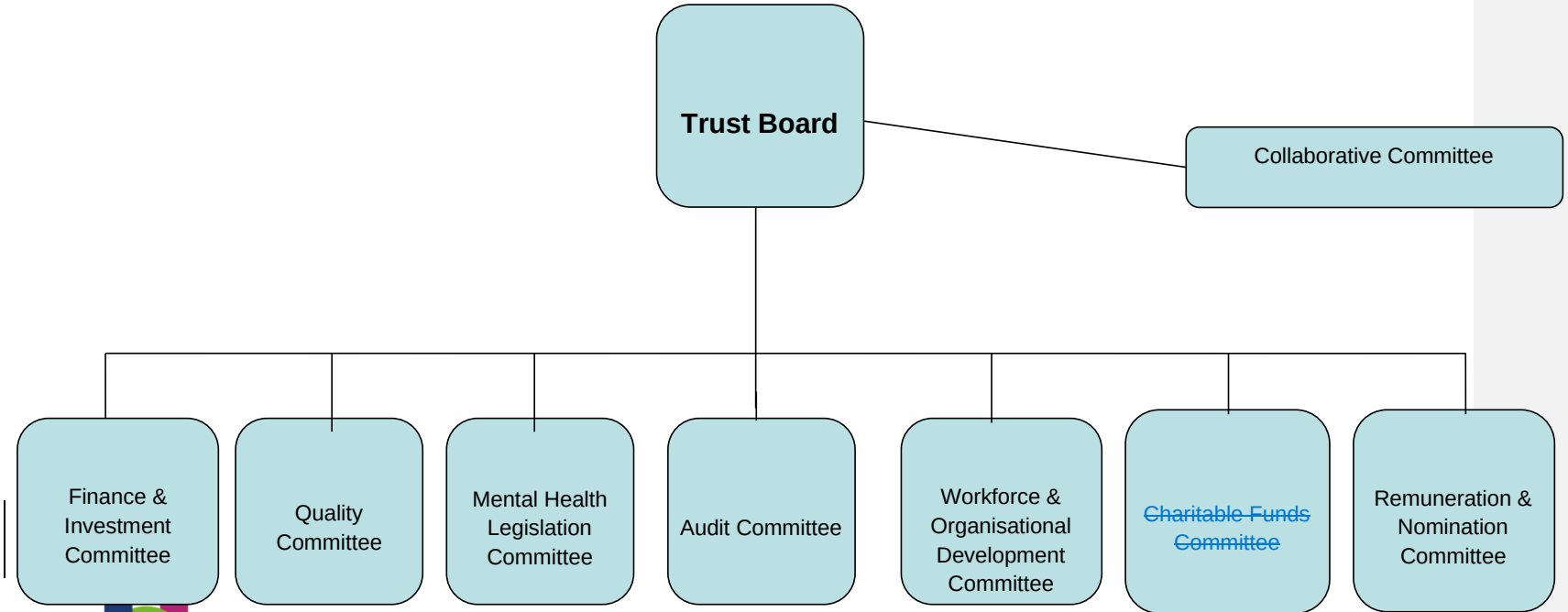
	A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in the Standing Orders and Constitution (or as agreed by the Chair) to all Directors. A link to the public agenda and papers and a copy of the private agendas will be sent to members of the Council of Governors prior to any meeting. The ~~Trust Secretary~~PA to the Chair and Chief Executive shall take the minutes and shall ensure these are presented to the next Board of Directors' meeting and signed by the person who presided at the meeting. Minutes from meetings of the Board of Directors will be presented to the Council of Governors when practicable, in accordance with a process agreed by the Council of Governors. The public agenda, papers and minutes of each meeting shall be displayed on the Trust's website.
Monitoring	A review of attendance and effectiveness will be undertaken annually. To comply with NHS Resolution Risk Management standards (which now incorporates the functions of the organisation formerly known as the NHS Litigation Authority (NHSLA), the Trust must include certain details in all its terms of reference documents. The Trust must also collect evidence of compliance with these areas.
Approval Date	~~29 May 2024~~28 May 2025
Review Date	May 202~~5~~6

Sub Committee Structure



Humber Teaching NHS Foundation Trust

Agenda Item 15

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Committee Effectiveness Reviews 2024/25
Author/s:	Name: Stella Jackson Title: Head of Corporate Affairs
Recommendation:	

To approve	/	To discuss	
To note		To ratify	
For assurance			

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The Board is asked to: • Note the results of the committee effectiveness reviews undertaken for the period 1 April 2024 to 31 March 2025. • Approve the terms of reference for each of the Board committees.

Key Issues within the report:

Positive Assurances to Provide:

- The effectiveness reviews demonstrate good governance with committees meeting the requirements of their terms of reference throughout the year.
- All committees have undertaken an annual effectiveness review and the results are contained in this report. The terms of reference for each Committee are attached as appendices for Board approval.
- The Executive Management Team has also undertaken an effectiveness review and no key areas of development were identified.

Key Actions Commissioned/Work Underway:

- The findings from the Board effectiveness review have been forwarded to the Board as a separate paper.

Matters of Concern or Key Risks:

- No issues raised.

Decisions Made:

- Terms of Reference (ToR) have been reviewed by respective Board committees and amendments agreed for ratification by the Board.

Governance:

	Date		Date
Audit Committee	19.5.25	Remuneration & Nominations Committee	30.4.25
Quality Committee	8.5.25	People & Organisational Development Committee	7.5.25

Please indicate which committee or group this paper has previously been presented to:	Finance Committee	15.4.25	Executive Management Team	25.3.25
	Mental Health Legislation Committee	1.5.25	Operational Delivery Group	
	Collaborative Committee	3.3.25	Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership and alliances
	Developing an effective and empowered workforce
√	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Trust Board and Committee Effectiveness Reviews 2024-2025

1. Introduction

The Board has delegated functions to each of its committees as outlined in the Terms of Reference for each Committee and the Standing Orders, Scheme of Delegation and Standing Financial Instructions document.

An annual review of effectiveness has been undertaken for the Trust Board and each of the sub committees as outlined in the table below.

Committee	Non-Executive Director Committee Chair
Quality Committee	Phillip Earnshaw
Finance and Investment Committee	Keith Nurcombe
People & Organisational Development Committee	Dean Royles
Collaborative Committee	Stuart McKinnon-Evans
Mental Health Legislation Committee	Stephanie Poole
Audit Committee	Stuart McKinnon-Evans
Remuneration and Nomination Committee	Trust Chair
Trust Board	Trust Chair

This paper contains the results of the effectiveness reviews undertaken by the committees during 2024/25. It also contains the terms of reference of each Committee for approval.

The results of the Board effectiveness review are contained in a separate paper.

3. Committee Effectiveness Review Results

3.1 Delivery of functions delegated by the Board

The committees continued to deliver the functions delegated to them by the Board, as detailed in their respective Terms of Reference. They also regularly reviewed the Strategic Goals allocated to them by the Board, as detailed in the Board Assurance Framework.

3.2 Attendance and Quoracy

The committees reviewed attendance at their meetings when considering the results of the effectiveness reviews. All committee meetings were quorate (with the exception of the Quality Committee where the meeting held on 19 September 2024 was not quorate for 30 minutes. No decisions were taken during this time). Attendance at meetings throughout the year was good.

3.3 Reporting Groups

In March 2025, the Board agreed that the operational reporting groups which reported into Board committees should, in future, report into EMT and that any key issues should be escalated to the relevant committee. Up until this point, the committees received minutes or Group Chair Assurance reports from the operational groups reporting into them.

3.4 Conduct of meetings

Each committee had a workplan for 2024/25 and considered this at its meetings. Items on the workplan informed the content of each agenda. Each committee also has a workplan for 2025/26 which is updated as appropriate following consideration at committee meetings.

The committees considered the quality of the papers received during the review of the meetings (this occurred at the end of the meetings). Generally, reports and papers were considered to be of a high quality and were issued five working days before the meeting. The quality and timeliness of the minutes was also good.

Each committee has an action log which is updated following each committee meeting and presented to the next meeting. Actions are clearly recorded and assigned to individuals with timelines for completion.

3.5 Review of Terms of Reference (ToR)

Terms of reference for each committee are attached as appendices for approval by the Board as follows (changes are highlighted in a colour or through track changes):

Appendix 1: Audit Committee (it is proposed that the words `Care Quality Commission (CQC)' in the `Role/Purpose' section are replaced with `Healthcare Financial Management Association (HMFA)' in the sentence which reads `…….and the robustness of the self-assessment against Care Quality Commission (CQC) regulations.

Appendix 2: Collaborative Committee (proposed changes have been made to the narrative to reflect regional and national guidance on Specialised Provider Collaborative: the term `Commissioning' has been replaced with `Planning', `Host Provider' has replaced `Lead Provider' and amendments have been made to reflect the new working relationship with the ICB from April 2025 and also includes reference to in-patient and day care service provision).

Appendix 3: Finance Committee (no changes were proposed)

Appendix 4: Mental Health Legislation Committee (it is proposed that reference to the operational reporting groups is removed as agreement has been reached that these should, in future, report into the Executive Management Team. It is also proposed that the membership section is amended to reflect fewer members of staff being required to attend all meetings and the Scope and Duties section is updated to incorporate reference to the Committee receiving updates regarding CQC Mental Health Act visits)

Appendix 5: People and Organisational Development Committee (it is proposed that the membership section is amended to reflect current practice, that a number of formatting issues are corrected and that the reporting group diagram is deleted).

Appendix 6: Quality Committee (it is proposed that the membership section is updated to reflect current practice. It is also proposed that the reference to the `Chairman' having an open invitation to attend meetings is changed to `Trust Chair')

Appendix 7: Remuneration and Nominations Committee (it is proposed that reference to the Associate Director of People and Organisational Development's attendance at the Committee is reflected in the terms of reference and that the title of the secretariat support to the Committee is updated).

3.6. Actions Arising from the Effectiveness Review?

Generally, the committees functioned effectively throughout the financial year 2024/25. A small number of recommendations were made regarding the future focus of some committees and these will be reflected in the relevant workplans as appropriate.

4. Summary

- The Trust Board and all sub committees have undertaken a committee effectiveness review for 2024-2025 and have reviewed their Terms of Reference.
- The Trust Board and all sub committees have a work plan for the 2025/26 year ahead and these are available on request.

4 Recommendations

- To note this report.
- To approve the Terms of Reference for the sub committees.

NHS
Humber Teaching
NHS Foundation Trust

Terms of Reference
Audit Committee

Constitution and Authority	The Audit Committee is constituted as a standing committee of the Trust's board of directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future board of directors meetings. The Audit Committee Terms of Reference are based on recommendations and guidance from the Cadbury Committee, the Combined Code, the NHS Audit Committee Handbook, the NHS Integrated Governance Handbook and subsequent guidance including Monitor's Audit Code, Code of Governance and Compliance Framework. **Delegated Authority** Section 4.8.1 of the Trust's Standing Orders, and Standing Financial Instructions sets out the modus operandi of the Audit Committee. The Terms of Reference of this Committee shall be reviewed by the Trust Board on an annual basis. As a Committee of the Trust Board, it will: • be accountable and report to the Trust Board. • advise and make recommendations to the Trust Board on areas which fall within its remit and responsibilities. • review and approve policy where relevant and judged appropriate by the Committee for the discharge of its functions. • Monitor, review and advise on the effectiveness of the systems of integrated governance, risk management, and internal controls, and to hold to account directors responsible for ensuring that these matters are effective and robust. • scrutinise any activity listed in its Terms of Reference and cycle of business • investigate any activity within the Terms of Reference and to seek any information it requires from any employee.

	• Any other measures deemed appropriate, relevant and proportionate by the Committee for the discharge of its functions.
Role / Purpose	The purpose of the Audit Committee is to scrutinise and review the Trust's systems, risk management, and internal control. It reports to the Trust Board on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against Healthcare Financial Management Association (HMFA) audit committee checklist. ~~Care Quality Commission (CQC) regulations.~~ **Key Responsibilities** The Audit Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. Its key responsibilities are to: • keep an overview of the key elements of the Trust's governance and finance. • monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them; • review the Trust's internal controls; • review and monitor the external auditor's independence and objectivity and the effectiveness of the external audit process, including approval of annual plans, taking into consideration relevant UK professional and regulatory requirements; • monitor risks that are identified by the systems of internal control; • make recommendations to the Council of Governors regarding the appointment, reappointment of the External Auditor and removal of the external auditor, including tender procedures; • develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; • monitor and review the effectiveness of the Trust's internal audit function and counter-fraud arrangements, including approval and review of related annual plans; • approve the appointment and/or removal of the internal auditors;

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	• report to the Board, identifying any matters in respect of which it considers that action or improvement is needed, making recommendations as to the steps to be taken; • produce an annual report for the Trust Board • review arrangements by which staff within the Trust may raise confidentially concerns over financial control and reporting, clinical quality and patient safety and other matters.

Scope and Duties	The Audit Committee's duties are detailed below under the following headings:
	
	• The Chair
	• The Audit Committee
	  ○ Governance, Risk Management and Internal Control
	  ○ External Audit
	  ○ Internal Audit
	  ○ Other Assurance Functions
	  ○ Counter Fraud
	  ○ Management
	  ○ Financial Reporting
	• Administrative Support
	
	<u>The Chair</u>
	
	The Chair is responsible for the following:
	
	• Approving agendas for meetings
	
	• Chairing pre meetings with the auditors and counter fraud specialists
	
	• Chairing meetings
	
	• Reporting to the Trust Board (highlighting any issues requiring further disclosure or executive action)
	
	• Reporting immediately those items of a significant nature regarding the Board Assurance Framework and the Risk Register;
	
	• Providing an executive summary report following each Committee meeting for the Trust Board meeting
	
	• Notifying the Chair(s) of any other Committee(s) of specific actions arising from the Audit Committee that affect the other Committee(s) and ensuring these actions are detailed in the minutes

- Approving the minutes of the Audit Committee before they are submitted to the Trust Board
- Ensuring there is unhindered access to the Heads of External and Internal Audit for any matters of internal control or risk requiring urgent advice or action.

The Audit Committee

Governance, Risk Management and Internal Control

The Audit Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management, internal control (clinical and non-clinical) across the whole of the organisation and activities that supports the achievement of the Trust's objectives.

In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement, regular reports on the activities of the Risk Management and Governance, self-certification statements to the Regulator, and Care Quality Commission declarations), together with any accompanying Head of Internal Audit statement, External Auditor opinion or other appropriate independent assurances, prior to endorsement by the Trust Board.
- underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. The Audit Committee will undertake periodic reviews of progress against the Board Assurance Framework and Corporate Risk Register, with significant changes highlighted. Where these items are of such a significant nature, 4 refers, the Chair of the Audit Committee will bring them to the immediate attention of the Trust Chair. A full copy of these key documents will be made available to the Audit Committee in accordance with the timetable agreed by the Trust Board and will normally be reviewed in full prior to the production of the Annual Report and Accounts and the Annual Governance Statement and as part of the Trust's mid-year review process.
- policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, and consider any training requirements to ensure Committee members are kept up to date with emerging requirements, policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authority.
- arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, with the aim of ensuring that arrangements are in place

for the proportionate and independent investigation of such matters and for appropriate follow-up action.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages. However, these other committee's must not usurp the Committee's role.

External Audit

The Council of Governors will take the lead in agreeing with the Audit Committee the criteria for appointing, reappointing and removing auditors. The Audit Committee will make recommendations to the Council of Governors via the Finance and Audit Governor Group who will then make recommendations to the full Council on these matters, and approve the remuneration and terms of engagement of the External Auditor. In accordance with its Standing Orders, the Council of Governors will appoint the external auditor following recommendation from the Audit Committee.

The Audit Committee shall develop and implement policy, in collaboration with the Finance Directorate, regarding the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance. All requests for the supply of non-audit services must be presented to the Audit Committee for noting.

The Audit Committee shall review and monitor the External Auditor's independence and objectivity, and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

The Audit Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work.

This will be achieved by:-

- consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit.
- review and agree, before the audit commences, the nature and

	scope of the audit as set out in the annual external audit plan • discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee • review of all audit reports that are specifically drawn to the attention of the Audit Committee by the auditors which will include the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses. • Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services. The Head of External Audit will have unhindered and confidential access to the Chair of the Audit Committee. **Internal Audit** The Audit Committee shall ensure that there is an effective Internal Audit function established by management that meets the Public Sector Internal Audit Standards, 2013 and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:- • consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal • review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework • where there is a requirement to undertake work outside of the approved annual work plan, all such requests must be presented to the Audit Committee for approval • consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources • ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation • annual review of the effectiveness of internal audit in such manner as is appropriate and agreed by the Audit Committee, including a review of the successful operation of the contract between the Trust and Internal Audit.

	The Head of Internal Audit will have unhindered and confidential access to the Chair of the Audit Committee. **Other Assurance Functions** The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the organisation. These will include, but not be limited to, any review by Department of Health arms-length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, Monitor etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.). In addition, the Audit Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. **Counter Fraud** The Audit Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and bribery, in accordance with Service Condition 24 of NHS Standard Contract. The Audit Committee will review the outcomes of work in these areas against the standards set by NHS Counter Fraud Authority (as referenced in Standard Condition 24). ttee will review the outcomes of work in these areas against the standards set by NHS Counter Fraud Authority (as referenced in Standard Condition 24). **Management** The Audit Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The Committee may also request reports from individual functions within the Trust (e.g. clinical audit) as may be appropriate to the overall arrangements. **Financial Reporting** The Audit Committee will monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them. The Audit Committee shall review the Annual Report and Accounts before submission to the Board, focusing particularly on:

- changes in, and compliance with, accounting policies and practices and estimation techniques
- major judgemental areas
- significant judgements in the preparation of the financial statements
- significant adjustments resulting from the audit
- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Audit Committee
- letters of representation
- explanations for significant variances
- unadjusted mis-statements in the financial statements.

Providing mandatory issues (as detailed in paragraph 1) are reserved for the attention of the full Committee in session, other matters including review of the Annual Report and Summary Financial Statements may be dealt with as the Audit Committee deems appropriate through a process co-ordinated by the Audit Committee Chair.

The Audit Committee should also ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Trust Board.

Administrative Support

The Audit Committee shall be supported administratively by the Finance Directorate Administrator whose duties in this respect will include:

- agreement of the agenda with the Chair and attendees and collation and circulation of papers in good time
- ensuring that those invited to each meeting attend
- minute-taking and keeping a record of matters arising and issues to be carried forward
- helping the Chair to prepare reports to the Board
- arranging meetings for the Chair – for example, with the internal/external auditors or local counter fraud specialists
- maintaining records of members' appointments and renewal dates etc

	• advising the Audit Committee on pertinent issues/areas of interest/policy developments • ensuring that action points are taken forward between meetings • supporting any ongoing training requirements for Non-Executive Directors as appropriate for their membership of the Audit Committee. Reference should be made, as appropriate to the Trust's Standing Orders, Reservations and Delegation of Powers and Standing Financial Instructions
Membership	The Audit Committee shall be composed of not less than 3 Non-Executive Directors of the Trust. • There will be appropriate cross-membership with other Board committees. • One member of the Audit Committee should have significant, recent and relevant financial experience as outlined in the Combined Code. • Members are required to attend at least 50% of meetings. Named substitutes may attend with the agreement of the Committee Chair. **Attendance by others at Meetings** External and Internal Auditors, and a representative of the Counter Fraud specialists are required to make themselves available when required for a private meeting with the Audit Committee Chair. The Director of Finance is the Executive lead for this Committee. The Director of Finance, Head of Corporate Affairs and Internal and External Audit and Counter Fraud representatives shall normally attend Audit Committee meetings. Other Executive Directors may be invited to attend, particularly when the Audit Committee is discussing areas of risk or operation that are the responsibility of that Director. The Chief Executive will have a standing invitation to attend Audit Committee meetings. The Chief Executive will usually attend the Audit Committee meeting where the end of year reporting, auditor's opinions, the Annual Governance Statement, the Annual Report and Annual Accounts are delivered. The Finance Directorate Administrator shall be Secretary to the Audit Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members. Representatives from other organisations (for example, NHS Counter

	Fraud Authority) and other individuals may be invited to attend on occasion. *The Trust Chair shall not be a member of the Audit Committee.*
Quorum	A quorum shall be 2 members.
Chair	One of the Non-Executive Directors will be appointed as Chair of the Audit Committee by the Trust Chair. If the Chair is absent from the meeting, another Non-Executive Director, shall preside.
Frequency of Meetings	Meetings shall be held quarterly as a minimum. One meeting will receive and review the annual submissions.
Agenda and Papers	An agenda for each meeting, together with relevant papers, will be forwarded to committee members to arrive 1 week before the meeting. Unapproved minutes will be circulated to the membership.
Minutes and Reporting	A written assurance report will be provided to the Board following each meeting. The Chair of the committee will provide a verbal summary/exception report to the Board in respect of meetings held for which assurance reports have not been produced. The Audit Committee minutes are deemed confidential, and not for publication. Confidential minutes shall be maintained, where necessary, for considerations of confidentiality, including commercial confidentiality. Matters specifically agreed to be confidential by the Audit Committee must be treated as entirely confidential. They must be minuted and reported to the Trust Board separately. In addition, all Committee business must be kept confidential until reported to the Trust Board or otherwise concluded, unless the Audit Committee agrees otherwise. **Servicing and Reporting Arrangements** The Audit Committee will maintain a rolling annual work plan that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. Reporting arrangements into the high level Committee with overarching responsibility for risk, the Audit Committee, will be as described in the rolling annual work plan together with anything extra agreed for a particular meeting. Agendas and papers shall be distributed one week prior to the meeting.

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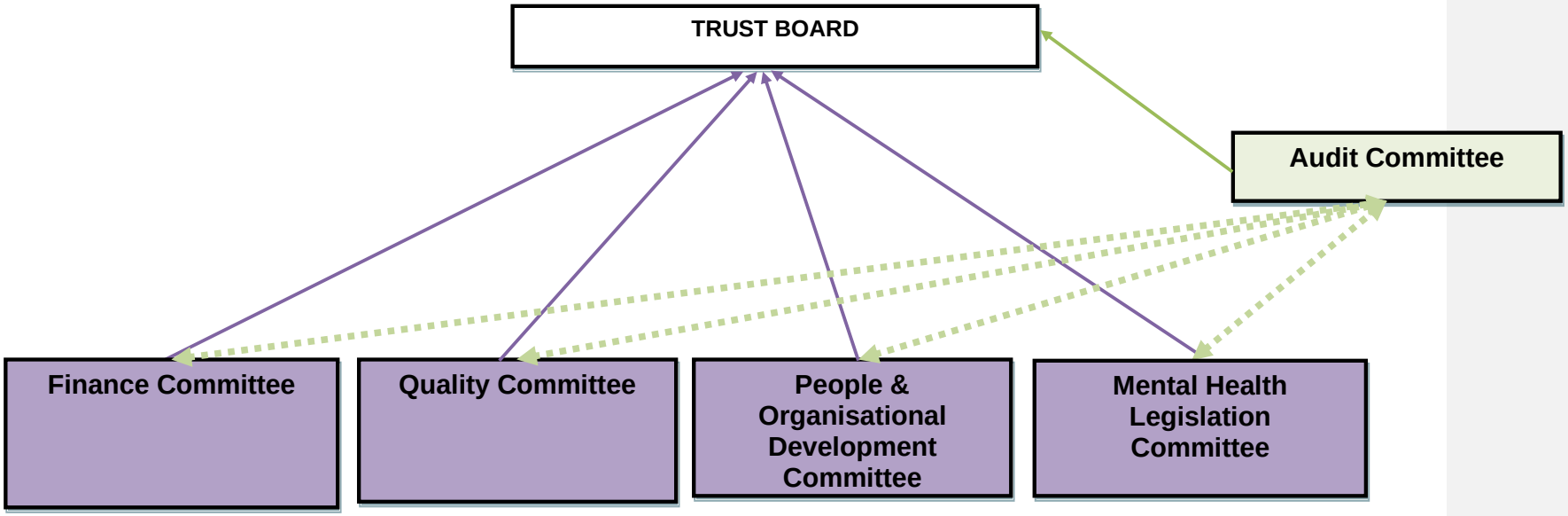
	The minutes of Audit Committee meetings shall be formally recorded by the Finance Directorate Administrator and submitted to the members of the Audit Committee. The Chair of the Audit Committee shall provide an executive summary report for the next Trust Board meeting that highlights substantive issues and recommendations. Minutes of the meeting will also be reported to the Trust Board in the part II session. The Audit Committee Chair shall draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board, or require executive action. Specific actions arising from one committee affecting the work of another Committee will be detailed in the minutes and notified to the Chair of the other Committee. The Audit Committee will report to the Trust Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the extent to which risk management is fully embedded in the organisation, the integration of governance arrangements and the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business and the robustness of the processes behind the quality accounts. An annual review of effectiveness will be undertaken and included in the annual report. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference. The Audit Committee shall report to the Board, identifying any matters within its remit in respect of which it considers that action or improvement is needed, and making recommendations as to the steps to be taken.
Agreed by Committee	14 May 2024
Board Approved	27 November 2024
Review Date	May 2025

AUDIT COMMITTEE REPORTING STRUCTURE



Caring, Learning
& Growing Together

Humber and North Yorkshire
Specialised Mental Health, Learning Disability and Autism
Provider Collaborative

NHS
Humber Teaching
NHS Foundation Trust

Humber Teaching NHS Foundation Trust
Collaborative Committee

Terms of Reference Updated for 2025

Constitution & Authority	Humber Teaching NHS Foundation Trust (HTFT) is the Host Provider of the Humber and North Yorkshire (HNY) Specialised Provider Collaborative (SPC), and holds the Contract with NHS E/I. The SPC will deliver the following: • Child and Adolescent Mental Health In-Patient and day care services • Adult Low and Medium Secure services • Adult Eating Disorder in-patient and day care Services. As Host Provider, HTFT will itself deliver services, as well as sub-contract services to a range of healthcare providers. The SPC is constituted as one of the new care models detailed in the *NHS Mental Health Implementation Framework*, which from April 2020 enabled local service providers to join together under NHS-led Provider Collaboratives. The Collaborative Committee has been established as an internal committee to provide assurance to the HTFT Board as Host Provider about the planning, finance, contracting, performance and quality assurance functions of the SPC. These functions have been traditionally described as commissioning. The Collaborative Committee is constituted as a standing committee of the Humber Teaching NHS Foundation Trust's Board of Directors. The Committee is delegated by the Board to exercise decision-making powers in discharging its duties, whilst recognising those matters reserved elsewhere. Key Relationships – The HNY Specialised Provider Collaborative Oversight Group (PCOG) is the forum in which the members of the SPC act together as partners using their collective expertise in provision, planning and quality assurance. PCOG holds collective accountability and responsibility to steer the strategy and support the operational delivery of the SPC programme in line with agreed principles of clinical quality and business requirements.

	The Collaborative Planning and Quality Team (CPaQT); reporting to PCOG and the Collaborative Committee, is an enabler based in HTFT which supports all partners in the SPC to ensure appropriate health care services are planned, provided, quality assured and reviewed. CPaQT works with all partners to develop proposals to improve care and meet the needs of the HNY population. In so doing, the partners in the SPC seek to: improve the efficiency, effectiveness, economy, and quality of services; reduce inequalities; and promote the involvement of patients, stakeholders, and the public in the development of our services. The Collaborative Committee has the authority to establish sub-groups as necessary to fulfil its objectives. However, it may not delegate any powers delegated by the HTFT Board and will remain accountable for the work of any such sub-group.
Role / Purpose	The purpose of the Collaborative Committee is to provide assurance to the HTFT Board on matters of planning, finance, contracting, performance and quality assurance of the SPC, thus supporting the overall strategic aim of the SPC to improve care pathways and outcomes for patients. Day to Day provision of patient care is the responsibility of Providers within the SPC. Services will be planned and funded utilising NHS Standard Contracts with clear Key Performance Indicators (KPIs) and Outcomes. Via the PCOG, the Collaborative Committee will support the partnership approach between the Providers of the SPC. The SPC aims to reduce reliance on in-patient care, reduce out of area treatments, increase provision of care closer to home and reduce the expenditure on bed-based care; in doing so it will aim to generate financial savings. These savings will be reinvested in other parts of the Adult Secure, CAMHS and Eating Disorders mental health, learning disability and autism pathways following agreed governance process for the review, new service proposal and formal contracting.
Scope & Duties	The objectives and duties of the Committee are to: • Provide assurance to the HTFT Board as Host Provider that it is fulfilling its duties and obligations within the SPC. • Be assured that appropriate arrangements are in place in respect of Serious Incidents, Safeguarding, and to ensure quality of care and continuous learning and improvement. • Working closely with PCOG and CPaQT, link with other Provider Collaboratives and local and national commissioners, with the aim of improving services along whole pathways of care and manage pressures within the wider health and care system. • Monitor overall contract management, including quality assurance across the NHS and independent sectors. The Committee may act as the next line of arbitration/mediation between partners if matters cannot be resolved at PCOG .

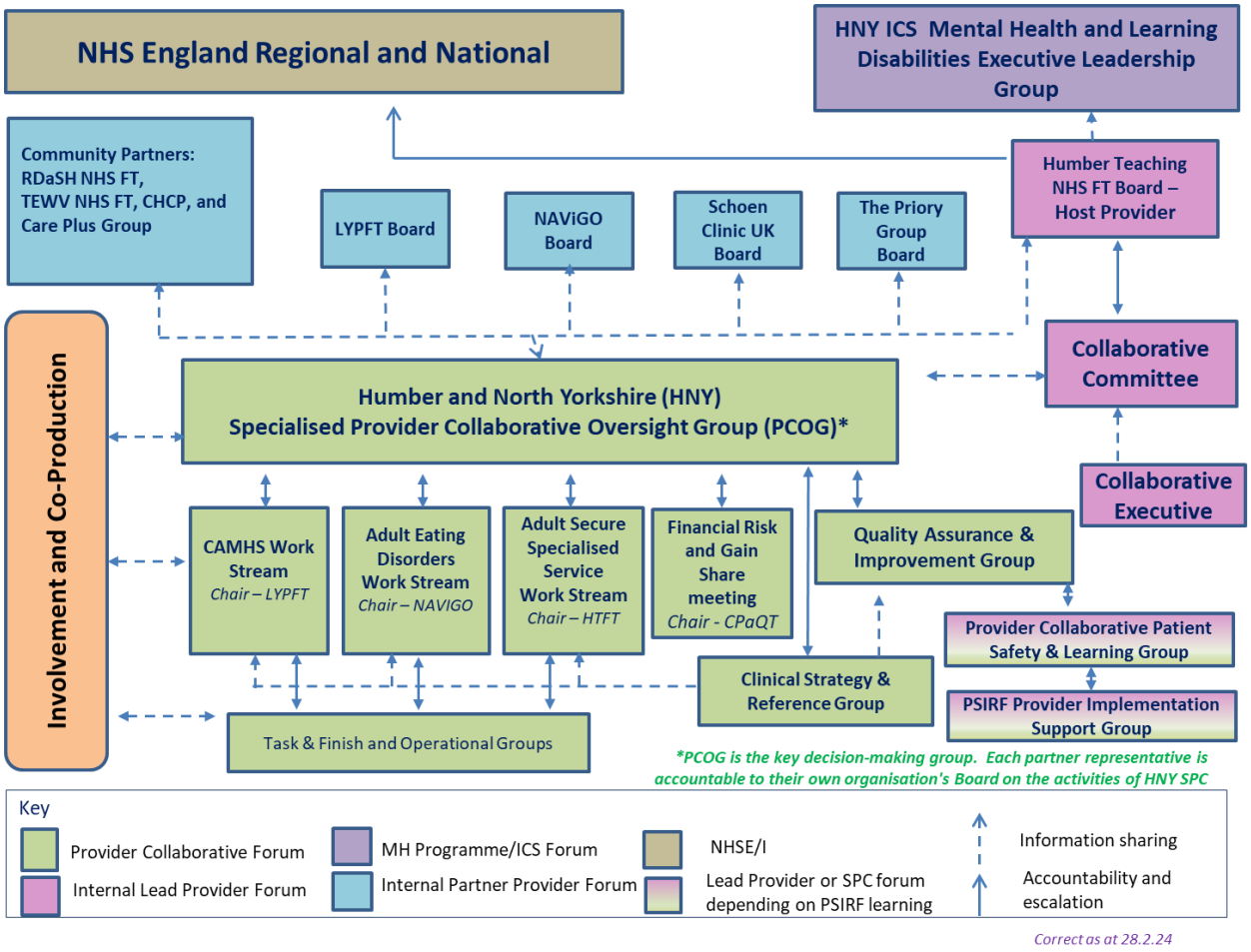
	Specific responsibilities *Financial planning* ❖ Provide assurance to the HTFT Board that the SPC's programme of work is well planned and supported by an appropriate risk management system. ❖ Gain assurance, via PCOG, that performance against financial plans is reviewed, financial risks and gain shares are agreed, and mitigated and/or realised, and that any remedial action plans are effective. ❖ Provide assurance to the HTFT Board as Host provider on the delivery of agreed improvement programmes to reduce cost and increase efficiency including assurance on benefits realisation and value for money. *Transactional* ❖ Following review and approval at PCOG, scrutinise and ratify business cases (for both new service proposal and reduction of service delivery) and investments and/or disinvestments, which will then be translated into contractual agreements which are held by the Host Provider *Contracting* ❖ Gain assurance that contracts are in place to address risk in relation to the quality and performance of commissioned services and thereby undertake the duties as expected of the Host Provider. ❖ Following discussion and approval at PCOG, ratify and enact Contract Variations and necessary formal Commissioning Intentions dialogue within the SPC. *Risk Management:* ❖ Each work stream is responsible for its own specific Risk Register. A summary of each work stream risk register will be shared at each PCOG and Collaborative Committee. ❖ The Collaborative Committee will review Risk Registers and will suggest modifications to the risk registers, including ownership and delivery of action plans against defined timescales. ❖ Discuss and review of any issue likely to require inclusion on the HTFT Risk Register. *Quality Assurance* ❖ To be assured that quality, clinical governance, patient and public engagement issues are appropriately addressed in all service developments/reconfiguration of services and are in line with statutory requirements, national policy and guidance. The Collaborative Committee will receive Chairs log and/or relevant reports from PCOG for review and overall assurance. The Collaborative Committee will have relationships as necessary with other groups and committees that will inform its work including links with:

	▪ Transforming Care Alliance Network/Forum to ensure the needs of patients with learning disability and autism are understood and service developments are in line with wider system developments. Further work will be necessary to define and agree definitive links once engagement with the Forum commences. ▪ HNY Integrated Care System and place-based health and care partners to ensure widest development of patient pathways to reduce admission to hospital care but also reduce length of stay. ▪ Local Authorities within the geographical footprint ▪ NHS England Regional and National Team
Membership	All members are required to make open and honest declarations of interest at the commencement of each meeting or to notify the Committee Chair of any actual, potential, or perceived conflict in advance of the meeting. **Humber Teaching NHS Foundation Trust – Lead Provider** • Non-Executive Director (Chair) • Non-Executive Director (Vice Chair) • Chief Executive • Executive Director of Finance/Senior Information Risk Owner • Director of Nursing, Allied Health and Social Care Professionals • Collaborative Planning Director • Clinical and Quality Assurance Director
Attendance	**HNY Provider Collaborative Planning and Quality team:** • Assistant Director of Clinical and Quality Assurance • Head of Secure Planning • Head of CAMHS and Adult Eating Disorder Planning • Finance Manager **Clinical Work Stream Leads (as per specific agenda items)** • Clinical Lead, Adult Secure • Clinical Lead, Adult Eating Disorders and CAMHS
Quorum	The quorum necessary for the transaction of business and decision making shall be three (3) members including. 1 Non-Executive Director and 1 Executive Director – one of whom must be the Chair or Vice Chair Decisions will be reached by consensus. If a decision cannot be reached by consensus, then it will be escalated to the Humber Teaching NHS FT Board for resolution.
Chair	The meeting Chair and Vice Chair will both be HTFT Non-Executive Directors. During 2025

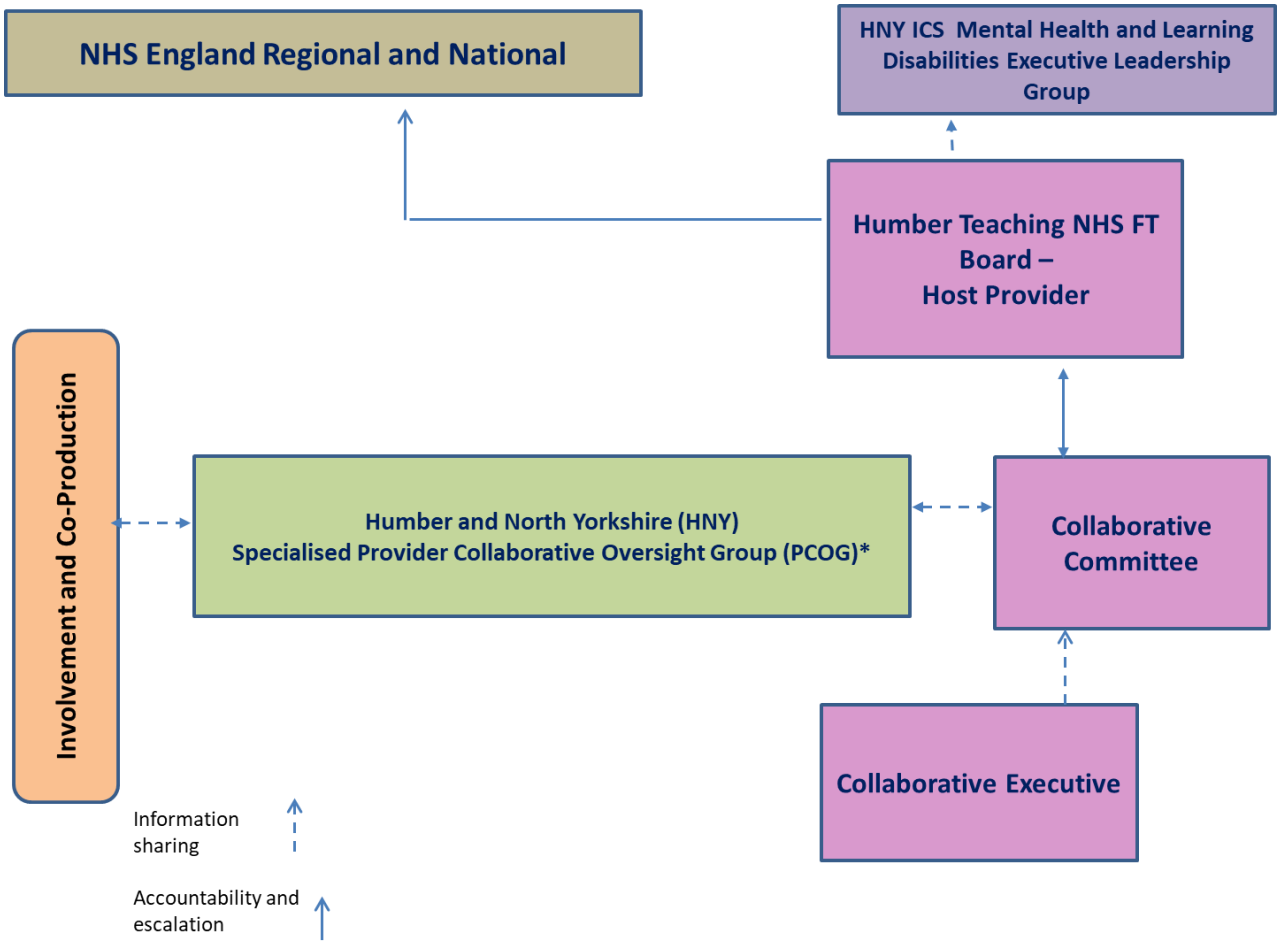
	Chair - Stuart McKinnon-Evans HTFT Non-Executive Director. Vice-Chair – Stephanie Poole HTFT Non-Executive Director.
Frequency of meetings	Meetings will be held quarterly. Frequency may increase during the annual planning cycle to ensure that the work undertaken by the Collaborative Planning and Quality Team is timely, reflecting the fast-paced nature of contract negotiations. Meetings may be held in person or utilising technology (Microsoft Teams)
Accountability and Reporting Arrangements	A written assurance report will be provided to the Trust Board following each meeting. The Chair of the committee will provide a verbal summary/exception report to the Board in respect of meetings held for which assurance reports have not been produced. Members will be invited to declare any conflicts of interest.
Agenda & Papers	The CPaQT administration will be responsible for arranging meetings. An agenda for each meeting, together with relevant papers, will be forwarded to members to arrive 1 week before the meeting. Unapproved minutes will be circulated to the membership. Record Keeping - Agenda and Papers can be accessed via the CPaQT administration.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Collaborative Committee Terms of Reference.
Agreed by Collaborative Committee (Date)	3 March 2025
HFT Board Approved (Date)	November 2024 *date / highlight to be updated following confirmation of Board approval*
Review Date	January 2026

Reporting Schematic:

Overall Provider Collaborative Governance Framework as at 3.3.2025



Lead Provider Delineation Governance Framework



Correct as at 28.2.24

Appendix 1

The Collaborative Committee will overall adhere to the Humber Teaching NHS FT Mission, Values and Principles in all its work: *Being Humber*

The Trust Mission:
Humber Teaching NHS Foundation Trust - a multi-specialty health and social care teaching provider committed to Caring, Learning and Growing.

Our Trust Vision:
We aim to be a leading provider of integrated health services, recognised for the care compassion and commitment of our staff and known as a great employer and a valued partner.

The HTFT Trust Values are at the centre of the HNY Provider Collaborative work programme. These are:

Caring for People while ensuring they are always at the heart of everything we do.
Learning and using proven research as a basis for delivering safe, effective, integrated care.
Growing our reputation for being a provider of high-quality services and a great place to work.

Our Goals (how we will get there)
- Innovating quality and patient safety
- Enhancing prevention, wellbeing, and recovery
- Fostering integration, partnership, and alliances
- Promoting people, communities, and social values
- Developing an effective and empowered workforce
- Optimising an efficient and sustainable organisation

The Characteristics of Being Humber

We Put Patients First
We Are Courteous and Civil
We Are Compassionate
We Are Inclusive
We Act with Integrity
We Communicate Effectively
We Prioritise Safety
We Work Together

NHS
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Terms of Reference
Finance Committee

Authority	The Finance Committee is constituted as a standing committee of the Trust's board of directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future board of directors' meetings. The Committee is delegated by the Board to exercise decision-making powers in discharging its duties, whilst recognising those matters reserved elsewhere. The Committee may form any working group, tasked for a specific purpose and for a fixed period, to support the delivery of any of its duties and responsibilities, or for relevant research. The Committee is authorised by the Board to obtain outside legal or other independent professional advice as it requires and to secure the attendance of those with relevant experience and expertise if it considers this necessary and appropriate by the Chair.
Overall Aim/Purpose	The Finance Committee exists to provide strategic overview and provide assurance to the Trust Board that there is an effective system of governance and internal control across all financial areas and any potential investment decisions. The primary role of the Committee is to monitor, review and support the Finance Directorate of the Trust, making recommendations to the Board as appropriate and taking actions as required. The Committee is authorised to require any Trust Officer to attend a meeting and provide information and/or explanation as required by the Committee
Duties	The Finance Committee will: - • Challenge the timeliness, accuracy and quality of financial and performance measures and reporting, and the systems underpinning them. It should ensure performance and relevant action plans are reviewed and managed in pursuit of Trust objectives. • Scrutinise all financial plans, including the Trust's annual financial plan, prior to seeking Board approval • Monitor delivery of the Trust's budget reduction strategy (BRS) and other financial savings programmes • Approve the processes and timetable for annual budget setting, and budget management arrangements • Review and challenge delivery of the Trust's Capital Investment Programme and approve the processes for managing the Trust's capital programme • Review and endorse the Trust's medium and long-term financial plans prior to Board approval • Monitor the detailed monthly income and expenditure position of the Trust, overall financial performance (capital and revenue) against plan, and projected final outturn • Receive assurance from the Operational and Corporate Directors in respect of performance against annual budgets, capital plans and the BRS, quality, innovation, productivity and prevention plans, commissioning for quality and

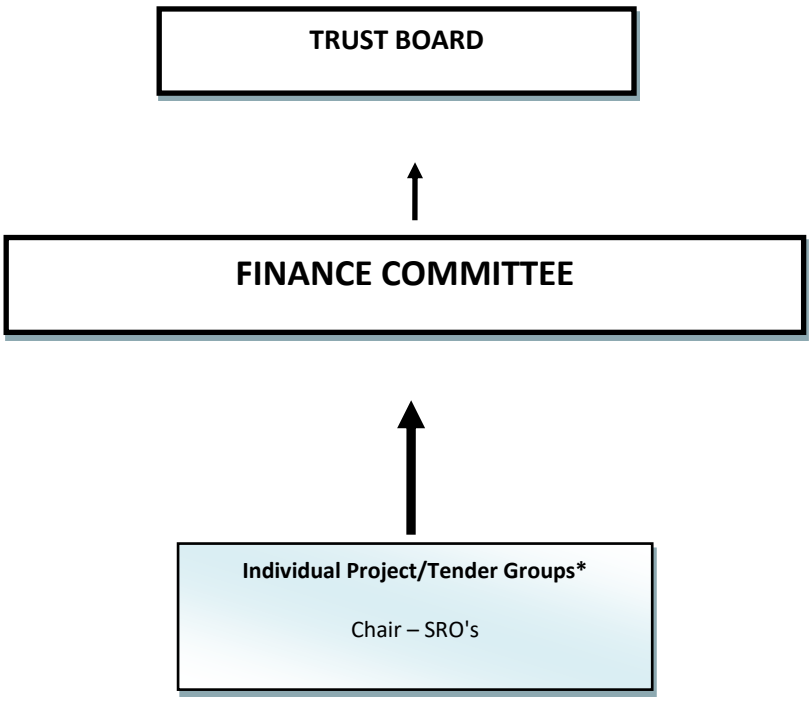
	innovation plans (CQUIN), activity and key performance indicators, corporate governance activities and responsibilities.
	• Monitor effective balance sheet management, including asset management and cash planning
	• Monitor financial performance indicators, including compliance with Public Sector Payment Policy
	• Monitor the development, application and delivery of financial recovery plans.
	• Monitor the development, application and delivery of financial contingency plans.
	• Review the robustness of the risk assessments underpinning financial forecasts
	• Review the Trust Wide Risk Register and Board Assurance Framework relevant to the work of this committee.
	• Work with the Audit, Workforce and Quality Committee's advising on the non-clinical aspects of risk management.
	• Identify opportunities for improvement and encourage innovation
	• Monitor contract negotiation and performance noting the position of contracts and raising any concerns; receiving assurance from the Executive Directors in respect of the organisation meeting the contractual requirements and expectations of commissioners, meeting the legislative / regulatory requirements of regulators and other bodies.
	• Review and challenge the Estates & Facilities Work Programme, and the delivery of the Trust's Estate Strategy.
	• Review and challenge the Digital Delivery work programme and any emerging digital innovations.
	• Scrutinise all business cases for new business and investment, in line with the Trusts Scheme of Delegation and Standing Financial instructions and review all tenders presented to the Committee taking on board the views provided by the Executive Management Team. This will be achieved by: -
	  • reviewing and approving the business development and investment framework to support and govern all investments, contracts and projects as set out in the ToR.
	  • evaluating post implementation, the financial performance of approved investments, contracts and development projects, and report the findings to the Board.
	  • considering the Trust's medium- and long-term strategies in relation to both revenue and capital investment expenditure, and make recommendations to the Board on a regular basis
	  • reviewing and assessing the business cases for:
	  ○ Capital expenditure over £500k
	  ○ New business development projects with an annual value in excess of £500k in total
	  ○ Any reconfiguration project which has a financial and/or resource implication over £500k per annum
	  ○ Leases, contracts or agreements with revenue, capital and/or resource investment/commitment in excess of £500k per annum
	  ○ The purchase or sale of any property
	  ○ The purchase or sale of any equipment above £250k
	  ○ All borrowing or investment arrangements
	  ○ Horizon scanning regarding business opportunities.
	  ○ To periodically consider strategic risks to business and ensure these are reflected and mitigated within any business cases.
	  ○ Ensure that Digital support the delivery of patient care
	  ○ Receive assurance to ensure the Trusts digital maturity improves on a annual basis

	○ Receive assurance the Trust is compliant with the digital section of the revised NHS Provider Licence ○ Ensure the Trust has the right infrastructure, governance and support in place to provide safe and secure services to patients. • Have due regard to the public sector equality duty and the Trust's equality objectives • Refer issues arising to other Trust committees or groups • Maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency, across the financial year. The Committee shall be proactive in agreeing the most appropriate reporting format and style to suit the particular needs of the following users and stakeholders in accordance with best practice: • the Board (who may at any time request additional information, or information in a different format) and committees • commissioners, including CCGs and NHS England • public, patients and staff • budget holders • other stakeholders, e.g., other Trusts, local authorities
Membership	Membership of the committee shall be comprised of the following: • 3 x Non-Executive Directors (1 of whom shall chair the committee) • Director of Finance (Executive Lead) • Chief Operating Officer In attendance at the Committee will be the following: • Deputy Director of Finance • Head of Partnerships and Strategy • Chief Information Officer General Managers and Deputy Directors will not be members but will attend for all or any part of a meeting as appropriate. The Medical Director will not be a member but will be invited to attend with a specific focus on digital assurance. Senior Clinical Leadership will be requested / invited to attend the Committee, a reciprocal arrangement will take place for Finance attendance at the Quality Committee Non-Executive Directors are entitled to attend any Trust committee meeting. The Chief Executive has a standing invitation to attend any meeting. The Chair of the Trust has the right to come to any committee at any time. **Declarations of interest** Members are required to state for the record any interest relating to any matter to be considered at each meeting, in accordance with the Trust's Conflict of Interest policy. Members will be required to leave the meeting at the point a decision on such a matter is being made, after being allowed to comment at the Chairs' discretion. Declarations shall be recorded in the minutes.

Quorum	A quorum shall be three of the above, comprising at least two Non-Executive Directors.
Chair	• The Committee shall be chaired by a Non-Executive Director with appropriate experience who will be appointed by the Trust Chair and confirmed annually in a Board minute. • In the absence of the Committee Chair, one of the remaining Non-Executive Directors present at that meeting shall act as Chair for that meeting. Deputies may attend by agreement with the Chair.
Frequency	• The Committee shall meet quarterly, however additional meetings will be diarised and held as necessary. • There is a requirement for flexibility when working to new business deadlines and virtual meetings may be required for investment decisions.
Agenda and Papers	• Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the Committee not less than 5 working days before the date of the meeting. • Minutes of all meetings of the Committee shall be taken by an appropriate and identified secretary and kept by the secretary • A record shall be kept of matters arising and/or issues to be carried forward at each meeting. • A record shall be kept of all investment decisions for the purposes of performance monitoring and reporting. • All investment papers submitted must be considered by the Executive Management Team prior to consideration by the Committee in line with the flow of investment decision making. • All meetings of the Committee shall be called at the request of the Chair. • Meeting agenda will be agreed with the Committee Chair before circulation and when circulated it will confirm the venue, time and date.
Minutes and Reporting	A written assurance report will be provided to the Board following each meeting. The Chair of the committee will provide a verbal summary/exception report to the Board in respect of meetings held for which assurance reports have not yet been approved.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference.
Agreed by Committee	April 2025
Board Approved Date	
Review Date	*April 2026*

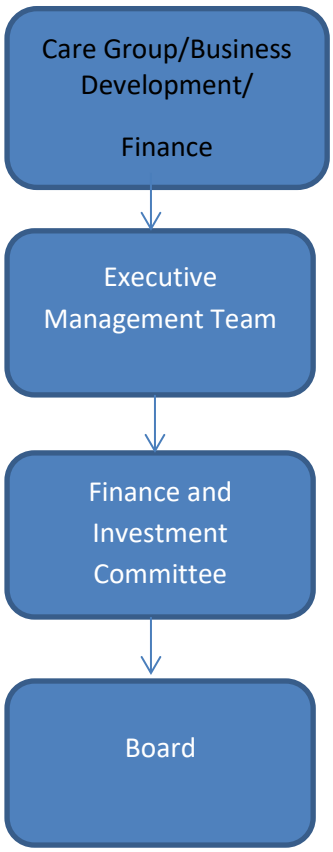
Schematic below:

FINANCE AND INVESTMENT COMMITTEE REPORTING STRUCTURE



** Not a formal subgroup of the Finance and Investment Committee, relevant groups established based on each tender requirement.*

Flow of decision-making process re Investments



Initial consideration of opportunity – to progress or not

Consideration of schemes to be progressed and advise F&I Committee

Consideration of schemes to progress and advise Board

Consideration of schemes to progress

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NHS Foundation Trust

Terms of Reference

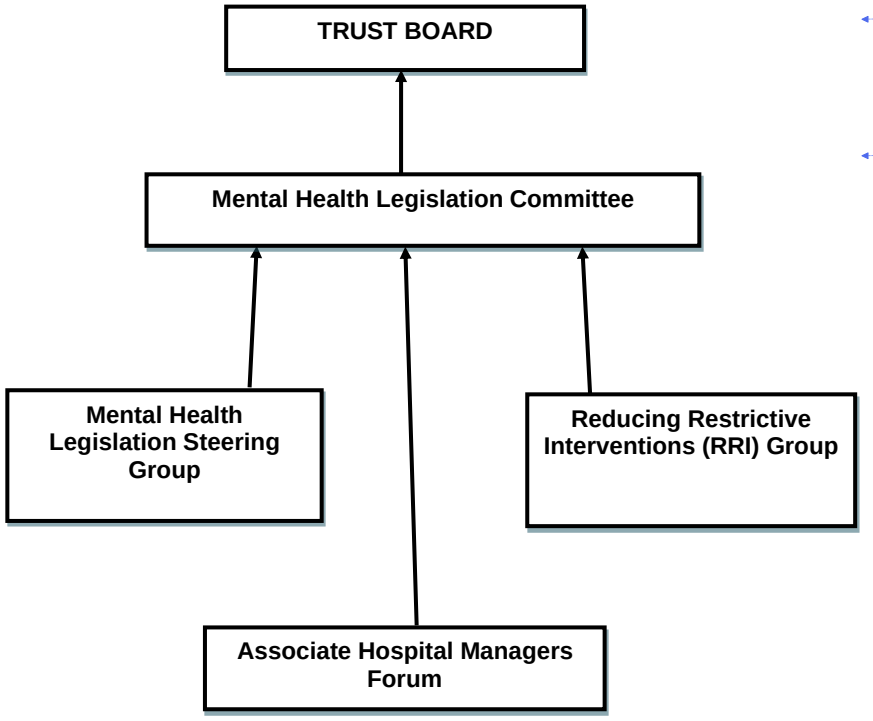
Mental Health Legislation Committee

Constitution and Authority	The Mental Health Legislation Committee is constituted as a standing Committee of the Trust's Board of Directors. Its Constitution and Terms of Reference shall be as set out below, subject to amendment at future Board of Directors meetings. For the purpose of these Terms of Reference, Mental Health Legislation refers to the Mental Health Act 1983, the Mental Capacity Act 2005 and other related primary and secondary mental health legislation. This includes government and regulatory policies, procedures and codes of practice which the Trust is bound to observe as a matter of law. The Committee is authorised by the Board of Directors to seek assurance on Mental Health Legislation. It is authorised to seek any information it requires from the relevant Director. The Committee is authorised by the Board of Directors to request the attendance of individuals with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.
Role / Purpose	The purpose of the Mental Health Legislation Committee (MHLC) is to: • Provide strategic leadership pertaining to the Mental Health Act, the Mental Capacity Act and their respective codes of practices and other mental health legislation as required. • Monitor, provide challenge and seek assurance of compliance with external standards relating to mental health legislation • Have oversight of mental health legislation procedures and policies • Promote and encourage joint working arrangements regarding the implementation of mental health legislation with partner organisations • Receive reports regarding inspecting authorities and to monitor the implementation of action plans in response to any recommendations made.
Scope & Duties	All persons agreeing to bring back action or information to the Committee will do so, using an appropriate deputy if necessary and, where this has not been possible, will come up with a revised plan of action and report such matters to the Chair prior to the next meeting. The Committee will keep under review the recruitment and retention of Associate Hospital Managers (AHMs), ensuring that an adequate number are retained and that their training and performance are regularly reviewed. The Committee will recommend to the Board the appointment of AHMs for periods not exceeding 3 years (after which they may be re-appointed by the Board). Responsibilities of the Committee: • To have oversight of Trust-wide policies and procedures relating to Mental Health Legislation.

	• To receive reviews of assessment reports and recommendations from external bodies relating to Mental Health Legislation in the Trust. • To monitor key indicators capable of showing Trust compliance with Mental Health Legislation. • To receive regular data on key indicators underpinning delivery of the Trust's duties and responsibilities under Mental Health Legislation. ~~• To receive minutes and/or reports from the Mental Health Legislation Steering Group. These will be presented by the Clinical Director.~~ • To receive regular updates on recent CQC MHA visits, including themes, associated actions, learning and progress. • To receive a summary of key issues arising from the Associate Hospital Managers Forum • To receive quarterly reports regarding the reduction of restrictive practices. These will be presented by the RRI Lead. • To regularly review the Board Assurance Framework (BAF). • Where appropriate to commission specific pieces of work and audits relating to Mental Health Legislation • Training of Non-Executive Directors - Rapid Review into data on MH inpatient settings recommended that Board's should provide Mental Health Act training so that at least half their non-executive directors are trained as associate hospital managers under the Mental Health Act and participate in hearings to best understand the clinical care provided, the challenges, and the views of patients, families and clinical teams for the patients.
Membership	The Committee will have full membership of: • One Non-Executive Director (who is designated Chair) • At least two other Non-Executive Directors (one of which is also a designated Associate Hospital Manager, if not the Chair) • Medical Director • Chief Operating Officer ~~• Clinical Director~~ • Director of Nursing, Allied Health & Social Care Professionals The following will be required ~~/ invited~~ to attend the meetings: • Clinical Director and Clinical lead for RRI ~~• Clinical Lead for RRI~~ • Mental Health ~~Act Clinical Manager~~Legislation Lead (Mental Health Legislation Manager to act as deputy in absence) • ~~• Mental Health Legislation Manager~~ ~~• Named Professional for Safeguarding (Adults), MCA and Prevent Lead~~ • Hull AMHP Lead The following will be invited to attend the meetings: • Local Authority representation covering the Humber area Core members are expected to attend each meeting. However where this is not possible deputies can attend by agreement of the Chair. Other individuals may be called to attend for all or part of any meeting, as and when appropriate. The Chief Executive has a standing invitation to attend any meeting.

	A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.
Quorum	The quorum necessary for the transaction of business shall be five including • two Non-Executive Directors, • the Medical Director (or authorised deputy – senior Consultant Psychiatrist) • one other Executive Director ~~and~~ ~~• another who must be a qualified clinician.~~ At least one of the Executives should be a qualified clinician Members of the Committee must attend at least 3 meetings in each financial year but should aim to attend all scheduled meetings.
Chair	The Chair of the Committee will be a Non-Executive Director and will be appointed by the Trust Chair. In the absence of the Chair a Non-Executive Director shall Chair the meeting.
Frequency of Meetings	The Committee shall meet at least every quarter. Additional meetings may be held on an exceptional basis at the request of the chair or any five members of the MHL Committee.
Agenda and Papers	The Mental Health ~~Act Clinical Manager~~Legislation Lead (with appropriate support), will ensure that: • There is agreement of the agenda with the Chair of the Committee, and that the necessary papers are produced, collated and circulated; • Minutes are taken of the proceedings and resolutions of all meetings of the Committee including recording the names of those present and in attendance. • Minutes shall be circulated promptly (within 20 working days) to all members of the Committee; • A record is kept of matters arising and issues to be carried forward; • An annual cycle of business is established
Minutes and Reporting	A written assurance report will be provided to the Board following each meeting. Formal minutes will be taken of the meeting and a Committee Chair assurance report will be forwarded to the Public Board.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference.
Agreed by Committee	~~02 May 2024~~01 May 2025
Board Approved	~~29 May 2024~~
Review Date	May202~~4~~5

MENTAL HEALTH LEGISLATION COMMITTEE REPORTING STRUCTURE



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People and Organisational Development Committee

Draft Terms of Reference

Authority	The People and Organisational Development Committee is constituted as a standing committee of the Trust's board of directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future board of directors meetings.
Overall Aim/Purpose	The purpose of the People and OD Committee is to assure the Trust Board that appropriate processes are in place to give confidence that: ~~:~~ • Workforce performance and associated risks are monitored effectively and that appropriate actions are taken to address any deviation from accepted standards and to manage identified risks. • Performance in relation to Workforce Equality and Diversity requirements is monitored effectively with appropriate actions being taken to address any performance issues and risks. • The workforce impact of proposed business change proposals (i.e., new models, budget reductions) are fully reviewed for their impact on people. • To provide assurance on the delivery of the relevant strategic objective assigned to the People and Organisational Development Committee - Goal 4 – Developing an effective and empowered workforce.
Duties	• To provide the strategic overview of and assurance against workforce (including bank and volunteers) issues in the Trust. • To provide a strategic overview of Workforce risks to the Trust Board. • To provide oversight and assurance to the Board in relation to all activities relating to Workforce on behalf of the Trust Board to include but not limited to sickness, vacancies, turnover, training compliance, equality and diversity, appraisals, employment relations issues.

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	• To provide assurance to the Trust Board that risks, and governance issues of all types are identified, monitored and controlled to an acceptable level. • To provide a regularly reviewed and appropriate risk register to the Trust Board identifying risks to achieving the Trust's strategic objectives. • To provide a regular review of the Board Assurance Framework relating to Workforce. • Drive improvements in the approach to workforce informed by the internal governance reporting structures and external horizon scanning and learning from others. Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for equality and diversity. • Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for staff health and wellbeing. • Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for safe working for junior doctors. • Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for freedom to speak up.
Declarations of Interest	All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.
Membership	The members of Committee are: • Non-Executive Director (Chair) • 2 Non-Executive Directors • Associate Director of People & OD • Chief Operating Officer • Medical Director • Executive Director of Nursing, Allied Health and Social Care Professionals The following will be routine attendees at the committee: • Deputy Associate Director of People & OD • ~~Head of People Experience~~ • Head of Operational People Services • Director of Finance

	• Head of Corporate Affairs All those that attend the meetings are required to attend a minimum of three meetings a year. Nominated deputies can attend meetings on behalf of Committee members and will count towards the quorum. The Chief Executive and the Chair~~has a standing invitation to attend.~~ ~~The Chair person~~each ~~has~~have a standing invitation to attend. The Chair of Audit Committee has a standing invitation to attend. Other relevant officers will be invited to attend as required by the Committee.
Quorum	2 Non-Executive Directors, 1 Executive Director and 1 other board member. The agenda will be agreed by the Chair, via the Associate Director of People and OD.
Chair	The Chair of the Committee will be a Non-Executive Director.
Frequency of meetings	The Committee will meet as a minimum 4 times a year.
Agenda & Papers	An agenda for each meeting, together with relevant papers, will be forwarded to committee members to arrive 5 working days before the meeting. Unapproved minutes will be circulated to the membership. Record Keeping - Agenda and Papers can be accessed via the Committee Secretary.
Minutes & Reporting	A written assurance report will be provided to the Board following each meeting. The Chair of the committee will provide a verbal summary/exception report to the Board in respect of meetings held for which assurance reports have not been produced.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference.
Agreed by Committee	~~17 May 2023~~ ~~Revised approved 13 November 2024~~07 May 2025
Approved by	~~27 November 2024~~

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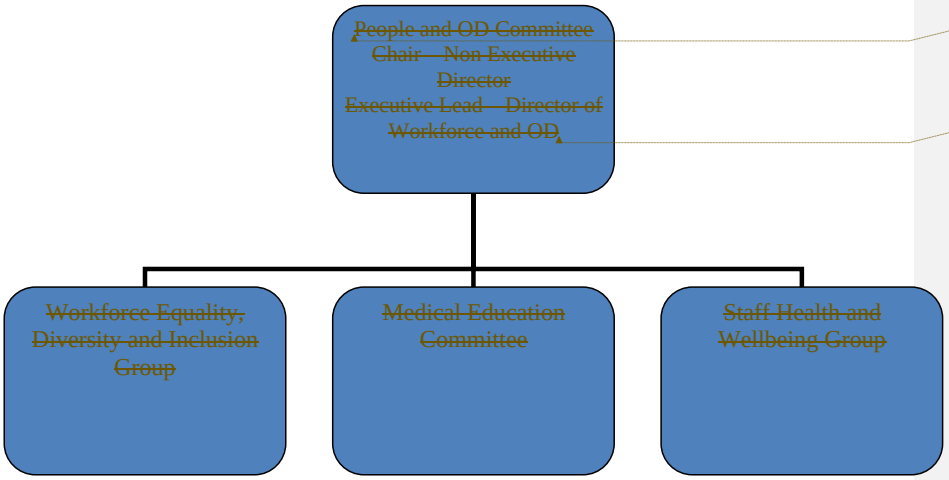
Trust Board	
Review	~~May 2025~~May 2026

~~People and Organisational Development Committee Schematic~~

Commented [KP1]: The reporting groups are no longer reporting to this committee so this graphic can be removed



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Humber Teaching NHS Foundation Trust

Terms of Reference
Quality Committee

Authority	The Quality Committee is constituted as a standing committee of the Trust's Board of directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings.
Overall Aim / Purpose	The purpose of the Quality Committee is to assure the Trust Board that appropriate processes are in place to give confidence that: - • Quality, patient safety performance and associated risks are monitored effectively and that appropriate actions are taken to address any deviation from accepted standards and to manage identified risks. • Performance in relation to research and development requirements is monitored effectively with appropriate actions being taken to address any performance issues and risks. • The quality impact of proposed business change proposals (i.e., new models, budget reductions) are fully reviewed for their impact on quality • The impact of quality improvements and audits are clearly tracked through performance and experience data.
Duties	To provide the strategic overview of and assurance against clinical and quality governance, clinical risk and patient and carer experience and engagement issues in the Trust • To provide a strategic overview of Clinical Governance, Risk and Patient Experience to the Trust Board • To provide oversight and assurance to the Board in relation to all activities relating to Quality, Patient Safety and Patient Experience on behalf of the Trust Board to include but not limited to learning from deaths, palliative and end of life care, care of children and young people, resuscitation, safeguarding, infection control. • To provide assurance to the Trust Board that risks, and governance issues of all types are identified, monitored and controlled to an acceptable level. • To provide a regularly reviewed and appropriate risk register to the Trust Board identifying risks to achieving the Trust's strategic objectives • To provide a regular review of the Board Assurance Framework relating to Quality • Drive improvements in the approach to quality improvement, innovation and quality assurance informed by the internal governance reporting structures and external horizon scanning and learning from others.

	• To advise the Trust Board on significant risks and governance issues, identifying recommendations, to enable it to take appropriate action. • To ensure that there is an effective mechanism for reporting significant quality related risks and governance issues to the Trust Board in a timely manner. • To provide a strategic overview of patient and carer experience, regularly reviewing outcomes and satisfaction • The Quality Committee will ensure that there is an integrated approach to quality and effectiveness, and patient and staff safety throughout the Trust. • To ensure that work plans are produced, and a range of actions are undertaken by other meetings, reporting to the Quality Committee to provide assurance to the Trust Board. • To monitor Trust compliance with the required standards for regulation and registration with the Care Quality Commission and other national guidelines • To monitor required actions to achieve regulatory and registration standards. **Learning Lessons** • Receive assurances that systems are in place across the organisation to embed learning from the consideration of actions and recommendations. • Advise the EMT and or Trust Board, directly on urgent risk management issues. **Sharing Good Practice** • Encourage learning to take place from the consideration of themes and Trust-wide recommendations on Clinical or non-clinical issues arising from Directorates, Care Groups and sub-committees. **Accountable for:** • Quality Accounts • Care Quality Commission processes
Declarations of Interest	All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.
Membership	**Committee Members:** • Non-Executive Director (Chair) • Two Non-Executive Directors • Director of Nursing, Allied Health and Social Care Professionals (Management support to the Committee) • Medical Director • Chief Operating Officer

	In attendance • Clinical Director • Head of Corporate Affairs • Head of Allied Health Professionals • Deputy Director of Nursing, Allied Health and Social Care Professionals • Head of Nursing and Patient Safety Specialist • ~~Assistant Director of Nursing, Patient Safety and Compliance.~~ • Administrator All those that attend the meetings are required to attend a minimum of three meetings a year. Nominated deputies can attend meetings on behalf of Committee members and will count towards the quorum. The Chief Executive, the Trust Chair ~~Chairman~~ and the Chair of Audit Committee have a standing invitation to attend. Other relevant officers will be invited to attend as required by the Committee
Quorum	2 Non-Executive Directors, 1 Executive Director and 1 other board member. The agenda will be agreed by the Chair, via the Director of Nursing, Allied Health and Social Care Professionals
Chair	Non-Executive Director
Frequency of meetings	The Quality Committee will meet as a minimum 4 times a year.
Agenda & Papers	An agenda for each meeting, together with relevant papers, will be forwarded to committee members to arrive 5 working days before the meeting. Unapproved minutes will be circulated to the membership. Record Keeping - Agenda and Papers can be accessed via the Committee Secretary.
Minutes and Reporting	A written assurance report will be provided to the Board following each meeting. The Chair of the committee will provide a verbal summary/exception report to the

	Board in respect of meetings held for which minutes have not yet been approved. The Quality Committee will provide an annual Quality Account to the Trust Board.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference.
Agreed by *Quality Committee*	*~~7 March 2024~~8 May 2025*
Date approved by *Trust Board*	*~~27 November 2024~~*
Review Date	*May 2026 ~~March 2025~~*

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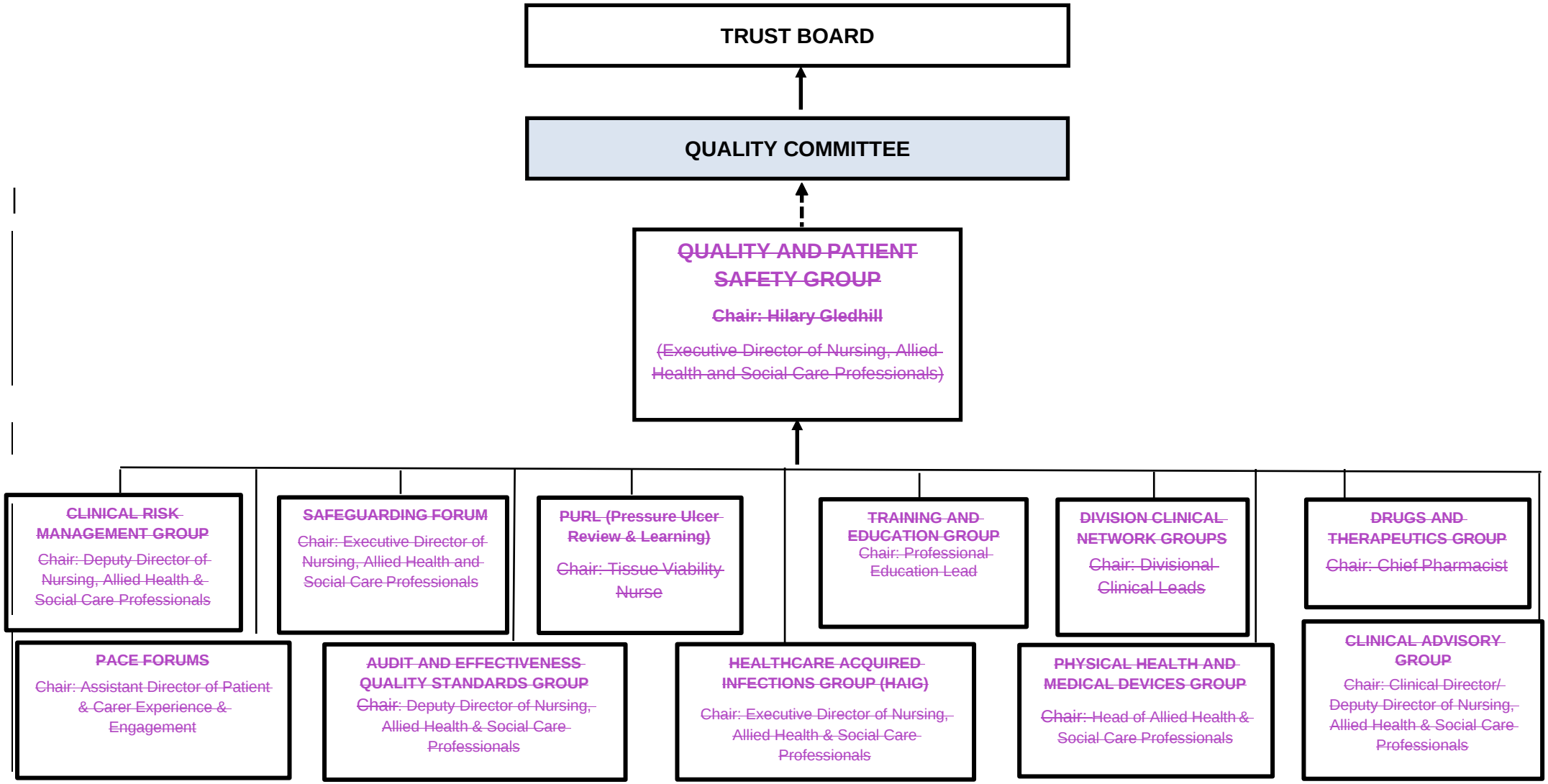
CLINICAL & QUALITY GOVERNANCE REPORTING STRUCTURE



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Remuneration and Nomination Committee

Terms of Reference

Constitution and Authority	The Remuneration and Nomination Committee is constituted as a standing Committee of the Trust's Board of Directors. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Board meetings. The Committee is authorised by the Board to act, in accordance with Standing Orders, Scheme of Delegation and Standing Financial Instructions, and within its Terms of Reference. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its' functions. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
Role / Purpose	To provide a forum for agreement of remuneration and terms of service for Trust Executive's and Trust Very Senior Managers (VSM) in accordance with national requirements.
Scope and Duties	The Remuneration Committee has delegated responsibility for setting remuneration for all Executive Directors (and also for those senior managers on the Very Senior Managers contract of employment) including pension rights and any compensation payments The Remuneration and Nomination Committee's duties are detailed below under the following headings: • National Requirements • Appointments Role • Remuneration Role **National Requirements** The Committee should ensure that any remuneration awards covered within the terms of reference of the committee should be in accordance with national pay guidance in effect at the time of decision making. **Appointments Role** The Committee will: • Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board and make recommendations

	to the Board and Appointment, Terms and Conditions Committee of the Council of Governors, as applicable with regard to any changes • Give full consideration to and make plans for succession planning for the Chief Executive taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future. The same consideration will be given to other Executive Directors on the advice or recommendation of the Chief Executive. • Receive assurance reports from the Chief Executive as required to ensure the executive level leadership needs of the Trust are kept under review to ensure the continued ability of the Trust to operate effectively in the health economy. • It is a requirement of the 2006 Act that the Chair, the other Non-Executive Directors and – except in the case of the appointment of a Chief Executive – the Chief Executive, are responsible for deciding the appointment of Executive Directors. The appointments panel will consist of the Chair and one non-executive director from the Remuneration and Nomination Committee and the Chief Executive, except in the case of the appointment of a Chief Executive. The panel has responsibility for identifying suitable candidates to fill executive director vacancies, including shortlisting, assessment and selection and they make recommendations to the Remuneration and Nomination Committee. • It is for the Non-Executive Directors to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors. The Governors are responsible for the appointment, re-appointment and removal of the Chair and the other Non-Executive Directors. • To approve appointments of all Executive Director positions on the Board determining their remuneration and other terms of service and monitoring their performance. • When appointing the Chief Executive, the Committee shall be the Committee described in Schedule 77, 17(3) of the National Health Service Act 2006 (the Act). When appointing the other Executive Directors the Committee shall be the Committee described in Schedule 7, 17(4) of the Act. • When a Board level Executive vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation ensure that a description of the role and capabilities required for the particular appointment is prepared. In identifying suitable candidates the Committee shall ensure the use of open advertising or the services of external advisers are used to facilitate the search. The Committee will ensure the Trust considers candidates from a wide range of backgrounds and consider candidates on merit against objective criteria. • Ensure that a proposed Executive Director's "other significant commitments" (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise. • Ensure the proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported. • Be advised of and consider any matter relating to the continuation in office of any Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract. • In considering appointments, receive assurance to ensure that all Directors meet the "fit and proper" person test of the general conditions of Monitor's provider licence. • An Appointments Advisory Committee (AAC) will be established by the Trust when required to progress consultant recruitment and appointments.

Consultant appointments will be reported to the public board meeting via the Chief Executive's report.

- Approval of annual Recruitment and Retention payments over £25k (these should not exceed a period of 4 years without review);
- Noting of Recruitment and Retention payments of up to £25k per annum and (these should not exceed a period of 4 years without review).

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Remuneration Role

The Committee will:

- Have delegated responsibility for setting remuneration for all Executive Directors (and also for those senior managers on the Very Senior Managers contract of employment) including pension rights and any compensation payments. Those managers within this definition who are not on the Very Senior Managers Contract or Executive Directors are on national pay and terms and conditions and their posts are subject to job evaluation in line with the national scheme. *NB: The rights of all staff on the VSM contract who are in the NHS pension are bound by the national pension rules.*
- To receive proposals from the Chief Executive relating to the remuneration of the other Executives.
- In accordance with relevant laws, regulations, Trust policies and Standing Financial Instructions (SFIs) decide and keep under review the terms and conditions of office of the Executive Directors and those senior managers on the Very Senior` Managers contract of employment, including:
    - Salary, including any performance related pay or bonus.
    - Provision for other benefits, including pensions and cars *NB rights of all staff on the VSM contract who are in the NHS pension are bound by the national pension rules.*
    - Allowances.
    - Payable expenses.
    - Compensation payments.

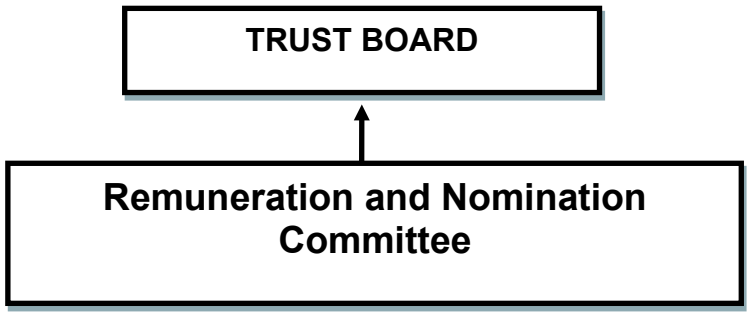
In adhering to all relevant laws, regulations and Trust policies:

- Approve levels or remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the Trust successfully without paying more than is necessary for this purpose, and at a level which is affordable to the Trust.
- Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors (including senior managers on the Very Senior Managers contract of employment) while ensuring that increases are not made where Trust or individual performance do not justify them.
- Be sensitive to pay and employment conditions elsewhere in the Trust.
- Monitor and assess the output of the evaluation of the performance of individual executive directors and consider this output when reviewing changes to remuneration levels.
- Advise upon and oversee contractual arrangements for Executive Directors (including senior managers on the Very Senior Managers contract of employment) including but not limited to termination payments to avoid rewarding poor performance.
- In accordance with Trust Standing Orders the Committee will be informed of all recruitment of retention premia awarded by the Chief Executive to any member

	of staff not covered by Agenda for Change where there are national recruitment and retention pressures (for example medical consultants). The Committee will be required to approve any recruitment and retention premia over £25,000 • To receive a report from the Chair on the objectives and performance of the Chief Executive. • To receive a report from the Chief Executive on the objectives and performance of the Executive Directors and senior managers on the Very Senior Managers contract of employment. • ***To approve any special severance payments in accordance with HM Treasury guidance***
Membership	The membership of the Committee shall consist of all Non-Executive Directors (including the Chair). Only members of the Committee have the right to attend Committee meetings. When discussing matters relating to the Executive Directors other than the Chief Executive, the Chief Executive shall attend the Committee. At the invitation of the Committee, meetings shall normally be attended by the Associate Director of People and Organisational Development. Other persons may be invited by the Committee to attend a meeting to assist in deliberations. Any non-member, including the Secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.
Quorum	The Committee shall be deemed quorate if there is representation of a minimum of two Non-Executive Directors plus the Chair (or person deputising for the Chair). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.
Chair	The Trust Chair shall chair the Committee.
Frequency of Meetings	Meetings shall be held not less than twice a year and at such other times as the Chair of the Committee shall require.
Agenda and Papers	The Board Support Unit Manager shall be the Secretary to the Committee and prepare and distribute papers and keep minutes of the Committee.
Minutes and Reporting	Formal minutes shall be taken of all Committee meetings. An assurance report summarising key discussions and decisions will be presented to the Board of Directors following each meeting.
Monitoring and Review	**The Committee shall monitor and review its performance through** • An annual effectiveness review against its terms of reference. The annual effectiveness review will be provided to the Board of Directors. • The Terms of Reference of the Committee shall be reviewed annually.

Agreed by Committee	30 April 2025
Board Approved	30 July 2025
Review Date	April 2026

REMUNERATION AND NOMINATION COMMITTEE REPORTING STRUCTURE



Humber Teaching NHS Foundation Trust

Agenda Item 16

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting – 28 May 2025</td></tr>
<tr><td>Title of Report:</td><td>Trust Compliance with the Fit and Proper Person Test Framework 2024/25</td></tr>
<tr><td>Author/s:</td><td>Caroline Flint
Trust Chair

Stella Jackson
Head of Corporate Affairs</td></tr>
<tr><td>Recommendation:</td><td><table>
<tr><td>To approve</td><td></td><td>To discuss</td><td></td></tr>
<tr><td>To note</td><td>✓</td><td>To ratify</td><td></td></tr>
<tr><td>For assurance</td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Purpose of Paper:</td><td>The Board is asked to note:

• The Trust's compliance with the Fit and Proper Person Test Framework requirements.
• All members of the Board (voting and non-voting) continue to be fit and proper.
• The outcomes of the FPPT Framework assessments will be shared with the Council of Governors.
• The annual declaration will be forwarded to NHS England by 30 June 2025 in accordance with Framework requirements.</td></tr>
<tr><td colspan="2">Key Issues within the report:</td></tr>
<tr><td>Positive Assurances to Provide:
• The Trust continues to comply with the Fit and Proper Person Test requirements.
• The Trust has a robust process in place to ensure those people undertaking Board level roles at the Trust are fit and proper.</td><td>Key Actions Commissioned/Work Underway:
• Some learning/areas for improvement were identified regarding the completion of the 2023/24 annual checks and these were addressed for the 2024/25 checks (mainly relating to logging in issues).</td></tr>
<tr><td>Key Risks/Areas of Focus:
No matters to escalate</td><td>Decisions Made:
• N/A</td></tr>
</table>

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Governance:		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		Workforce & Organisational Development Committee	
	Finance & Investment Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail) Board report	

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership and alliances
	Developing an effective and empowered workforce
√	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Trust Compliance with the Fit and Proper Persons Test Framework 2024/25

1. Introduction

The Kark Review (2019) was commissioned by the Government in July 2018 to review the scope, operation and purpose of the Fit and Proper Person Test (FPPT) as it applied under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The review highlighted areas that needed improvement to strengthen the existing regime and a Fit and Proper Person Test Framework was developed and launched by NHS England which NHS organisations are required to abide by.

The Framework is applicable to anyone undertaking Board level roles including Executive Directors, Non-Executive Directors, Associate Non-Executive Directors and Associate Directors. Organisations are able to extend the assessment to other key roles, for example, to those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions. The assessment has, therefore, also been undertaken for the Head of Corporate Affairs but the annual submission requirement is limited to Board members only.

The regulations (Section 1, Paragraph 5, or 'Regulation 5' as CQC refers to them in its guidance) place a duty on trusts to ensure that their directors, as defined above, are compliant with the FPPT.

According to the regulations, trusts must not appoint a person to an executive or non-executive director level post unless they meet the following criteria:

- are of good character
- have the necessary qualifications, competence, skills and experience
- are able to perform the work that they are employed for after reasonable adjustments are made
- have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity
- can supply information as set out in Schedule 3 of the Regulations

While it is the Trust's duty to ensure that it has fit and proper directors in post, the CQC has the power to take enforcement action against the Trust if it considers that the Trust has not complied with the requirements of the FPPT. This may come about if concerns are raised to CQC about an individual or during the annual well-led review of the appropriate procedures.

The Trust Chair is responsible for ensuring that the Trust conducts and keeps under review a FPPT to ensure board members are, and remain, suitable for their role.

2. Trust Position

The Trust has a robust system, managed by the Head of Corporate Affairs, to ensure FPPT's are undertaken for those people undertaking Board levels roles on appointment and on an annual basis. This includes ensuring any identified issues are escalated, that the Board and Council of Governors are informed of the outcome of the checks undertaken and that declarations are made in accordance with the framework requirements.

3. Compliance

Annual declarations were requested and provided by all Board members for 2024/25 (the checks undertaken for the Director of Nursing, Allied Health and Social Care Professionals was undertaken at recruitment and not repeated as part of the annul checks due to the recency of the checks and appointment) and the Chair concluded all remained fit and proper and that a robust process had been followed. The Senior Independent Director (SID) concluded the Chair was fit and proper.

An external company was commissioned to undertake a number of the checks, but DBS checks continue to be undertaken in-house in accordance with company policy.

The outcome of the checks and supporting evidence were documented on a checklist for each Board member. The checklist template in Appendix 7 of the Fit and Proper Person Test Framework (below) was completed for each person that the FPPT was undertaken for.

4. Recommendation

The Board is asked to note:

- The Trust's compliance with the Fit and Proper Person Test Framework requirements.
- All members of the Board (voting and non-voting) continue to be fit and proper.
- The outcomes of the FPPT Framework assessments will be shared with the Council of Governors
- The annual declaration will be forwarded to NHS England by 30 June 2024 in accordance with Framework requirements.

Appendix 7: FPPT checklist

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
First Name				x – unless change			Application and recruitment process.	Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / InterAuthority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second Name/Surname				x – unless change				
Organisation (ie current employer)		x		N/A				
Staff Group		x		x – unless change				
Job Title Current Job Description				x – unless change				
Occupation Code		x		x – unless change				
Position Title		x		x – unless change				
Employment History Including: • job titles • organisation/ departments • dates and role descriptions • gaps in employment		x		x			Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Training and Development						*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, eg clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (eg professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers				x			Recruitment process	Including references where the individual resigned or retired from a previous role

Last Appraisal and Date						*	Recruitment process and annual update following appraisal	* For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Disciplinary Findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement							Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance against the board member								
Whistleblowing claim(s) against the board member								
Behaviour not in accordance with organisational values and behaviours or related local policies								

Type of DBS Disclosed							ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.
Date DBS Received							ESR	
Date of Medical Clearance* (including confirmation of OHA)		x		x – unless change			Local arrangements	
Date of Professional Register Check (eg membership of professional bodies)		x				x	Eg NMC, GMC, accountancy bodies.	
Settlement Agreements							Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Insolvency Check							Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register Check							Companies House	

Disqualification from being a Charity Trustee Check							Charities Commission	
Employment Tribunal Judgement Check							Employment Tribunal Decisions	
Social Media Check							Various – Google, Facebook, Instagram, etc.	
Self-Attestation Form Signed							Template self-attestation form	Appendix 3 in Framework
Sign-off by Chair/CEO		x					ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.
Other Templates to be Completed								
Board Member Reference			x	x			Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday whichever latest. Appendix 2 in Framework.
Letter of Confirmation	x						Template	For joint appointments only - Appendix 4 in Framework.
Annual Submission Form	x						Template	Annual summary to Regional Director - Appendix 5 in Framework.
FPPT Area	**Record in ESR**	**Local evidence folder**	**Recruitment Test**	**Annual Test**	**ED**	**NED**	**Source**	**Notes**

Privacy Notice	x		x	x			Template	Board members should be made aware of the proposed use of their data for FPPT – Example in Appendix 6.

NHS
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Agenda Item 17

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Insightful Board
Author/s:	Sarah Smyth Executive Director of Nursing, Allied Health and Social Care Professionals Stella Jackson Head of Corporate Affairs
Recommendation:	

To approve		To discuss	
To note	✓	To ratify	
For assurance			

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	Trust Board is asked to note this update regarding the work being undertaken by the Trust in response to the publication of the Insightful Board guidance.

Key Issues within the report:

Positive Assurances to Provide: • The Board can demonstrate good governance arrangements against many of the areas in the guidance. • An Insightful Board briefing has taken place with senior managers at the Trust, particularly regarding the quality of information provision. • The Board considered the guidance at the Strategic Board Development meeting held on 25 February 2025 and agreed the Committees should seek assurance regarding the relevant sub-sections/domains within the guide.	**Key Actions Commissioned/Work Underway:** • The domain areas have been assigned to the relevant committees for consideration.
Key Points/Risks: • N/A	**Decisions Made:** • Trust Board agreed the Committees should seek assurance regarding the relevant sub-sections within the guide.

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail)	EMT/ODG Time Out 28.11.24 Trust Board 25.2.25

Caring, Learning
& Growing Together

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership, and alliances
√	Developing an effective and empowered workforce
√	Maximising an efficient and sustainable organisation
√	Promoting people, communities, and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Insightful Board Update

1. Introduction

On Tuesday 12 November NHS England (NHSE) published The Insightful Provider Board. This non-mandatory guidance aims to support provider boards to turn data into useful insight. Effective governance practice around board reporting and assurance-seeking is also considered. Suggested measures are incorporated into the guidance that boards might wish to consider using for planning, monitoring, and seeking assurance about progress.

The guidance aims to properly equip boards, making sure they have got the right information at the right time, and can use it in the right way to both lead and track improvement, as well as respond quickly to problems.

The guidance is in three sections covering:

- The board's role in governance and organisational culture
- Suggestions for ensuring that information boards receive, and review is meaningful.
- Domains for consideration by boards, with related key questions they might wish to consider, and measures and indicators that might enable them to gain adequate assurance about performance.

2. Trust's Response

Senior managers at the Trust received a briefing regarding the guidance (and in particular the information regarding the quality of information provision) at an Executive Management Team/Operational Delivery Group Time Out meeting held on 28 November 2024.

The Board subsequently considered the guidance at a Strategic Board Development meeting held on 25 February 2025 and agreed the committees should review the relevant questions and measures detailed within the six domain areas and, in doing so, consider whether there is any more the Trust should be doing to monitor and gain assurance. This review has been timetabled into relevant Committee work plans.

A paper regarding compliance against the best practice within the Strategy section of the guidance will be forwarded to July Board, as will an update regarding the reviews being undertaken at committee level.

3. Recommendations

The Trust Board is asked to note this update regarding the work being undertaken by the Trust in response to the publication of the Insightful Board guidance.

Humber Teaching NHS Foundation Trust

Agenda Item 18

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Finance Report April 2025
Author/s:	Name: Peter Beckwith Title: Director of Finance
Recommendation:	To approve: ; To discuss: ; To note: ✓ ; To ratify: ; For assurance:
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	This report is being brought to the Trust Board to provide the financial position for the Trust as at the 30th April 2025 (Month 1). The report provides assurance regarding financial performance, key financial targets and objectives.

Key Issues within the report:

Positive Assurances to Provide: • At Month 1 a financial position consistent with the Trust plan has been recorded • Cash balance at the end of April was £18.395m.	**Key Actions Commissioned/Work Underway:** • Work on year end accounts is ongoing.
Key Risks/Area of Focus: • None.	**Decisions Made:** • The Trust Board are asked to note the Finance report for April 2025, and comment accordingly.

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

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

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*				
√ *Tick those that apply*				
	Innovating Quality and Patient Safety			
	Enhancing prevention, wellbeing and recovery			
	Fostering integration, partnership and alliances			
	Developing an effective and empowered workforce			
	Maximising an efficient and sustainable organisation			
	Promoting people, communities and social values			
Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

FINANCE REPORT – April 2025

1. Introduction

This report is being circulated to the Trust Board to present the financial position for the Trust as at the 30th April 2025 (Month 1). The report provides assurance regarding financial performance, key financial targets and objectives.

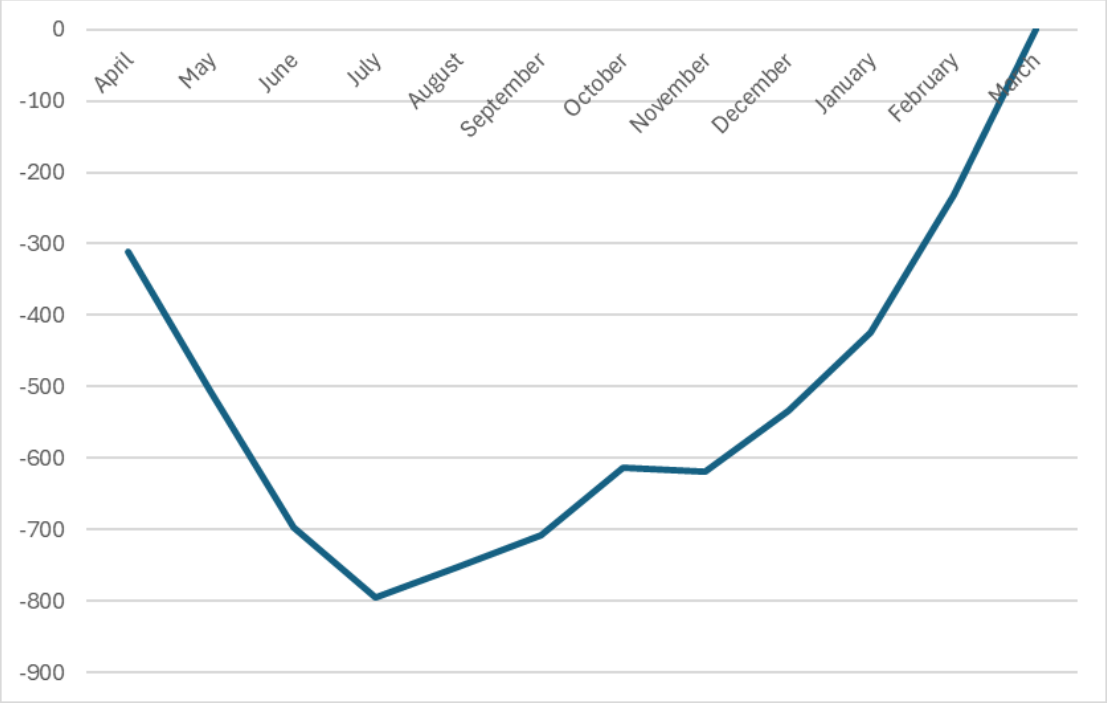
The Trust Board are asked to note the financial position for the Trust and raise any queries, concerns or points of clarification.

2. Background and Month 1 Position

The Trust has submitted a break-even plan for 2025/26, and a budget consistent with the financial plan has been uploaded onto the Trust Ledger.

A monthly profile has been included, reflective of timing of efficiency programmes, the cumulative monthly profile has a cumulative deficit position of £0.8m by July, returning to break even by the end of the year (as per the profile below).

Table 1: Agency Target Spend by Staff Group



There are no formal reporting requirements to NHSE at Month 1 due to year end accounting priorities.

As at the end of Month 1 the Trust has recorded a position consistent with the profiled plan, this was a deficit position of £0.312m, future reports to the board will focus on the forecast outturn position.

3. Pay Award

The current financial position reflects pay award funding of 2.8% which is consistent with the plan submission and the planning guidance.

4. Agency

An agency expenditure target has been set for 2025/26 at £3.209m, this represents a reduction in expenditure of 41% from 2024/25 Outturn.

Table 2: Agency Target Spend by Staff Group

Division	Actual £	Reduction £	Target £
CHILDRENS AND LD	1,132,289	467,404	664,886
COMMUNITY & PRIMARY CARE	178,519	73,692	104,827
MENTAL HEALTH	3,641,527	1,503,205	2,138,322
SECURE SERVICES	498,772	205,891	292,881
CORPORATE	14,071	5,809	8,263
Total	5,465,179	2,256,000	3,209,179

The current target means that agency expenditure will account for 1.8% of the total pay costs of the Trust.

5. Cash

As at the end of April 2025 the Trust held £18.395m in its Cash Balances.

6. Better Payment Practice Code

Under the Better Payment Practice Code (BPPC) the Trust has a target to pay 95% of undisputed invoices on time.

The current BPPC performance figures are shown in Table 3 below, work continues to maintain this level of performance.

Table 3:

Better Payment Practice Code

Better Payment Practice Code	YTD Number	YTD £'000
NON NHS		
Total bills paid	2,090	9,840
Total bills paid within target	2,051	9,734
Percentage of bills paid within target	**98.1%**	**98.9%**
NHS		
Total bills paid	122	2,010
Total bills paid within target	109	1,717
Percentage of bills paid within target	**89.3%**	**85.4%**
TOTAL		
Total bills paid	2,212	11,851
Total bills paid within target	2,160	11,451
Percentage of bills paid within target	**97.6%**	**96.6%**

7. Recommendations

The Trust Board are asked to note the Finance report for April 2025, and comment accordingly.

Humber Teaching NHS Foundation Trust

Agenda Item 19

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Trust Performance Report – April 2025
Author/s:	Name: Peter Beckwith/Richard Voakes Title: Director of Finance/Business Intelligence Lead
Recommendation:	To approve: ☐ To receive & discuss: ☐ For information/To note: ☑ To ratify: ☐
Purpose of Paper: ***Please make any decisions required of Board clear in this section:***	This purpose of this report is to inform on the current levels of performance as at the end of April 2025. The report is presented using statistical process charts (SPC) for a select number of indicators with upper and lower control limits resented in graphical format. Long Term Plan performance dashboard is attached at appendix B (this report has been updated to reflect measures applicable to the Trust).

Key Issues within the report:

Positive Assurances to Provide:

- Mandatory Training – the Trust continues to maintained a strong position against the Trust target of 85%, reporting current compliance at 94.3%
- The overall trust vacancy position is 7.0%.
- Clinical Supervision continues to perform above target, in month performance was recorded at 91.8%.
- Turnover continues to demonstrate an improving position, with the Trust currently at the target of 10%
- Virtual Ward occupancy was recorded at 79.1% in Month.

Key Actions Commissioned/Work Underway:

- Work to improve the recording of contacts following the change of system is taking place through the EPR optimisation group.
- In response to the high levels of sickness absence reported in inpatient areas, a bespoke targeted intervention is being delivered collaboratively between operational areas and the People team, across five inpatient settings. This work is being reported into EMT and the People & OD Committee. This is being reviewed in relation to the Trust Wide Risk Register
- Operational Delivery Group and Executive Management Team continue to oversee the waiting times position with targeted work across all services that are challenged by meeting over 52 week and 18 week waiting time standards. This work is underpinned by capacity and demand analysis which is refreshed on a regular basis. We are awaiting the planning guidance for 2025/26 but the work on capacity and demand will continue to inform the operational planning

	discussions taking place with commissioners.
Matters of Concern or Key Risks: • Sickness absence has continued to be above target, with specific work undertaken to focus on inpatient sickness absence which is showing the highest prevalence of sickness. • Safer Staffing Dashboard – there are no units with 5 or more Red flags however 14 units are flagging red for sickness - The number of units with sickness rates above 10% has decreased further from 8 in February to 5 in March. • Waiting times for children's neurodiversity services continues to be the most significant area of pressure and challenge. • Inappropriate MH Out of Area Placements has improved but continues to be monitored, and solutions are being actively progressed to reduce usage. • Perinatal access - the service is currently achieving 8.2% of the birth rate when compared to the target of 8.6%, 2 of the 4 areas are below target for the reporting period • Memory Assessment waiting times are deteriorating for both 18 and 52 ww due to staffing pressures	**Decisions Made:** • None (report is to note)

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

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

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership and alliances
	Developing an effective and empowered workforce
	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Financial Year
2025-26

Humber Teaching
NHS Foundation Trust

TRUST PERFORMANCE REPORT

This document provides a high level summary of the performance measures stemming from the Integrated Quality and Performance Tracker.

The purpose of this report is to present to the Board a thematic review of the performance for a select number of indicators for the last 24 months including Statistical Process Control charts (SPC) with upper and lower control limits.

Reporting Month:
Apr-25

Chief Executive: Michele Moran

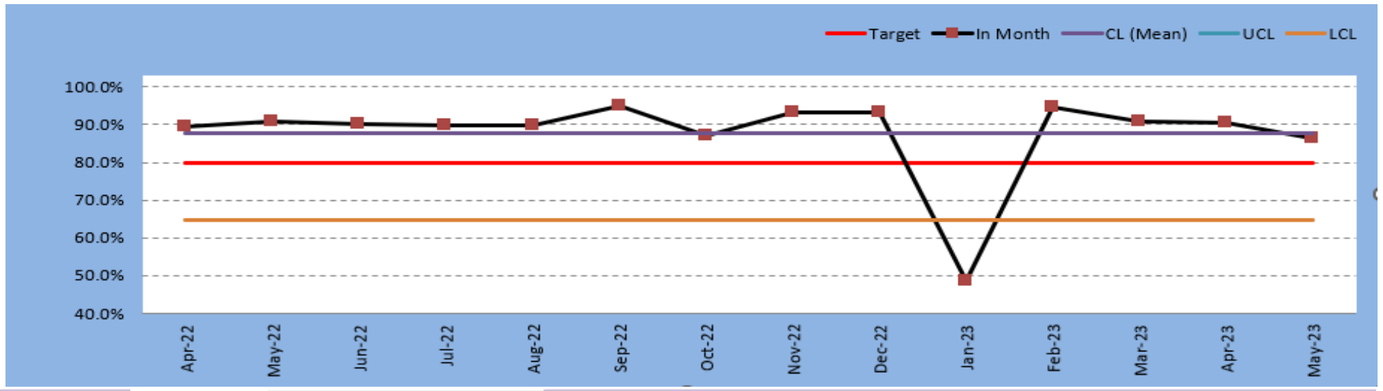
Prepared by: Business Intelligence Team

Humber Teaching NHS Foundation Trust

Trust Performance Report

For the period ending:	April 2025

Purpose	This paper provides a summary on the progress being made against a basket of NHS performance indicators together with executive summary and underpin the Trust's Strategy 2017-2022. A sample of the strategic goals are represented in this report. Particular attention is drawn to the use of Statistical Process Control Charts (SPC).
What are SPCs?	SPCs contain upper and lower control limits which are in the most part based on 2 standard deviation points above and below the average. SPC averages are best plotted over a minimum of 12 data points. The majority of charts, if not all, within the TPR are based over 24 data points and include targets where these have been set. The charts can help us understand the scale of any problem, gather information and identify possible causes when used in conjunction with other investigative tools such as process mapping. SPC tells us about the variation that exists in the systems that we are looking to improve. SPCs should be used to help to set baselines and evaluate how we are currently operating within these thresholds. They can also help us to assess whether service changes have made a sustainable difference. They give an indication as to whether there is relatively stable variation over time or whether there are special causes creating exceptional variance. This is done by analysing the chart looking at how the values fall around the average and between or outside the Upper Control Limit (UCL) and the Lower Control Limit (LCL). These lines fall either side of the mean/average. They do not indicate whether the indicator is achieving the target that has been set, but they allow us to better understand how stable the performance is and whether or not it is changing. Attention would be specifically drawn to peaks and troughs outside of the control limits and initiate further investigation as to what the causes of these may be. SPCs are not always useful with low numbers, short periods of time or where data would normally be expected to be more erratic or seasonal unless this is plotted over a substantial amount of time. An example of an SPC chart with an exception is below:
Example SPC Chart	S – statistical, because we use some statistical concepts to help us understand processes. P – process, because we deliver our work through processes ie how we do things. C – control, by this we mean predictable.



Strategic Goal 1	Innovating Quality and Patient Safety	**Strategic Goal 4**	Developing an effective and empowered workforce
Strategic Goal 2	Enhancing prevention, wellbeing and recovery	**Strategic Goal 5**	Maximising an efficient and sustainable organisation
Strategic Goal 3	Fostering integration, partnership and alliances	**Strategic Goal 6**	Promoting people, communities and social values

Key Indicators	The following is a list of indicators highlighted within this report and the Goal to which they are set against. Other than the Safer Staffing dashboard, each indicator uses SPC charts

Humber Teaching NHS Foundation Trust

Trust Performance Report

For the period ending: **April 2025**

Dashboard	Safer Staffing	A dashboard to provide overview on a number of clinical indicators for the Trust's inpatient units across all services
Dashboard	Mortality	Learning from Mortality Reviews
Goal 1	Mandatory Training	A percentage compliance for all mandatory and statutory courses
Goal 1	Vacancies	Proportion of posts vacant when compared to the budgeted establishment. This information is taken from the Trust financial ledger.
Goal 1	Number of Incidents per 10,000 Contacts	Number of Incidents per 10,000 Contacts (based on contacts and occupied bed days)
Goal 1	Clinical Supervision	Percentage of staff with appropriate clinical supervision taken place within the last 4-6 weeks
Goal 1	FFT - Patient Recommendation	Results where patients would recommend the Trust 's services to their family and friends
Goal 2	FFT - Patient Involvement	Results where patients felt they were involved in their care
Goal 2	72 hour follow ups	Percentage of patients who had a follow up within 72 hours (3 days) of discharge from hospital
Goal 2	CPA - Reviews	Percentage of patients who are on CPA and have had a review in the last 12 months
Goal 2	Memory Diagnosis	Number of patients waiting 18 weeks or more since referral to the service
Goal 2	RTT - Completed Pathways	Based on patients who have commenced treatment during the reporting period and seen within 18 weeks of their referral
Goal 2	RTT - Incomplete Pathways	Based on patients who are waiting for assessment and/or treatment and are waiting less than 18 weeks since referral.
Goal 2	RTT - 52 Week Waits	Number of patients who have yet to be seen for treatment and have been waiting more than 52 weeks. (Excludes ASD & ADHD Services for both Adult and Paediatrics)
Goal 2	RTT - 52 Week Waits - Adult Neuro (ASD/ADHD)	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service and ADHD for Adult and have been waiting more than 52 weeks
Goal 2	RTT - 52 Week Waits - CYP Neuro (ASD/ADHD)	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service and ADHD for Children and have been waiting more than 52 weeks
Goal 2	RTT - 52 Week Waits - CAMHS	Number of patients who have yet to receive treatment in CAMHS and have been waiting more than 52 weeks
Goal 2	RTT - Early Interventions	Percentage of patients who were seen within two weeks of referral
Goal 2	NHSER Talking Therapies - 6 and 18 week waits	Percentage of patients who were seen within 6 weeks and 18 weeks of referral

Humber Teaching NHS Foundation Trust

Trust Performance Report

For the period ending: **April 2025**

Goal 2	NHSER Talking Therapies - Moving to Recovery	Recovery Rates for patients who were at caseness at start of therapeutic intervention
Goal 2	CMHT Access (New)	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services for adults and older adults with severe mental illness. Rolling 12 months.
Goal 2	CYP MH Access (New)	Number of CYP aged under 18 accessing support by NHS funded community services and school or college based Mental Health Support Teams (receiving at least one contact). Rolling 12 months. *Includes ADHD but excludes ASD and LD (National guidance)*
Goal 2	Perinatal Access (New)	Number of women with at least one attended contact (F2F or video) with a specialist community perinatal mental health service in the last 12 months.
Goal 2	Liaison 1 hour response	New referrals to liaison psychiatry teams from A&E in the reporting period with first face to face contact within 1 hour
Goal 2	UCR 2 hr response	The percentage of 2-hour Urgent Crisis Response (UCR) referrals that achieved the 2-hour standard in the reporting month
Goal 2	Virtual Ward	Virtual Ward Bed Occupancy Rate
Goal 3	Out of Area Placements	Number of days that Trust patients were placed in out of area wards including split across Adult, Older Adult and PICU
Goal 4	Delayed Transfers of Care	Results for the percentage of Mental Health delayed transfers of care
Goal 4	Staff Sickness	Percentage of staff sickness across the Trust (not including bank staff). Including and Excluding Covid Sickness
Goal 4	Staff Turnover	Percentage of leavers against staff in post (excluding employee transfers wef April 2021)

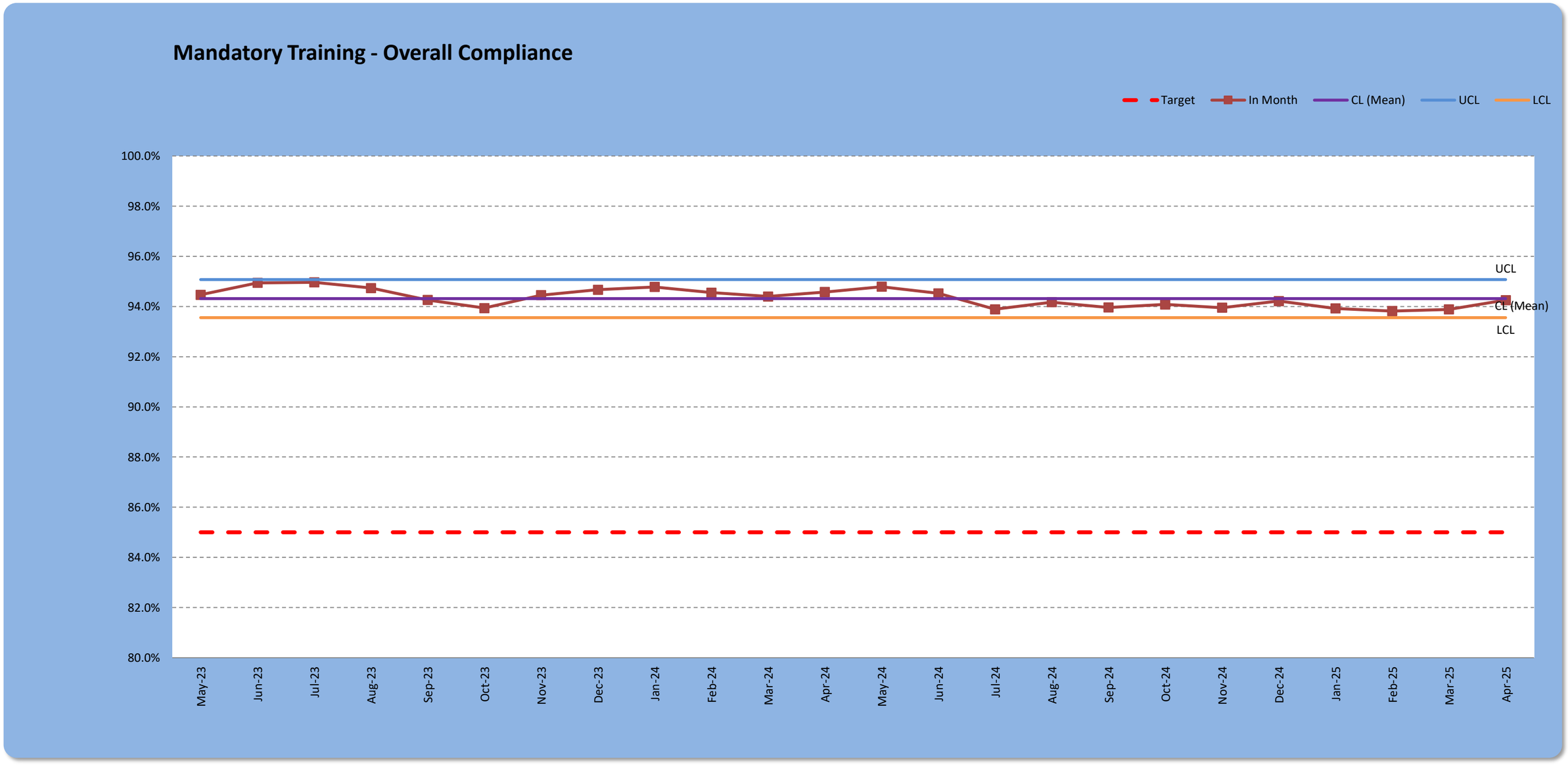
PI RETURN FORM 2025-26

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **April 2025**

Target:	Amber:	Current month stands at:
85%	80%	94.3%

Indicator Title	Description/Rationale		KPI Type
Mandatory Training	A percentage compliance based on an overall target of 85% for all mandatory and statutory courses	Executive Lead Karen Phillips	WL 5



Please refer to the accompanying front sheet/report for any relevant commentary

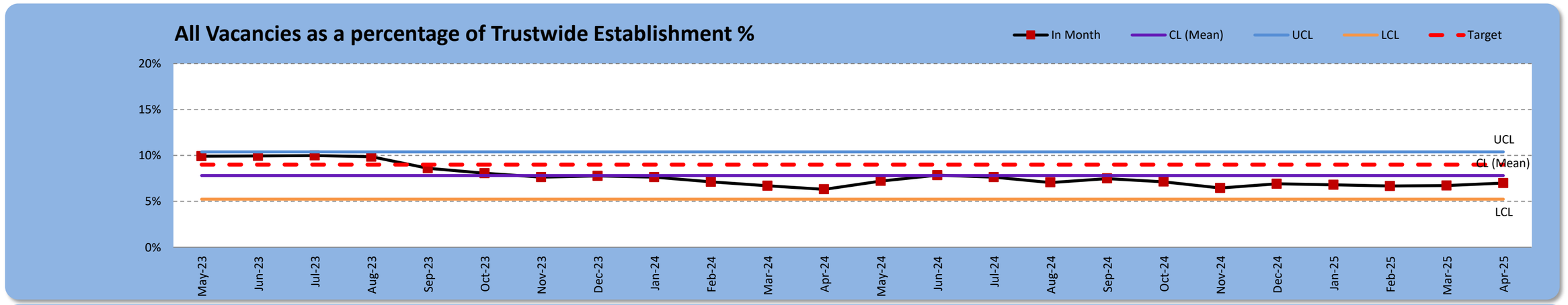
PI RETURN FORM 2025-26

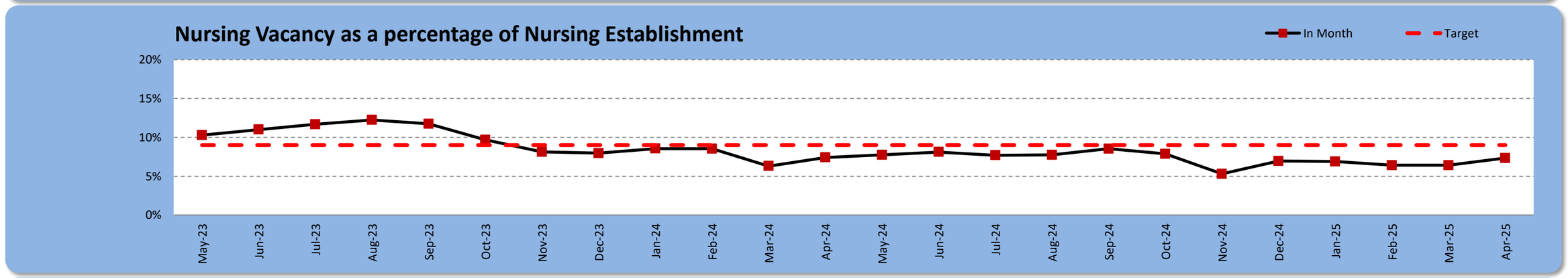
Goal 1 : Innovating Quality and Patient Safety

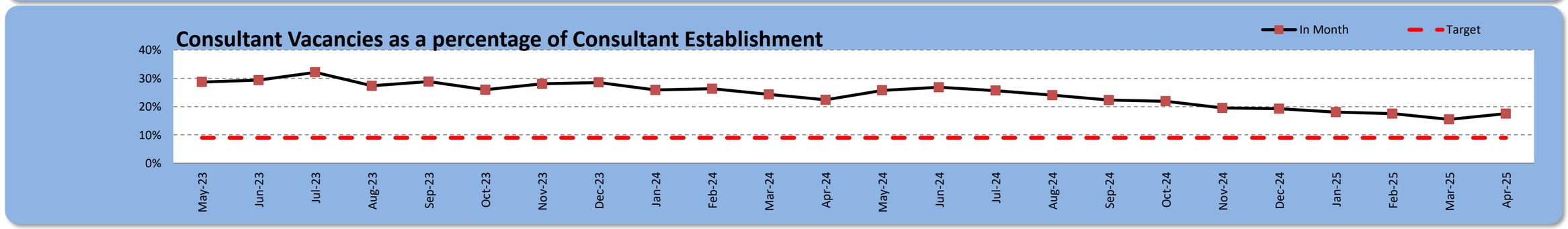
Target:	Amber:	Current month stands at:
N/A	N/A	7.0%

For the period ending: **April 2025**

Indicator Title	Description/Rationale		KPI Type
Vacancies (WTE)	Proportion of posts vacant when compared to the budgeted establishment. This information is taken from the Trust financial ledger.	Executive Lead Karen Phillips	WL 2 VAC







Please refer to the accompanying front sheet/report for any relevant commentary

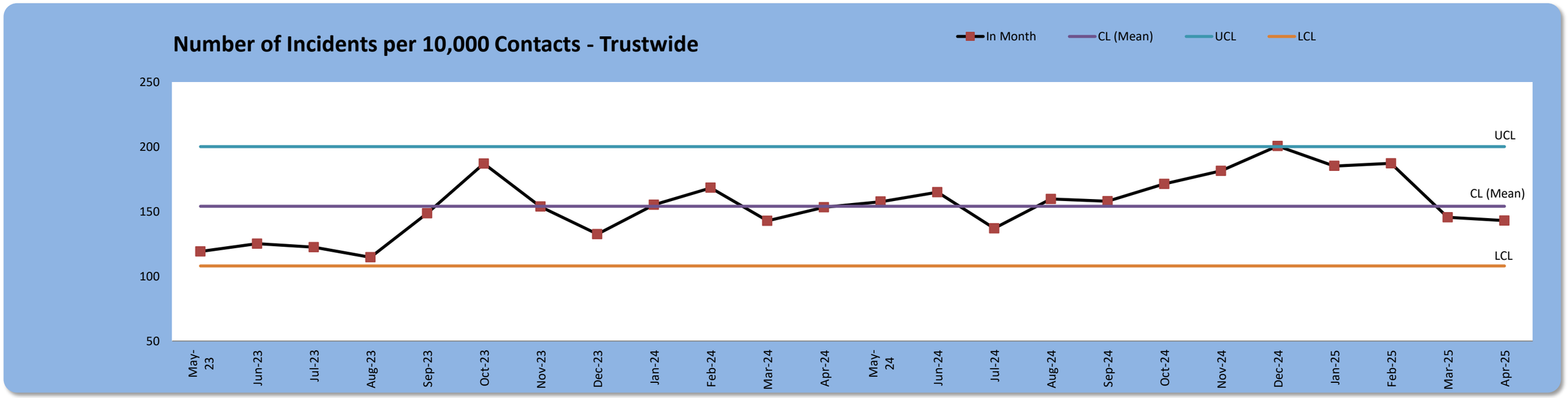
PI RETURN FORM 2025-26

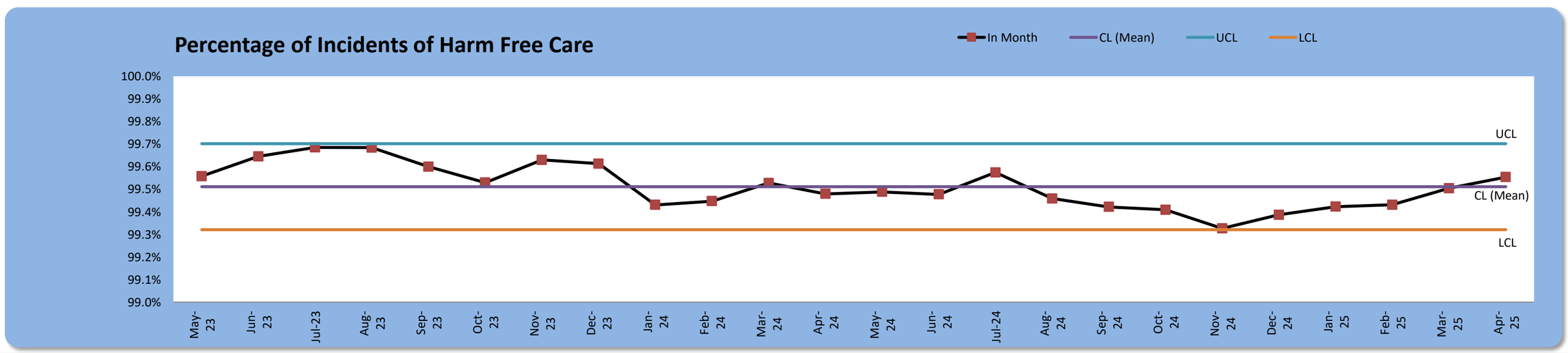
Goal 1 : Innovating Quality and Patient Safety

For the period ending: **April 2025**

Target:	Amber:	Trustwide current month stands at:
0	0	143

Indicator Title	Description/Rationale		KPI Type
Incidents	Number of Incidents per 10,000 Contacts (based on contacts and occupied bed days)	Executive Lead Sarah Smyth	IA_TW





Please refer to the accompanying front sheet/report for any relevant commentary

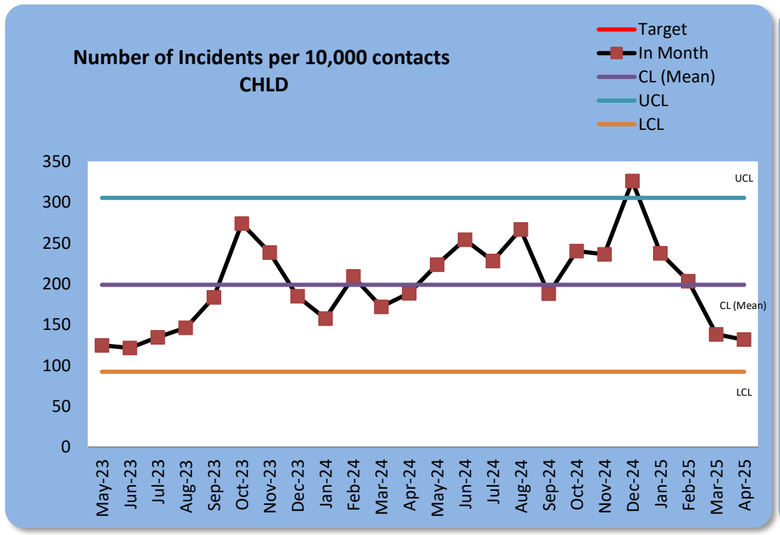
PI RETURN FORM 2025-26

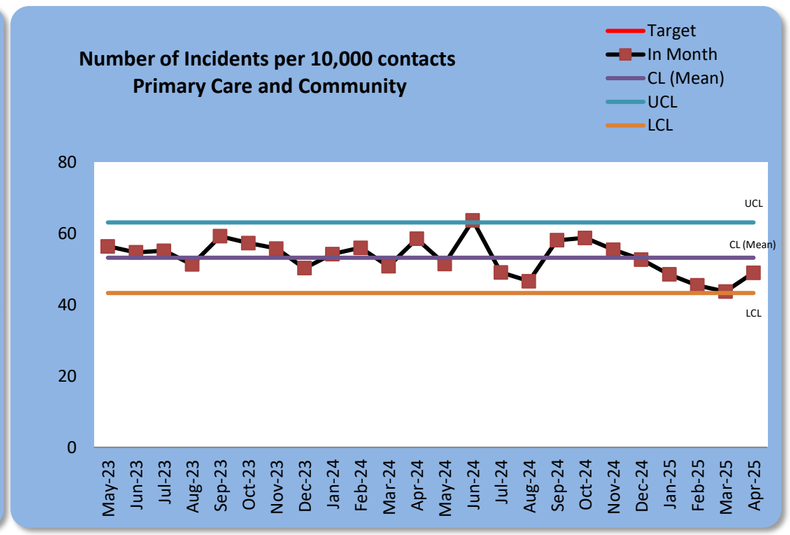
Target:	Amber:	Trustwide current month stands at:
0	0	143

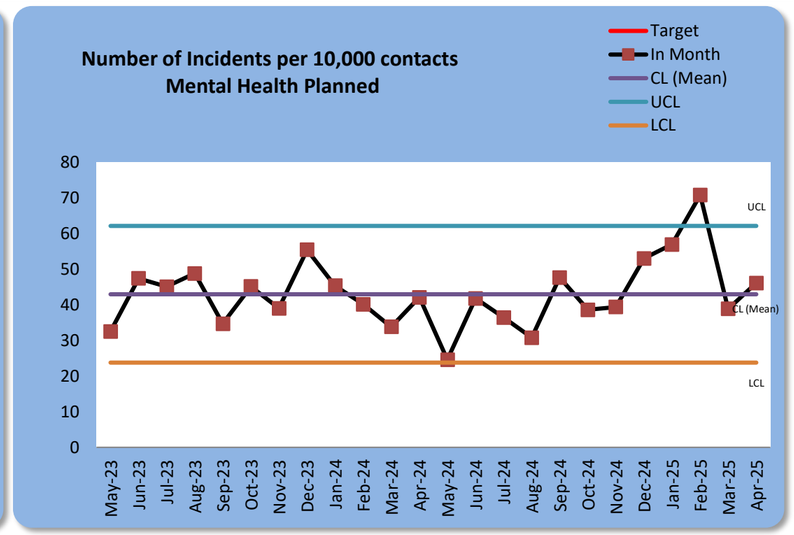
Goal 1 : Innovating Quality and Patient Safety

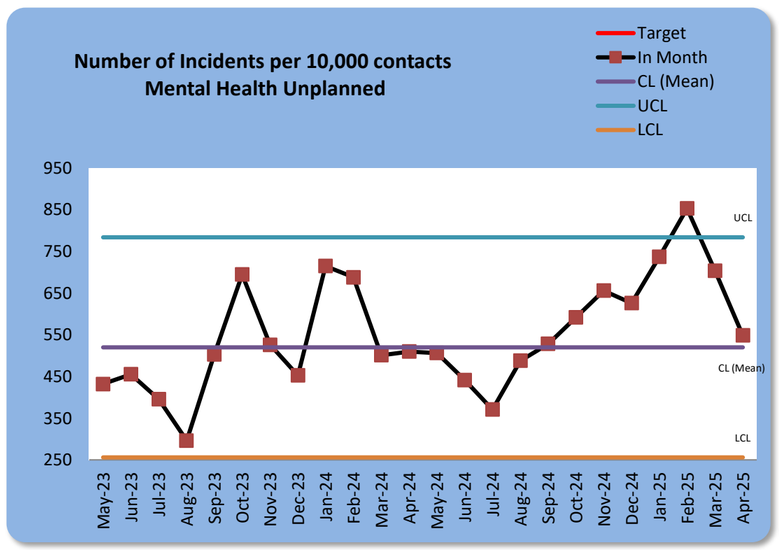
For the period ending: **April 2025**

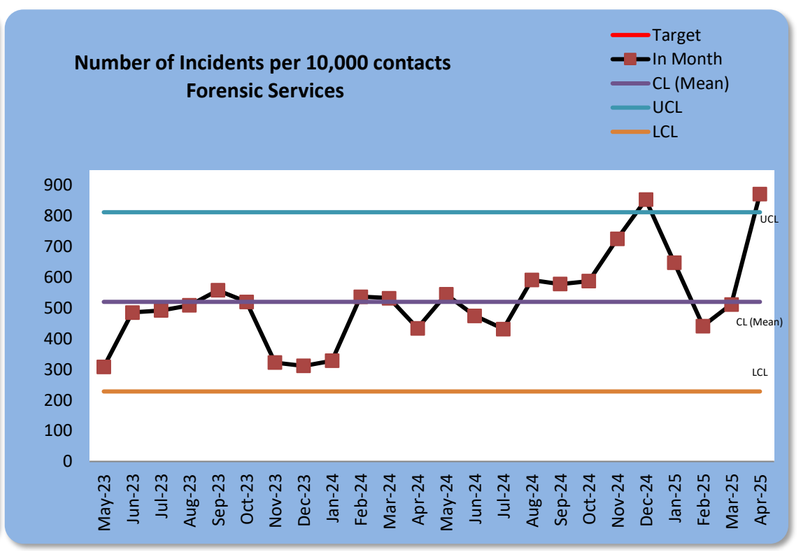
Indicator Title	Description/Rationale		KPI Type
Incidents	Number of Incidents per 10,000 Contacts (based on contacts and occupied bed days)	Executive Lead Sarah Smyth	IA_TW











Current Month per Division

Children and Learning Disability	132
Primary Care and Community	49
Mental Health Planned	46
Mental Health Unplanned	549
Forensic Services	872

Incident Analysis

	Mar-25	Apr-25
Never Events	0	0
% of Harm Free Care	99.5%	99.6%
% of Incidents reported in Severe Harm or Death	0.4%	0.8%

Please refer to the accompanying front sheet/report for any relevant commentary

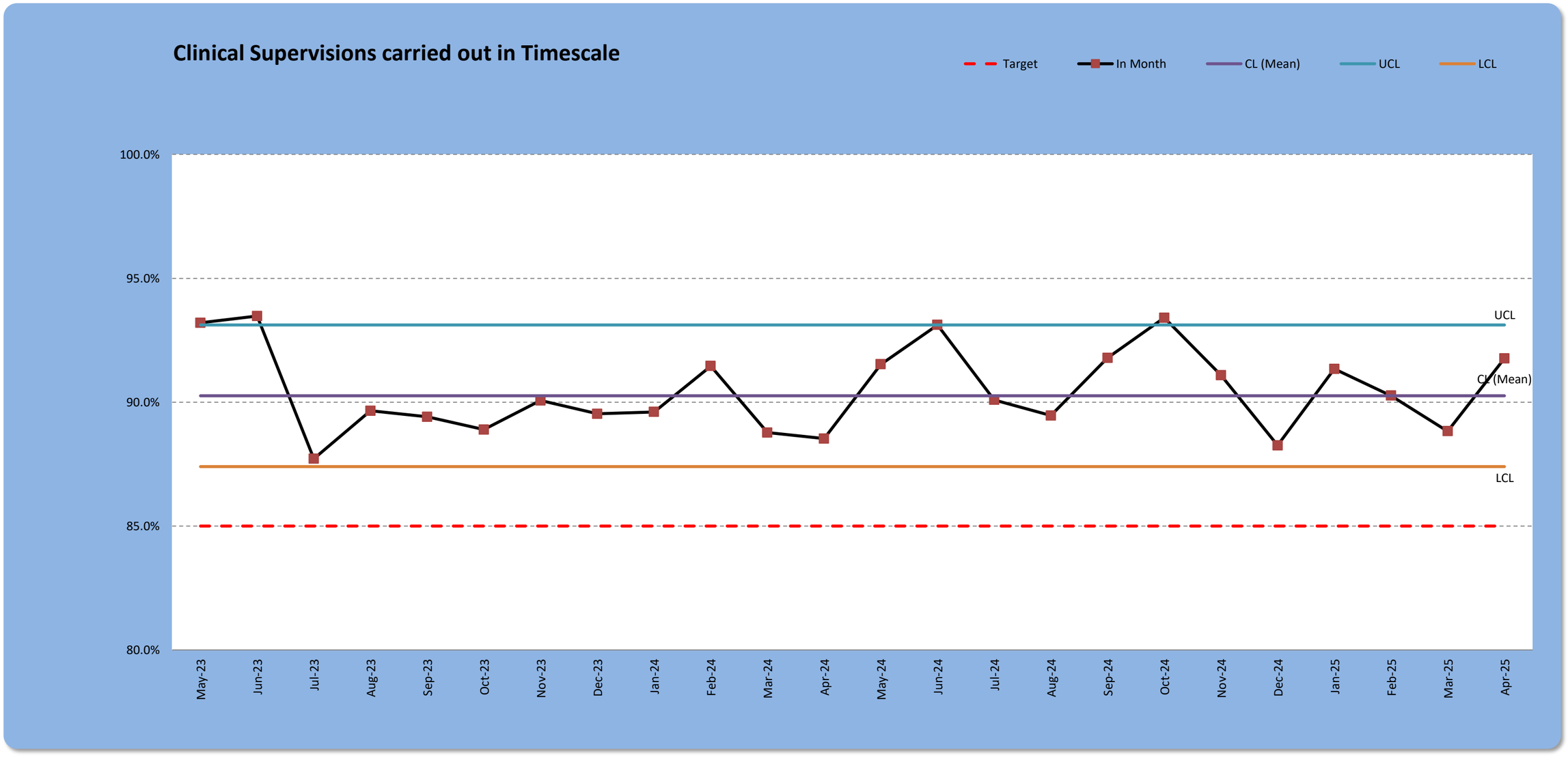
PI RETURN FORM 2025-26

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **April 2025**

Target:	Amber:	Current month stands at:
85%	80%	91.8%

Indicator Title	Description/Rationale		KPI Type
Clinical Supervision	Percentage of staff with appropriate clinical supervision taken place within the last 4-6 weeks	Executive Lead Sarah Smyth	WL 9a



Please refer to the accompanying front sheet/report for any relevant commentary

HUMBER TEACHING NHS FOUNDATION TRUST
SAFER STAFFING INPATIENT DASHBOARD

	Staffing and Quality Indicators
Contract Period:	2024-25
Reporting Month:	Mar-25

NHS Humber Teaching NHS Foundation Trust

Shown one month in arrears

Units							Bank/Agency Hours				Average Safer Staffing Fill Rates				High Level Indicators																				Indicator Totals	
											Day		Night		QUALITY INDICATORS (YTD)																						
Speciality	Ward	Speciality	WTE	OBDs (including leave)		CHPPD Hours (Nurse)	Improvement	Bank % Filled	Improvement	Agency % Filled	Improvement	Registered	Un Registered	Registered	Un Registered	Staffing Incidents (Poor Staffing Levels)	Incidents of Physical Violence / Aggression	Complaints (Upheld/ partly upheld)	Failed S17 Leave	Clinical Supervision		Mandatory Training (ALL)		Mandatory Training (ILS)		Mandatory Training (BLS)		Sickness Levels (clinical)		WTE Vacancies (RNs only)	Feb-25		Mar-25	
Adult MH	Avondale	Adult MH Assessment	31.0	✓	80%	✓ 11.5	↓	22.6%	↓	3.9%	↓	✓ 97%	✓ 115%	✓ 98%	✓ 117%	0	43	5	0	✓	85.3%	✓	93.1%	✓	100.0%	✓	86.7%	✓	1.6%		1.0	✓	0	✓	0
	New Bridges	Adult MH Treatment (M)	39.0	✗	101%	✓ 9.2	↑	37.0%	↓	0.2%	↓	✓ 97%	✓ 131%	✓ 101%	✓ 155%	1	39	4	0	✓	88.9%	✓	95.1%	✓	94.1%	✓	100.0%	✗	7.4%		0.0	✓	1	!	2
	Westlands	Adult MH Treatment (F)	21.7	✗	97%	! 7.4	↑	36.7%	↓	0.6%	↑	✓ 92%	! 81%	! 88%	✓ 107%	2	51	4	0	✗	N/R	✓	90.4%	✓	94.1%	✓	83.3%	✗	7.8%		-0.6	!	3	!	3
	Mill View Court	Adult MH Treatment	33.4	✗	99%	! 7.4	↓	22.3%	↓	2.8%	↓	✓ 98%	✓ 98%	✓ 100%	✓ 100%	4	35	2	0	✓	96.7%	✓	91.3%	✓	88.2%	✓	100.0%	✓	1.6%		1.8	✓	1	✓	1
	STARS	Adult MH Rehabilitation	13.8	✗	97%	✓ 16.7	↓	34.8%	↑	1.4%	↑	✓ 114%	! 82%	✓ 102%	✓ 100%	7	6	1	0	✓	100.0%	✓	94.5%	✓	80.0%	✓	90.0%	✗	6.9%		2.0	!	2	!	2
	PICU	Adult MH Acute Intensive	31.3	✓	74%	✓ 23.3	↑	46.3%	↓	3.1%	↓	✓ 108%	✓ 92%	✓ 94%	✓ 123%	0	110	1	2	!	78.6%	✓	93.0%	✓	93.8%	✓	100.0%	✗	10.6%		1.6	✓	1	✓	1
OP MH	Maister Lodge	Older People Dementia Treatment	35.6	✓	75%	✓ 15.7	↓	34.2%	↓	1.9%	↑	✓ 123%	! 86%	✓ 100%	✓ 125%	4	142	0	0	✗	N/R	✓	91.5%	✓	92.3%	✓	88.0%	✗	9.8%		-0.3	✓	1	!	2
	Mill View Lodge	Older People Treatment	32.1	✗	94%	✓ 12.8	↑	25.8%	↑	3.0%	↑	✗ 69%	! 79%	✓ 100%	✓ 99%	1	26	0	0	✗	69.0%	✓	95.3%	✓	100.0%	✓	90.5%	✗	13.2%		2.0	!	3	!	4
	Maister Court	Older People Treatment	18.4	✗	99%	✓ 15.6	↑	32.2%	↑	0.0%	↑	✓ 124%	✗ 74%	✓ 100%	✓ 103%	0	6	1	0	✓	100.0%	!	82.7%	✗	37.5%	✓	100.0%	✓	2.9%		0.0	!	3	!	3
	Pine View	Forensic Low Secure	29.7	✓	69%	✓ 11.4	↑	30.8%	↑	0.0%	→	✓ 92%	✗ 71%	! 83%	✓ 104%	2	1	0	8	✓	100.0%	✓	93.3%	✓	92.9%	✓	89.5%	✗	10.0%		0.9	!	2	!	2
	Derwent	Forensic Medium Secure	28.7	✓	72%	✓ 16.4	↓	29.9%	↓	0.0%	→	✓ 100%	✗ 75%	✓ 107%	✓ 107%	8	23	0	0	✓	100.0%	✓	95.6%	✓	91.7%	✓	76.5%	✗	7.9%		-0.8	!	2	!	2
	Ouse	Forensic Medium Secure	26.6	✓	86%	✓ 9.7	↓	40.0%	↑	0.0%	→	✓ 93%	✓ 119%	✓ 120%	✓ 164%	5	4	4	0	✓	86.4%	✓	93.8%	✓	90.0%	✓	93.8%	✗	11.6%		-0.8	✓	1	✓	1
	Swale	Personality Disorder Medium Secure	27.5	✗	93%	✓ 9.3	↑	25.5%	↑	0.0%	→	! 76%	✓ 100%	✓ 100%	✓ 93%	3	5	2	0	✓	100.0%	✓	99.0%	✓	100.0%	✓	89.5%	✓	2.4%		2.0	✓	0	✓	1
	Ullswater (10 Beds)	Learning Disability Medium Secure	30.2	!	90%	✓ 14.3	↓	35.4%	↑	0.0%	→	✓ 102%	✓ 128%	✓ 105%	✓ 132%	3	42	1	2	✓	92.9%	✓	93.8%	✓	90.9%	!	73.7%	✗	16.0%		-0.7	✓	1	✓	1
Child & LD	Townend Court	Learning Disability	43.4	✓	43%	✓ 32.7	↑	29.8%	↓	4.9%	↓	✗ 47%	! 82%	✓ 97%	! 89%	7	623	1	0	✓	85.0%	✓	94.5%	✓	90.0%	✓	87.5%	✗	9.0%		2.4	!	2	!	2
	Inspire	CAMHS	49.0	✓	84%	✓ 30.3	↓	19.9%	↓	0.0%	→	✓ 99%	✓ 117%	✓ 97%	✓ 128%	1	19	0	0	✗	75.0%	✓	91.4%	✓	75.0%	✓	89.7%	!	4.8%		-2.0	!	2	✓	1
	Granville Court	Learning Disability Nursing Care	54.3	✓	71%	✓ 18.6	↓	27.0%	↓	0.0%	→	✓ 110%	! 88%	✓ 118%	✓ 104%	0	2	0	0	!	81.5%	✓	97.5%	!	71.4%	✓	97.5%	✗	10.6%		-2.4	✓	1	✓	1
CH	Whitby Hospital	Physical Health Community Hospital	29.9	✓	82%	✓ 8.5	↑	11.4%	↓	0.0%	→	! 82%	✗ 73%	✓ 98%	✓ 100%	9	1	0	0	✓	94.7%	✓	90.6%	✓	87.5%	!	73.7%	✗	6.5%		1.3	!	2	!	2
	Malton Hospital	Physical Health Community Hospital	30.4	✓	83%	! 7.1	↑	22.7%	↑	0.0%	→	! 84%	! 79%	✓ 118%	✗ 71%	3	2	1	0	✓	100.0%	✓	88.1%	!	70.6%	✗	56.3%	✗	7.6%		0.7	✓	0	!	3

Key			
	✓ Target met	! Within 5% of target	✗ Target not met

HUMBER TEACHING NHS FOUNDATION TRUST
SAFER STAFFING INPATIENT DASHBOARD

	Staffing and Quality Indicators
Contract Period:	2024-25
Reporting Month:	Mar-25

Humber Teaching NHS Foundation Trust

Exception Reporting and Operational Commentary

Safer Staffing Dashboard Narrative : Mar

14 units are flagging red for sickness in March, which remains the same as February however down from 17 in January.

The number of units with sickness rates above 10% has decreased further from 8 in February to 5 in March. STaRS had a sickness rate of 25% in February and this position has improved in March to 6.9%. There is 1 units with a sickness rate above 15% (Ullswater = 16.0%). Targeted support continues for areas with continued high sickness rates.

There are no units with 5 red flags, however 4 units have 3 or above (Westlands x3, MVL x4, Maister Court x3, and Malton x3).

CHPPD is strong for most units however Westlands, MVC and Malton inpatient unit are slightly below their target in March which is consistent with February's report. Westlands and MVC both have a target of 8.0 CHPPD which was achieved over a 6 month average. Bed occupancy continued to be high in March. Malton, as noted in previous months, continues to flag red for CHPPD but benchmark positively against model health system peers. Day time fill rates for both registered and unregistered staff on days are below target with a rise in sickness absence noted in March.

RN fill rates are satisfactory with the exception of TEC and MVL who are under the lower target threshold of 75% on days. Review of the roster by the matron at MVL suggests there were some occasions were staffing shortfalls fell below the planned hours and this is being explored further. Review by the matron at TEC notes that some part shifts were not covered, with matrons and band 7s covering shortfalls during the day and IST provided support on weekends. Further exploration is taking place as part of during the safe staffing reviews in May.

TEC continue to have low bed occupancy (43%) and a strong CHPPD (32.7). Sickness continues to improve and is now under 10%.

Mandatory training (all) has remained consistently above 85% for all units however Maister Court is under the target for March impacted by ILS figures. A recovery action plan has been requested from the resuscitation officer in respect of all areas of low compliance for ILS and BLS.

There have been 2 nil returns for clinical supervision in March (Westlands, Maister Lodge). Maister Lodge has had 4 nil returns in the previous 5 months reporting period, escalated to the matron and divisional clinical lead last month and assurance received from the divisional clinical lead that this is being monitored through the divisional governance processes.

STARS was a nil return in February however are currently at 100% and Whitby, also a nil return in February are currently at 94.7%.

The CHPPD RAG ratings are following discussions with and agreed by EMT in November 2022. Breakdowns are as follows:

Red RAG falls below the lowest rating, Green RAG is greater than the highest rating. Amber RAG falls between

Red RAG	Green RAG	Units applied (Note: Some thresholds were changed for June data (Townend, Ullswater and Malton)
<=4.3	>=5.3	STaRS
<=5.3	>=6.3	Pine view, Ouse
<=7	>=8	New Bridges, Westlands, Mill View Court, Swale, Whitby, Malton
<=8	>=9	Avondale
<=9.3	>=10.3	Maister Lodge, Maister Court, Derwent, Inspire, Granville
<=10.5	>=11.5	Mill View Lodge
<=11.0	>=12.0	Ullswater
<=15.6	>=16.6	PICU
<=27.0	>=28.0	Townend Court

Registered Nurse Vacancy Rates (Rolling 12 months)

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
9.10%	9.59%	9.66%	10.20%	10.28%	8.92%	6.80%	6.30%	7.39%	7.77%	7.57%	7.15%

Slips/Trips and Falls (Rolling 3 months)

	Jan-25	Feb-25	Mar-25
Maister Lodge	16	5	7
Millview Lodge	4	2	5
Malton IPU	1	2	4
Whitby IPU	5	5	0

Malton Sickness % is provided from ESR as they are not on Health Roster

HUMBER TEACHING NHS FOUNDATION TRUST
SAFER STAFFING COMMUNITY DASHBOARD

	Staffing and Quality Indicators
Contract Period:	2024-25
Reporting Month:	Mar

Humber Teaching NHS Foundation Trust

			Workforce Indicators					Quality Indicators						Trend	
Area	Team	Speciality	WTE in post	Vacancies Budget - WTE	Sickness	Bank Spend £	Agency Spend £	Mandatory Training Overall	Clinical Supervision	Friends and Family YTD Responses	Friends and Family YTD %	Serious Incidents (reported to STEIS) YTD	Complaints Upheld (wholly or in part) YTD	Feb-25	Mar-25
Adult MH Services	Mental Health Response Service	Adult Crisis	65.9	6.1%	7.4%	£39,109	-£7,717	90.2%	64.9%	13	76.9%	0	1	2	3
	Hull East Mental Health Team	Hull Adult MHT	29.7	24.4%	9.6%	£914	£0	85.7%	N/R	1	0.0%	0	1	1	2
	Hull West Mental Health Team	Hull Adult MHT	11.7	17.0%	6.9%	£0	£0	95.1%	N/R	0	NS	0	1	1	1
	Beverley Mental Health Team	ER Adult MHT	6.6	10.4%	0.0%	£1,899	£0	93.4%	100.0%	0	NS	0	0	0	0
	Goole Mental Health Team	ER Adult MHT	9.4	1.6%	4.4%	£116	£0	94.4%	100.0%	11	90.9%	0	0	0	0
	Haltemprice Mental Health Team	ER Adult MHT	9.9	3.2%	2.2%	£1,139	£0	97.7%	N/R	0	NS	0	0	0	0
	Holderness Mental Health Team	ER Adult MHT	12.1	-1.9%	17.6%	£0	£0	93.2%	100.0%	0	NS	0	0	1	1
	Bridlington & Driffield MHT	ER Adult MHT	14.7	7.2%	6.2%	£0	£0	95.0%	93.8%	5	100.0%	0	0	1	1
Older People MH Services	Crisis Intervention Team for Older People (CITOP)	OP Crisis	20.1	22.4%	3.1%	£5,253	£0	96.7%	100.0%	0	NS	0	0	0	0
	Hull Intensive Care Team for Older People (HICTOP)	Hull OP CMHT	21.5	12.9%	5.2%	£0	£0	95.9%	100.0%	1	100.0%	0	0	0	0
	Beverley and Haltemprice OP CMHT	ER OP CMHT	7.4	14.2%	12.6%	£0	£0	100.0%	100.0%	2	50.0%	0	0	1	2
	Bridlington & Driffield OP CMHT	ER OP CMHT	7.3	10.7%	14.6%	£0	£0	91.6%	100.0%	5	80.0%	0	0	1	1
	Goole & Pocklington OP CMHT	ER OP CMHT	6.1	12.3%	1.9%	£0	£0	95.9%	100.0%	4	100.0%	0	0	0	0
	Holderness OP Community Team	ER OP CMHT	5.3	-0.1%	15.6%	£0	£0	96.6%	100.0%	3	100.0%	0	0	1	1
Universal	Early Intervention in Psychosis	14-65 MHT	24.7	19.5%	5.3%	£0	£0	90.3%	100.0%	1	100.0%	0	0	1	1
	Hospital Mental Health Team	Liaison Services	34.0	12.5%	2.3%	£0	£36,514	89.8%	N/R	4	100.0%	0	1	1	0
Community Services	Ryedale Team	Comm Services	20.9	-0.1%	5.9%	£48	£0	92.2%	90.0%	2	100.0%	0	0	0	1
	Scarborough Hub	Comm Services	63.6	9.1%	7.4%	£19,023	£7,338	89.8%	79.0%	0	NS	0	0	2	2
	Whitby Community Nurses	Comm Services	28.4	19.4%	4.2%	£3,489	£0	92.4%	100.0%	0	NS	0	0	1	0
	Pocklington Nurses	Comm Services	18.1	8.1%	0.3%	£252	£0	81.2%	100.0%	0	NS	0	0	0	0

Points of Note:

Complaints - Zero figures indicate at least one complaint was made but not upheld. Figures above zero indicate these complaints were either Upheld or Partly Upheld. These incur a Red flag.

Active Caseload - patients seen at least once for treatment within the team. ER Adult Teams do not have the local authority staffing numbers included.

No returns for clinical supervision will incur a Red Flag

FFT % results based on the number of responses received with a satisfactory outcome

Waiting Assessment - Total number of patients not seen for assessment

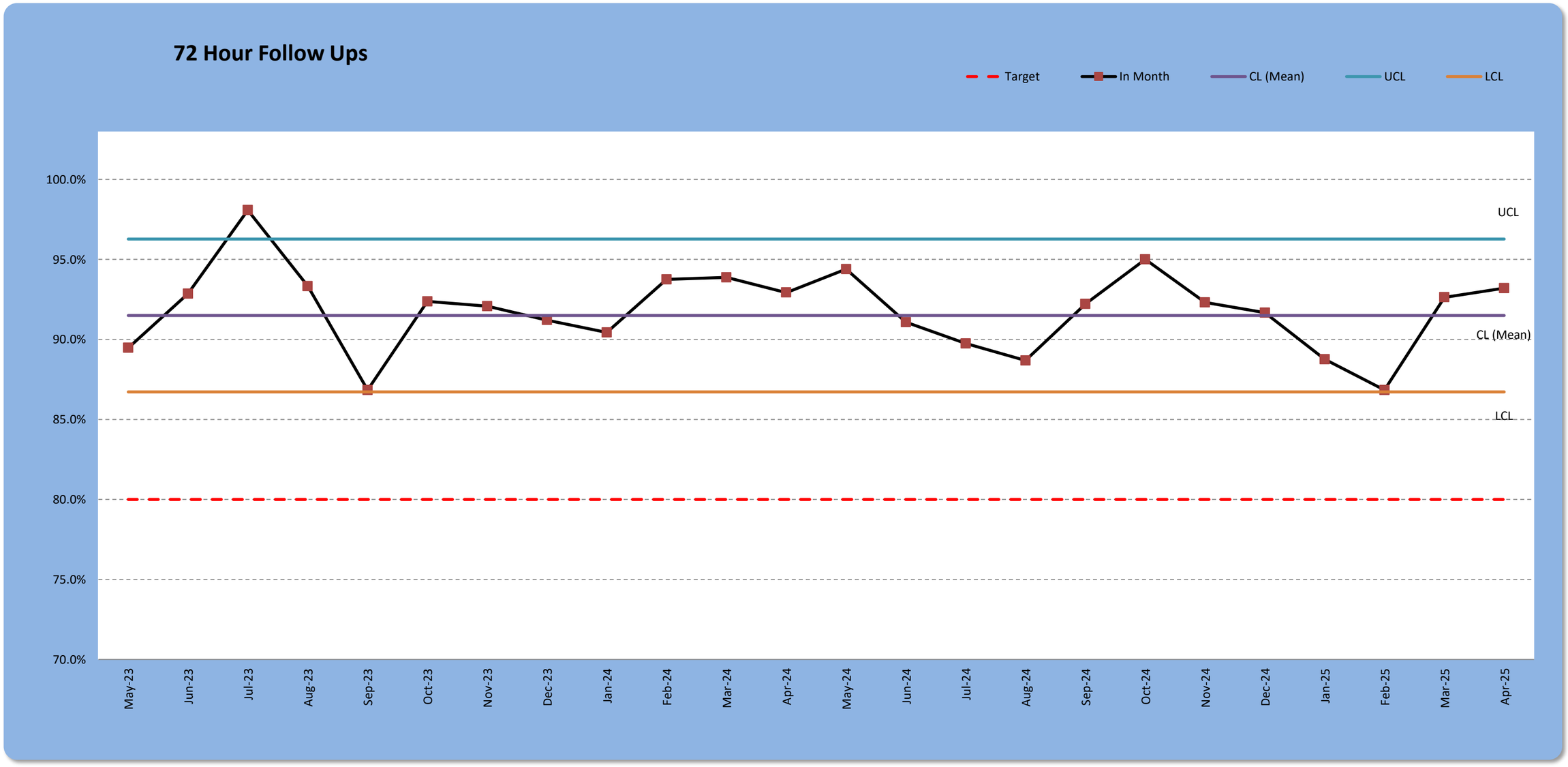
PI RETURN FORM 2025-26

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **April 2025**

Target:	Amber:	Current month for 72 hour stands at:
80%	60%	93.2%

Indicator Title	Description/Rationale		KPI Type
72 Hour Follow Ups	This indicator measures the percentage of patients who were in the CQUIN scope and had a follow up within 72 hours of discharge	Executive Lead Lynn Parkinson	OP 12



Please refer to the accompanying front sheet/report for any relevant commentary

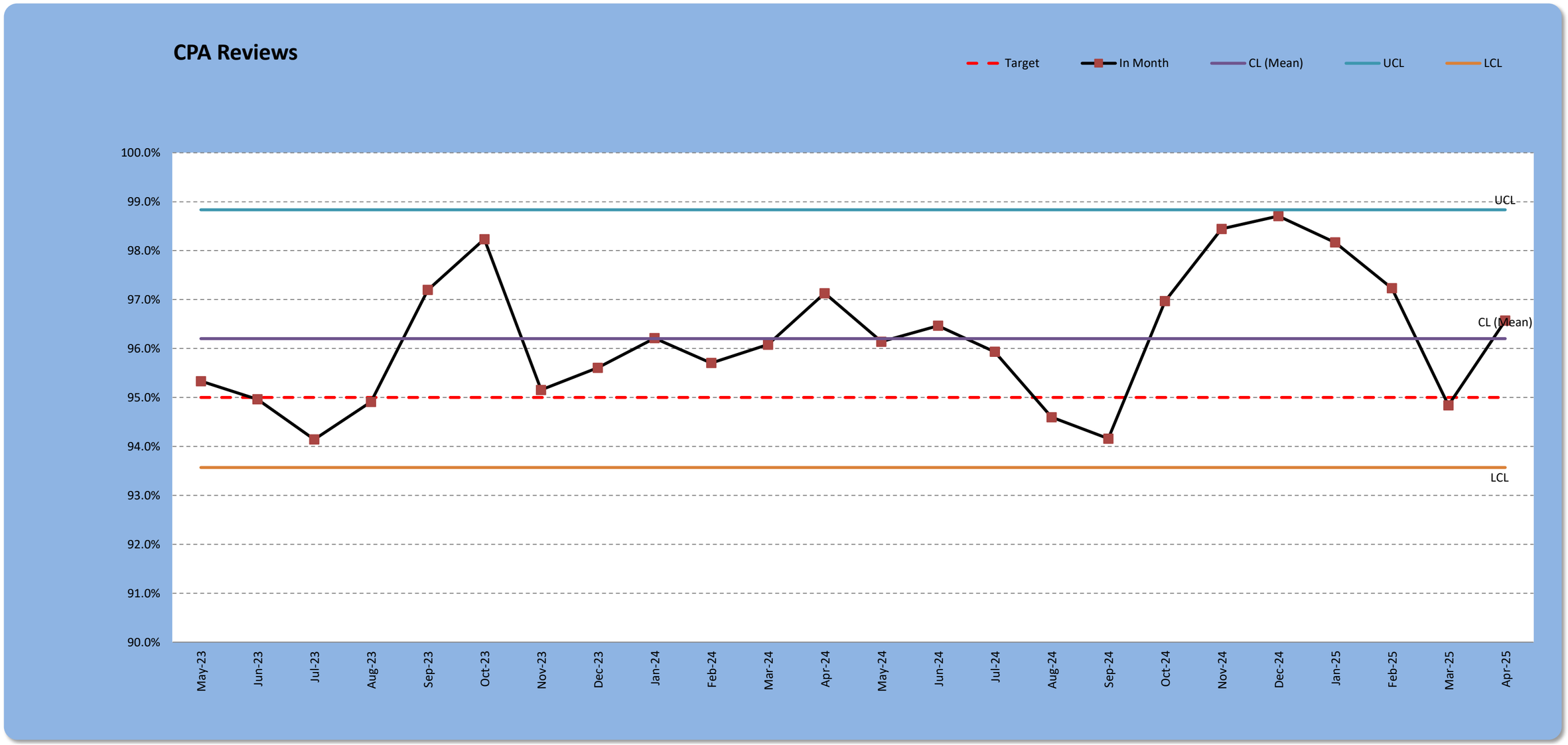
PI RETURN FORM 2025-26

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **April 2025**

Target:	Amber:	Current month stands at:
95%	85%	96.6%

Indicator Title	Description/Rationale		KPI Type
Care Programme Reviews	This indicator measures the percentage of patients who are on CPA and have had a review in the last 12 months	Executive Lead Lynn Parkinson	OP 7



Please refer to the accompanying front sheet/report for any relevant commentary

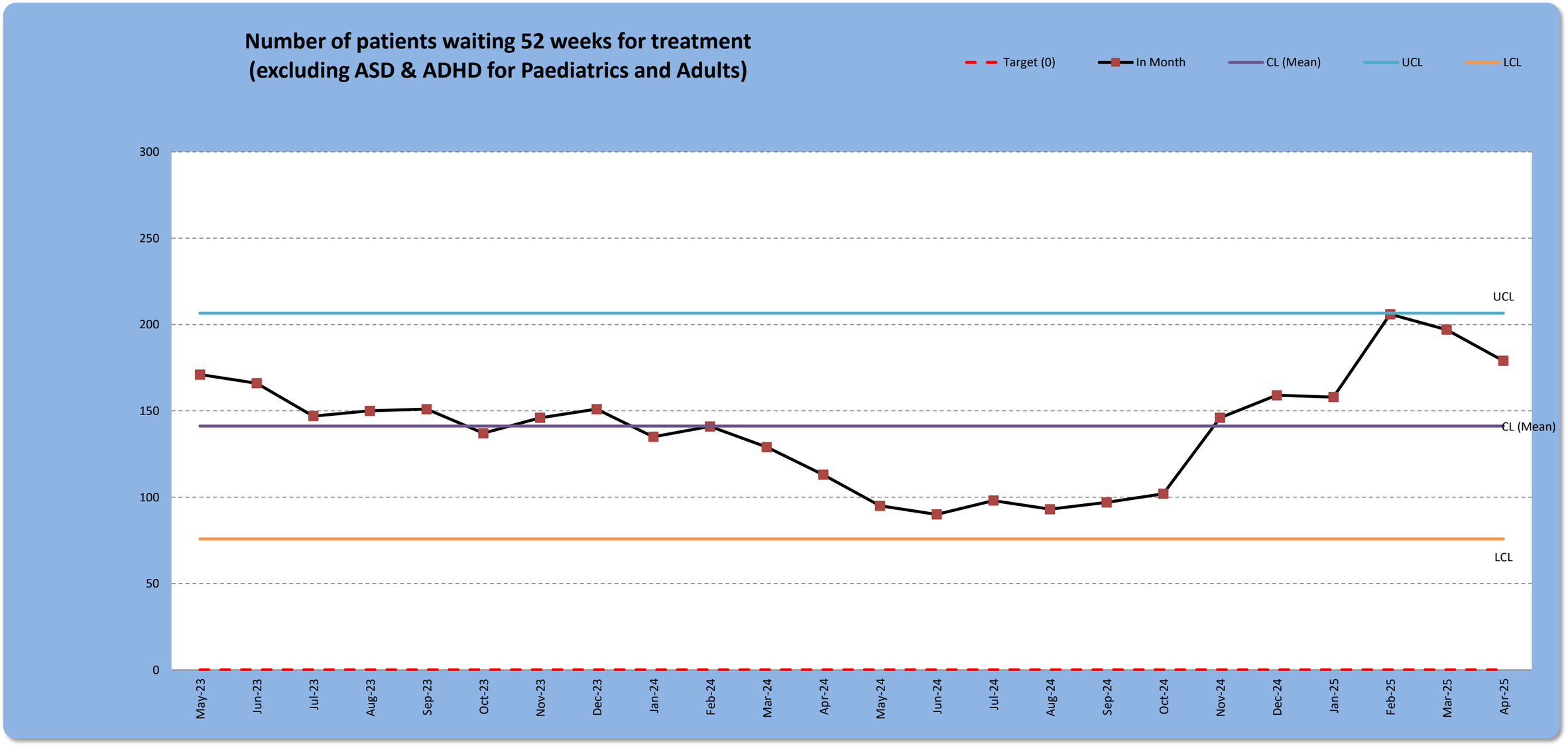
PI RETURN FORM 2025-26

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
0	0	179

For the period ending: **April 2025**

Indicator Title	Description/Rationale		KPI Type
52 Week Waits	Number of patients who have yet to be seen for treatment and have been waiting more than 52 weeks. ***(Excludes ASD & ADHD Services for both Adult and Paediatrics)***	**Executive Lead Lynn Parkinson**	OP 22x



Please refer to the accompanying front sheet/report for any relevant commentary

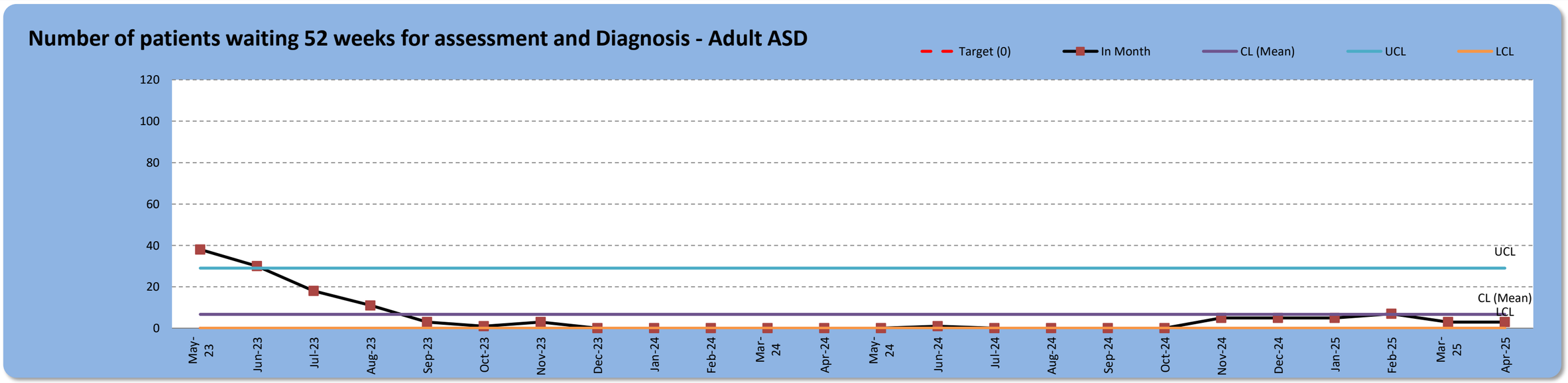
PI RETURN FORM 2025-26

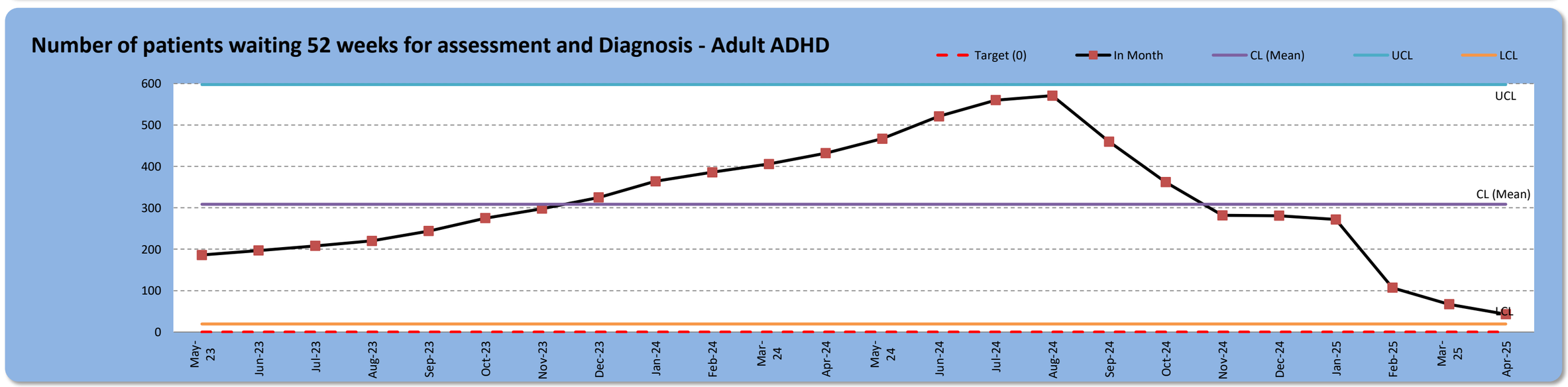
Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
0	0	46

For the period ending: **April 2025**

Indicator Title	Description/Rationale		KPI Type
52 Week Waits - Adult (18+) ASD/ADHD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service and ADHD for Adults (18+) and have been waiting more than 52 weeks	Executive Lead Lynn Parkinson	OP 22u





Please refer to the accompanying front sheet/report for any relevant commentary

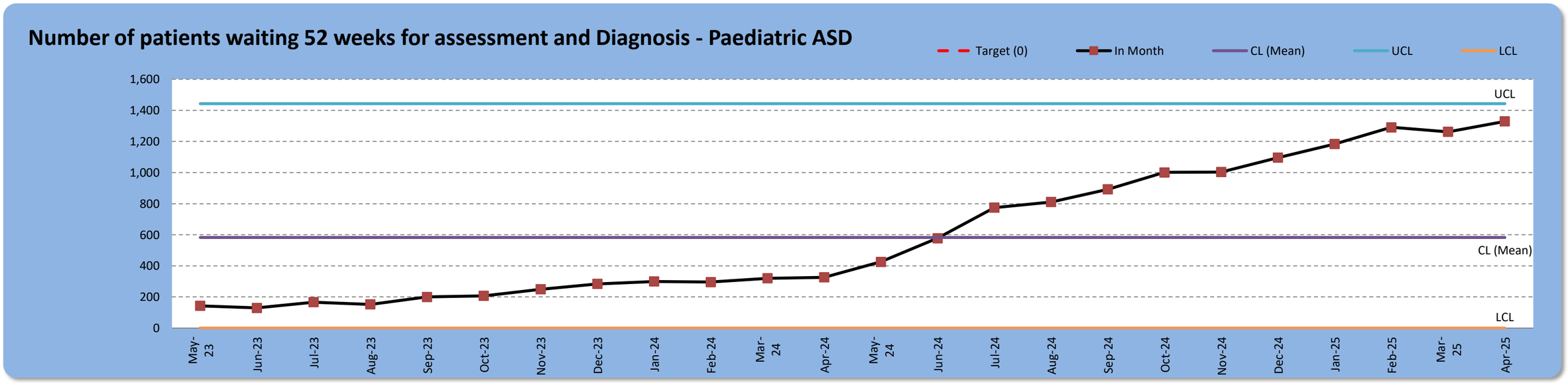
PI RETURN FORM 2025-26

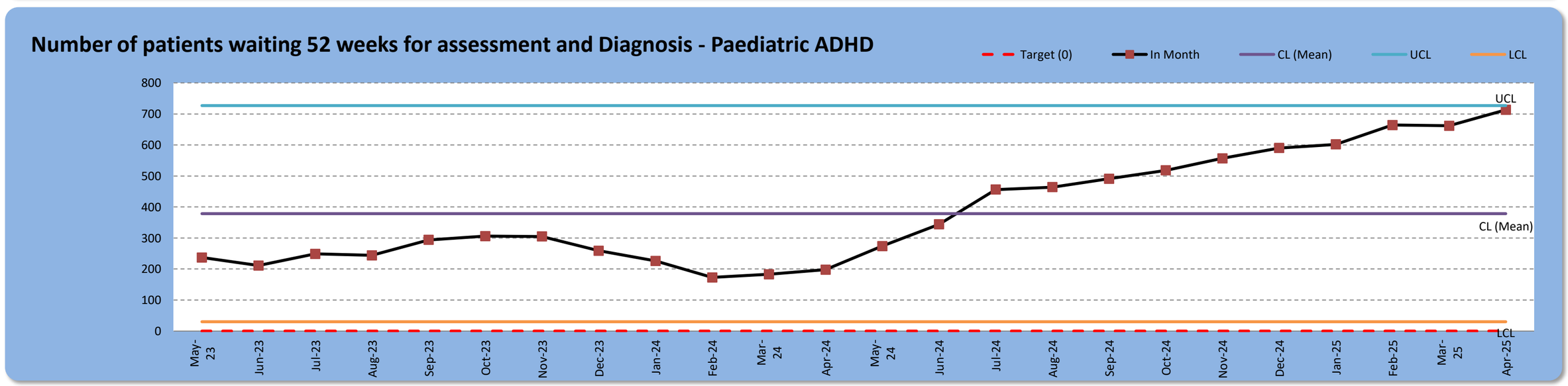
Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
0	0	2042

For the period ending: **April 2025**

Indicator Title	Description/Rationale		KPI Type
52 Week Waits - Paediatric ASD/ADHD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service and ADHD for Children and have been waiting more than 52 weeks	Executive Lead Lynn Parkinson	OP 22s





Please refer to the accompanying front sheet/report for any relevant commentary

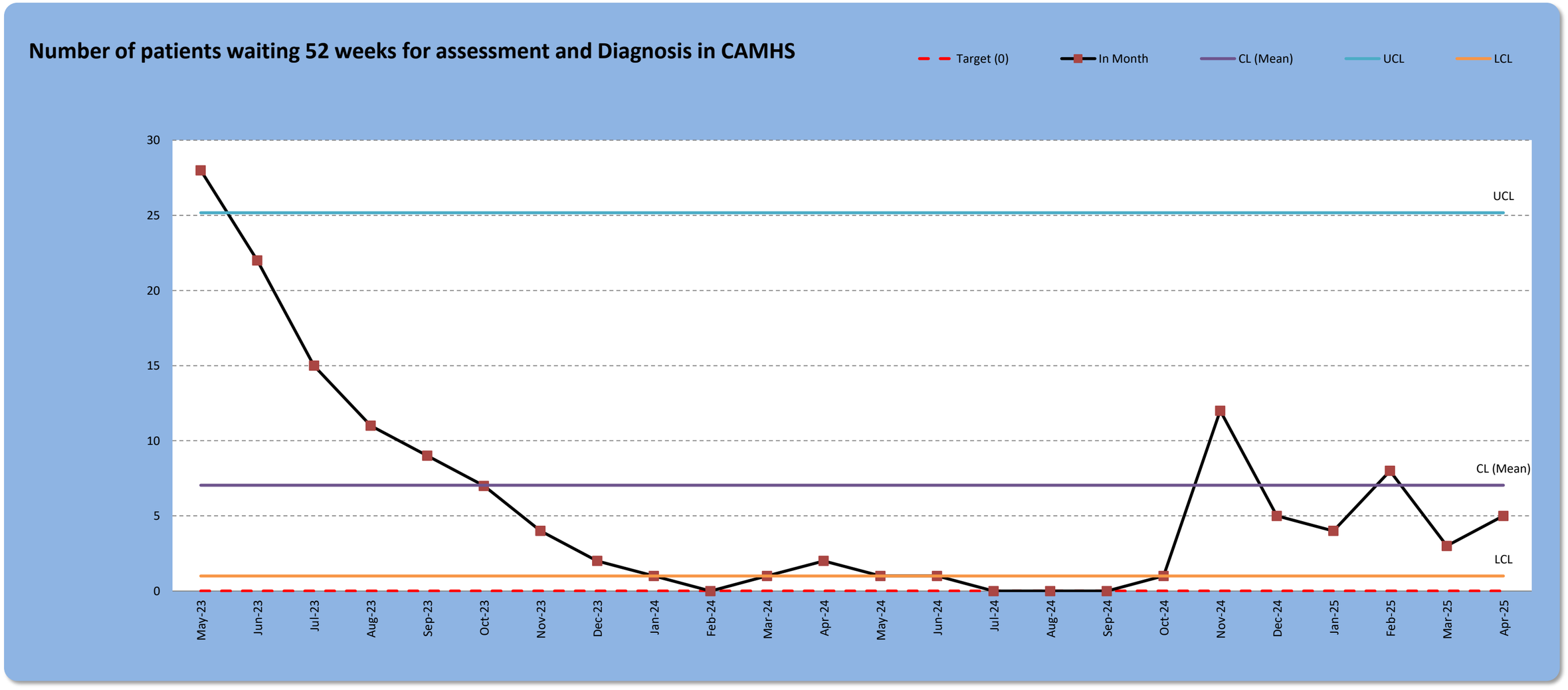
PI RETURN FORM 2025-26

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
0	0	5

For the period ending: **April 2025**

Indicator Title	Description/Rationale		KPI Type
52 Week Waits - CAMHS	Number of patients who have yet to receive treatment in CAMHS and have been waiting more than 52 weeks (excluding paediatric ASD/ADHD)	Executive Lead Lynn Parkinson	OP 22j



Please refer to the accompanying front sheet/report for any relevant commentary

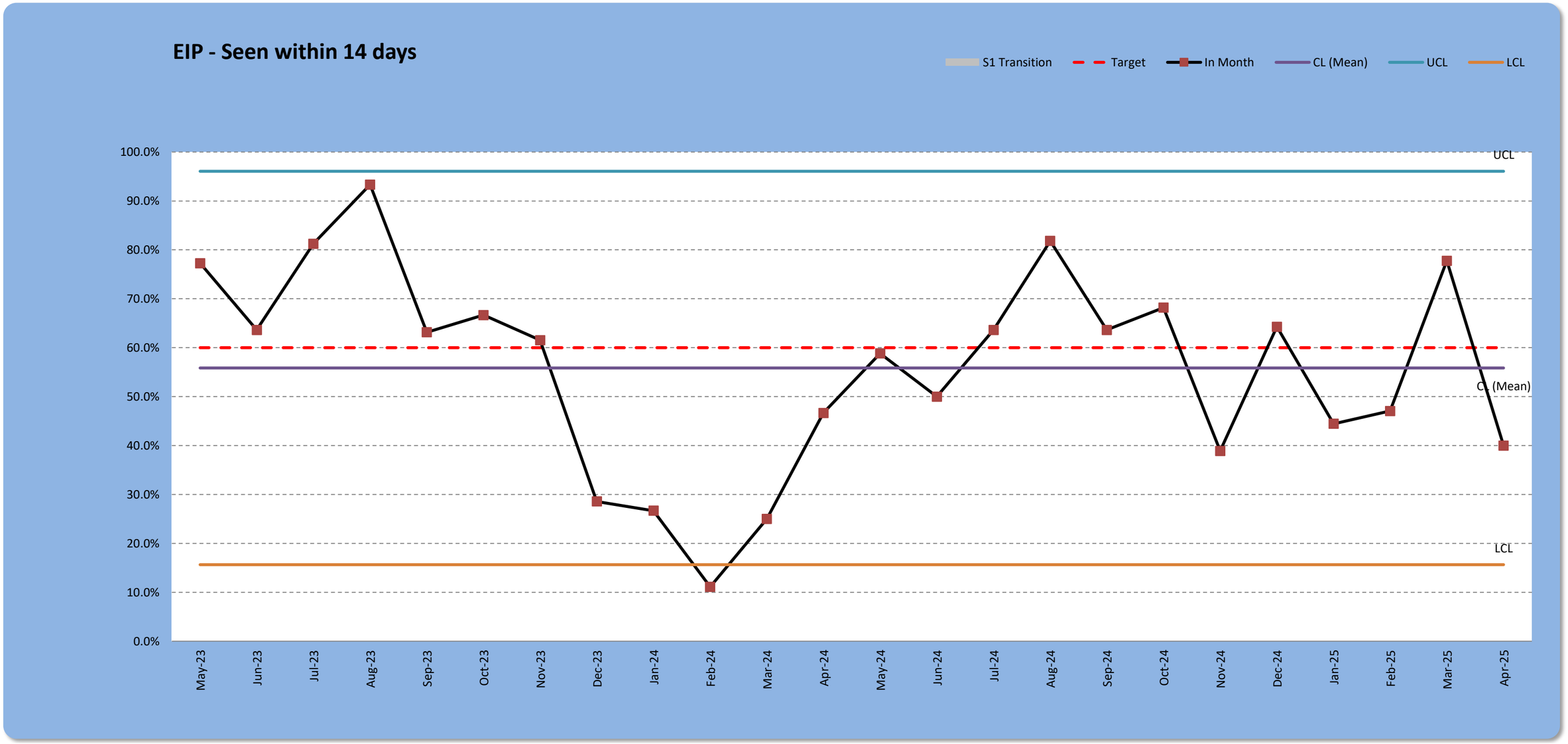
PI RETURN FORM 2025-26

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
60%	55%	40.0%

For the period ending: **April 2025**

Indicator Title	Description/Rationale		KPI Type
Early Intervention in Psychosis	Percentage of patients who were seen within two weeks of referral	Executive Lead Lynn Parkinson	OP 9



Please refer to the accompanying front sheet/report for any relevant commentary

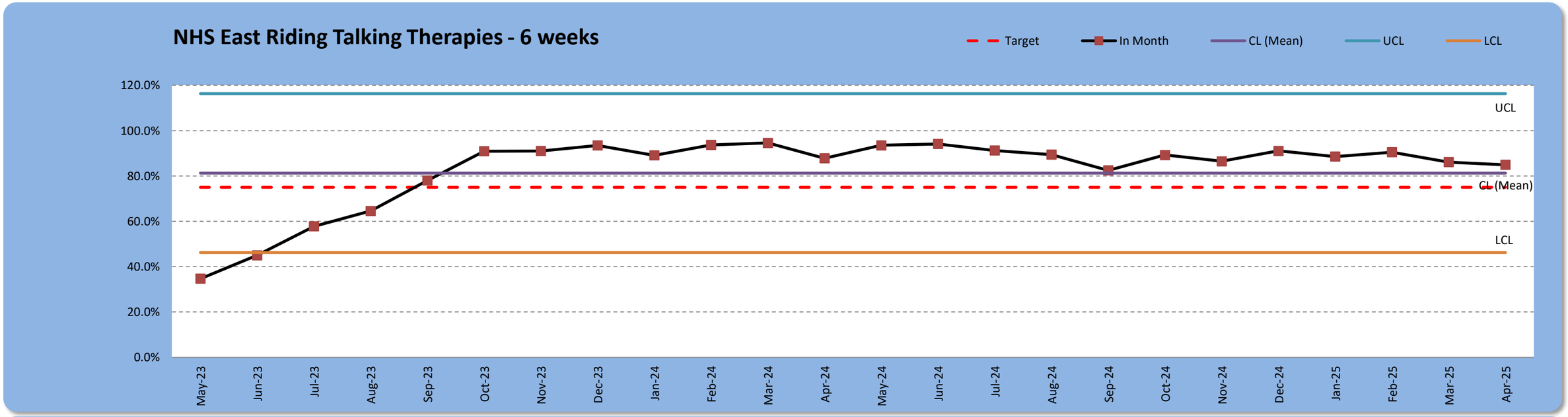
PI RETURN FORM 2025-26

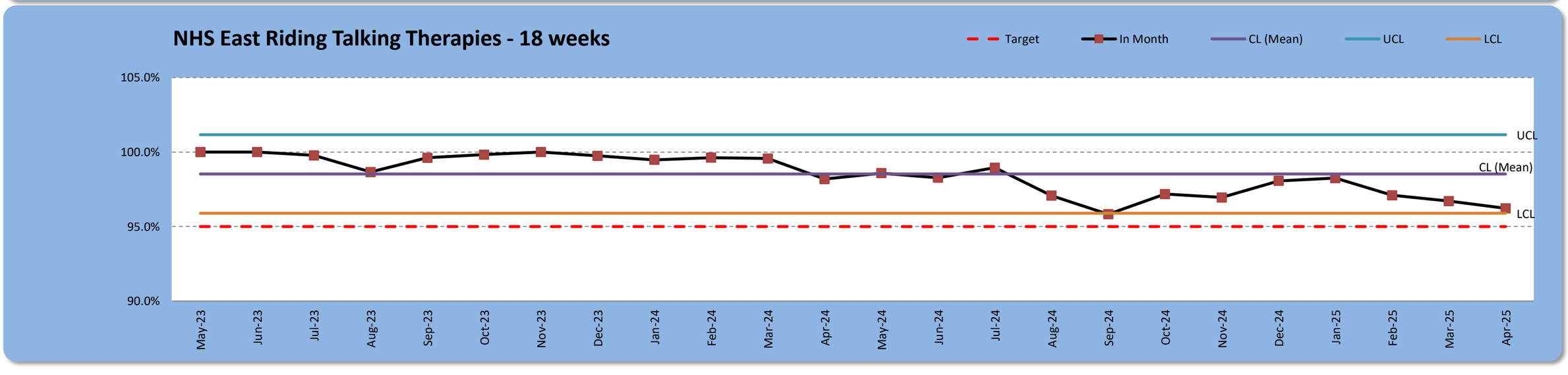
Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **April 2025**

Target:	Amber:	Current month 6 weeks stands at:	Target:	Amber:	Current month 18 weeks stands at:
75%	70%	84.9%	95%	85%	96.2%

Indicator Title	Description/Rationale		KPI Type
NHS East Riding Talking Therapies	Two graphs to show percentage of patients who were seen within 6 weeks and 18 weeks of referral (East Riding)	Executive Lead Lynn Parkinson	OP 10a





Please refer to the accompanying front sheet/report for any relevant commentary

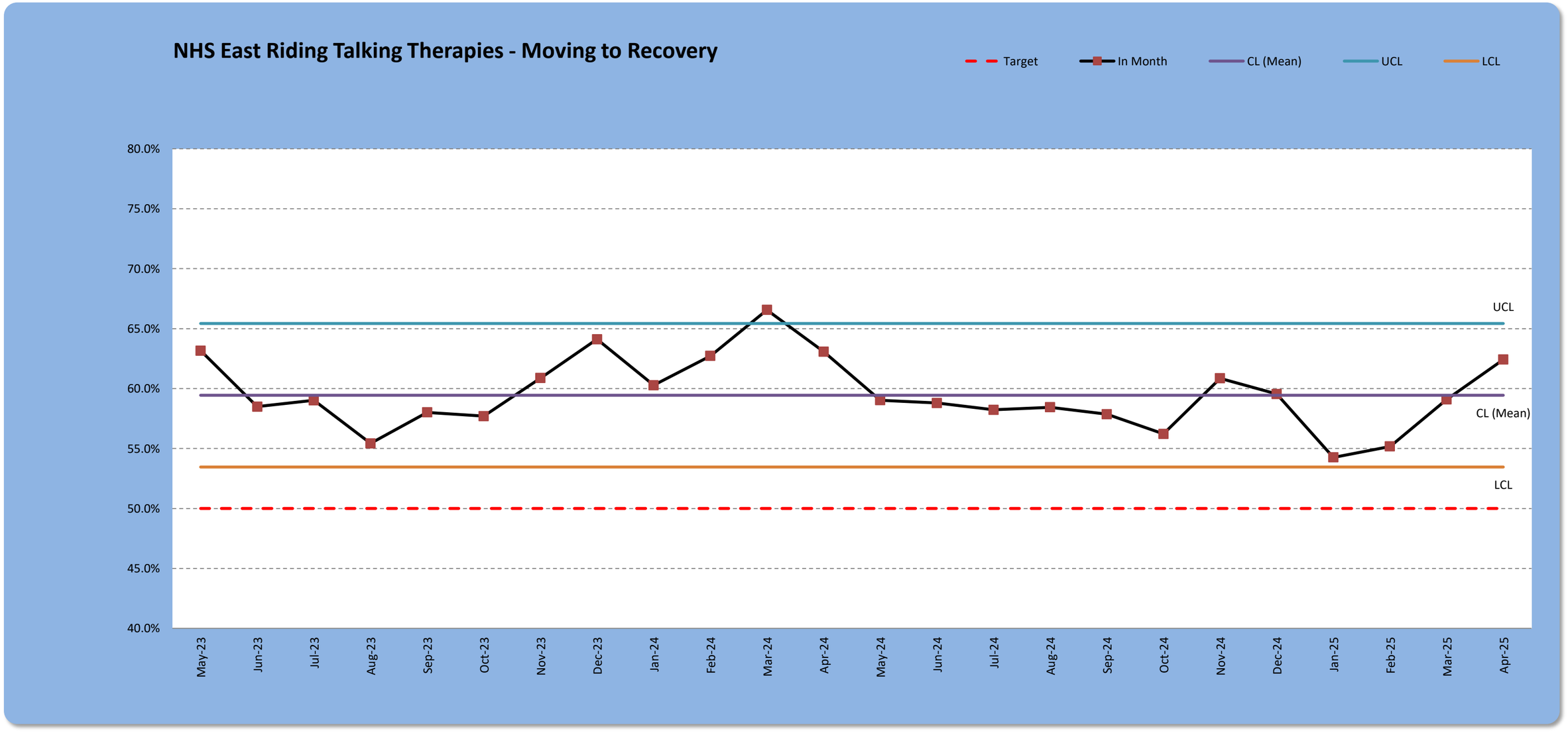
PI RETURN FORM 2025-26

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
50%	45%	62.4%

For the period ending: **April 2025**

Indicator Title	Description/Rationale		KPI Type
NHS East Riding Talking Therapies	This indicator measures the Recovery Rates for patients who were at caseness at start of therapeutic intervention (East Riding)	Executive Lead Lynn Parkinson	OP 11



Please refer to the accompanying front sheet/report for any relevant commentary

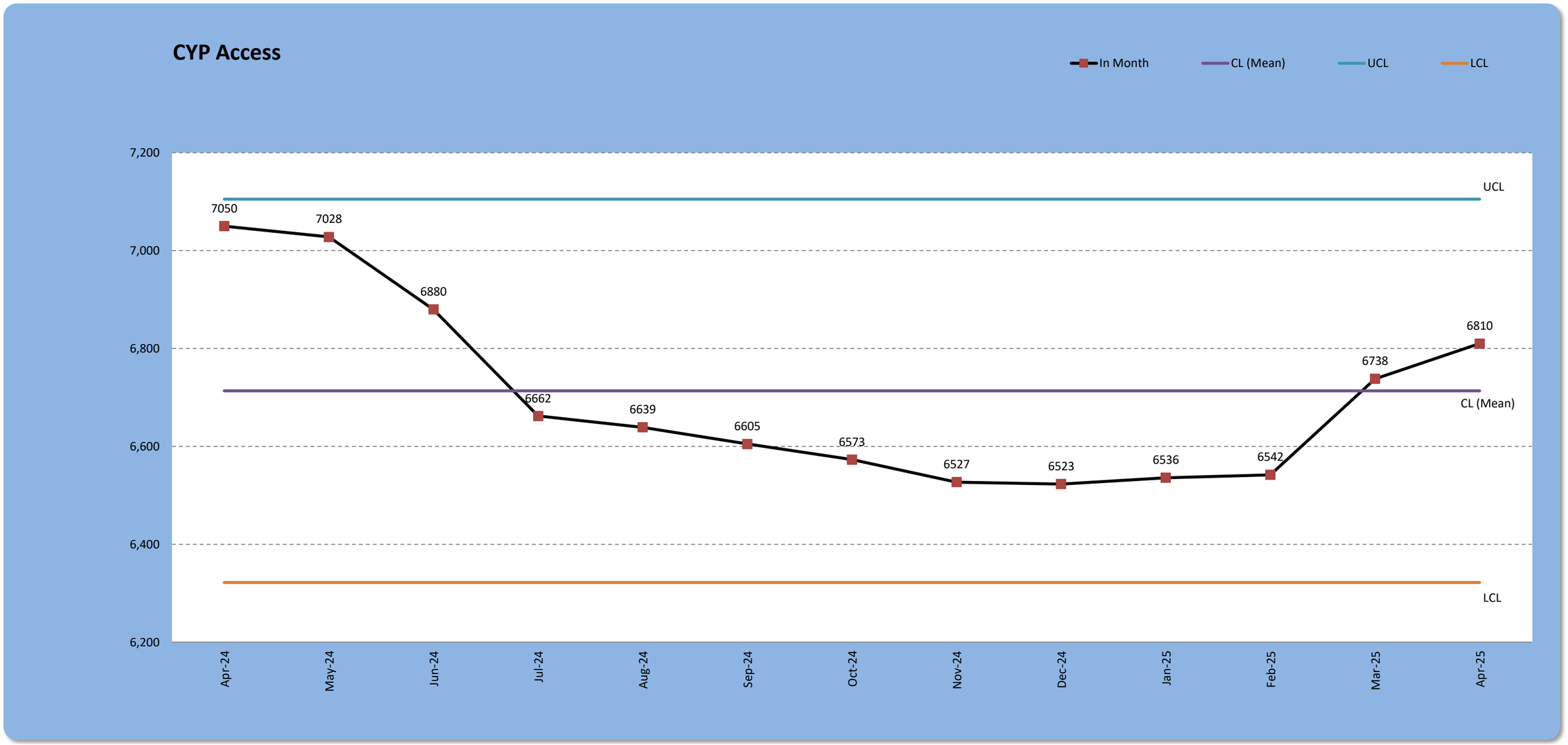
PI RETURN FORM 2025-26

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
TBC	TBC	6810

For the period ending: **April 2025**

Indicator Title	Description/Rationale		KPI Type
CYP MH Access	Number of CYP aged under 18 accessing support by NHS funded community services and school or college based Mental Health Support Teams (receiving at least one contact). Rolling 12 months. *Includes ADHD but excludes ASD and LD (National Guidance)*	**Executive Lead Lynn Parkinson**	MHS95.2



Please refer to the accompanying front sheet/report for any relevant commentary

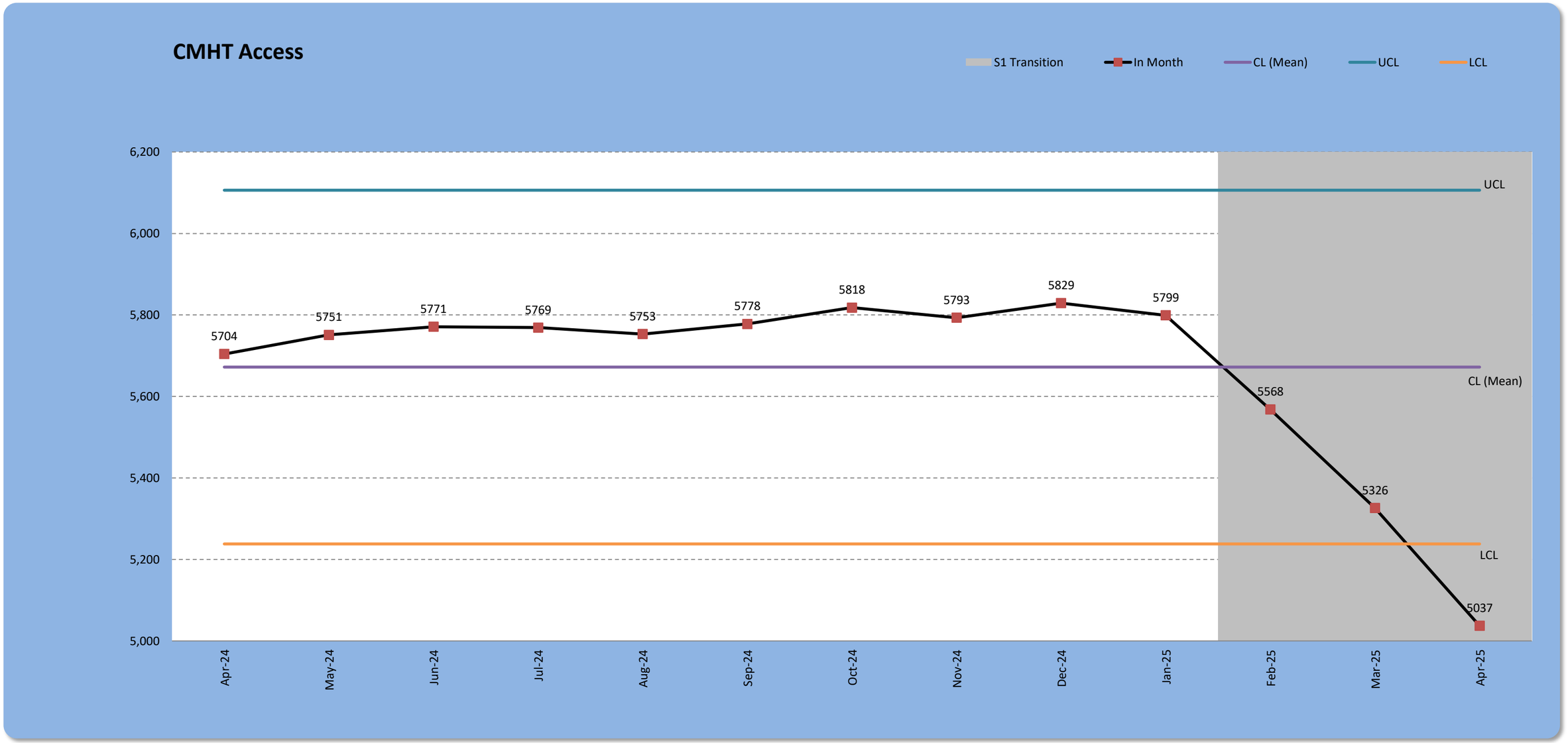
PI RETURN FORM 2025-26

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
TBC	TBC	5037

For the period ending: **April 2025**

Indicator Title	Description/Rationale		KPI Type
CMHT Access	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services for adults and older adults with severe mental illness. Rolling 12 months.	Executive Lead Lynn Parkinson	MHS108.1



Please refer to the accompanying front sheet/report for any relevant commentary

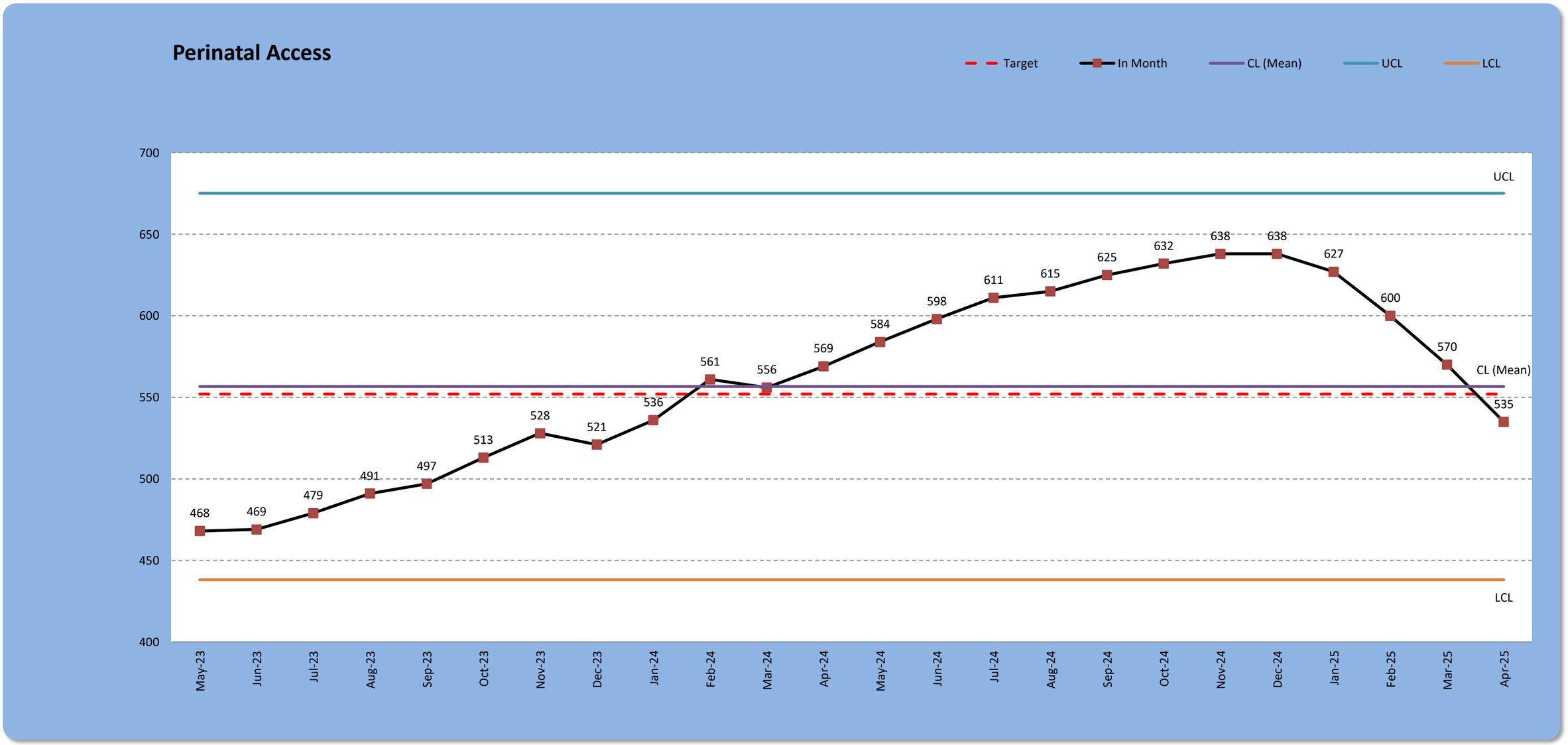
PI RETURN FORM 2025-26

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **April 2025**

Target:	Amber:	Current month stands at:
TBC	TBC	535

Indicator Title	Description/Rationale		KPI Type
Perinatal Access - rolling 12 months	Number of women with at least one attended contact (F2F or video) with a specialist community perinatal mental health service in the last 12 months *(Hull, East Riding & North Lincs only)*	**Executive Lead Lynn Parkinson**	MHS91.1



Please refer to the accompanying front sheet/report for any relevant commentary

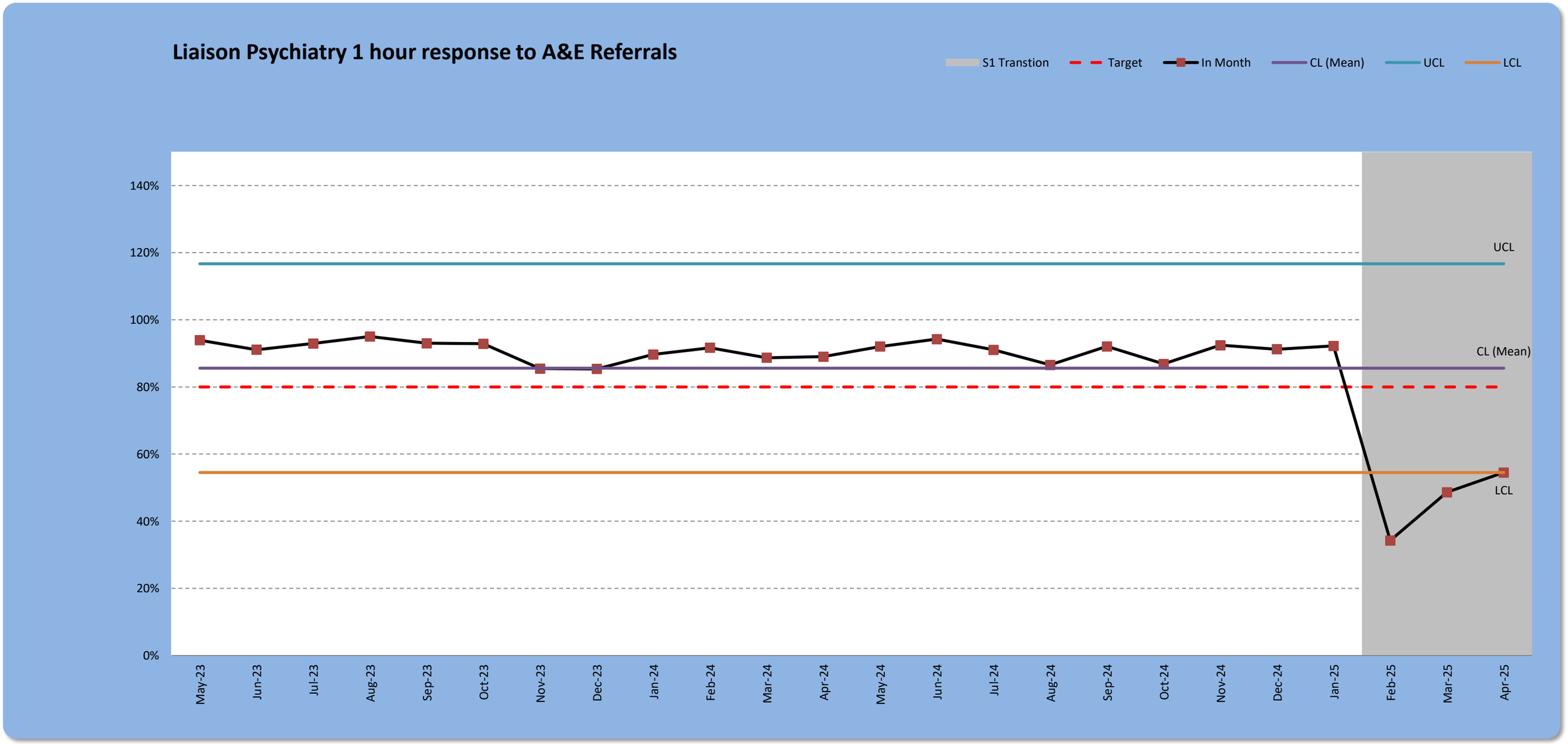
PI RETURN FORM 2025-26

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
80%	75%	54.5%

For the period ending: **April 2025**

Indicator Title	Description/Rationale		KPI Type
Liaison 1 hour response	New referrals to liaison psychiatry teams from A&E in the reporting period with first face to face contact within 1 hour	Executive Lead Lynn Parkinson	LPS1hr



Please refer to the accompanying front sheet/report for any relevant commentary

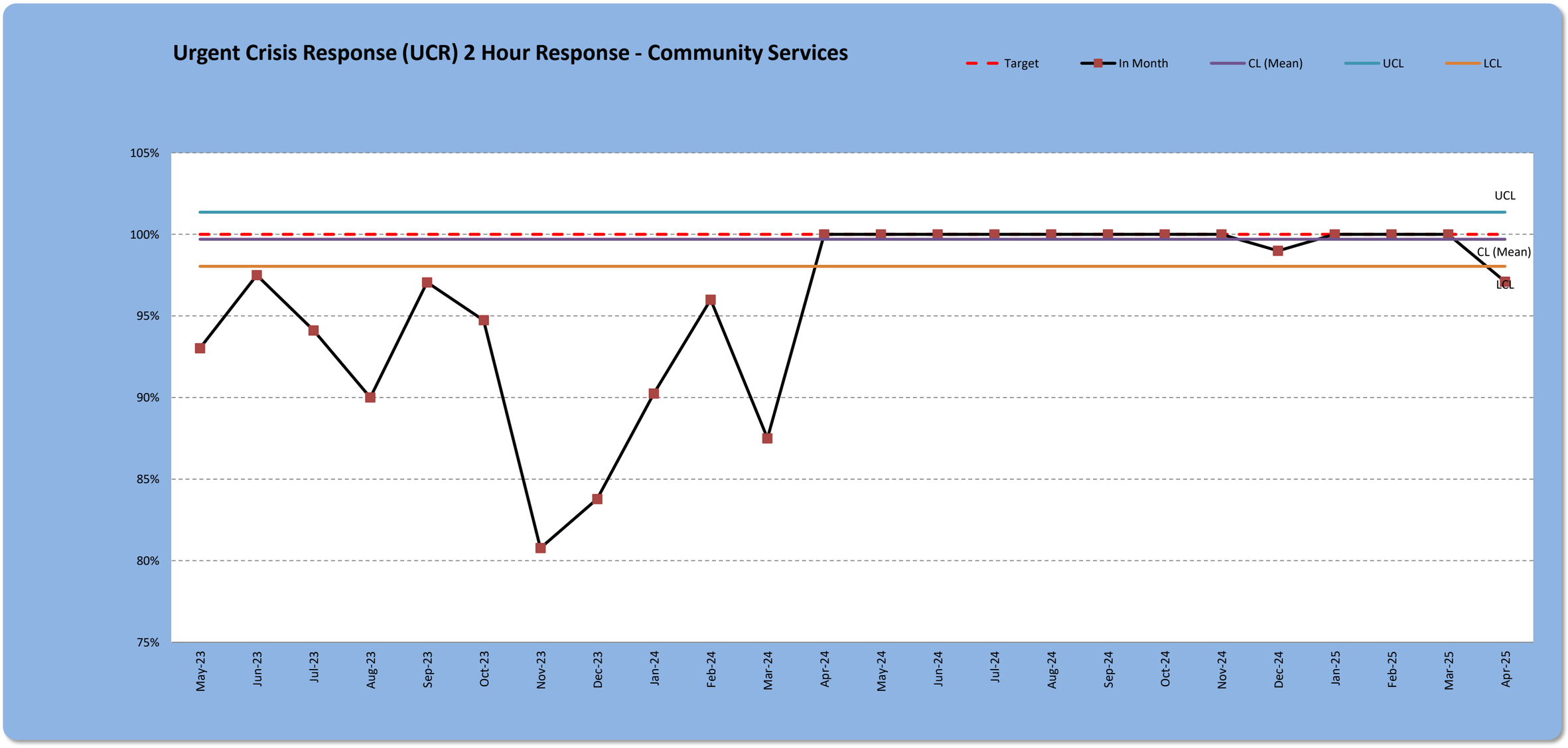
PI RETURN FORM 2025-26

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
100%	95%	97.1%

For the period ending: **April 2025**

Indicator Title	Description/Rationale		KPI Type
UCR 2 hr response	The percentage of 2-hour Urgent Crisis Response (UCR) referrals that achieved the 2-hour standard in the reporting month	Executive Lead Lynn Parkinson	UCR2hr



Please refer to the accompanying front sheet/report for any relevant commentary

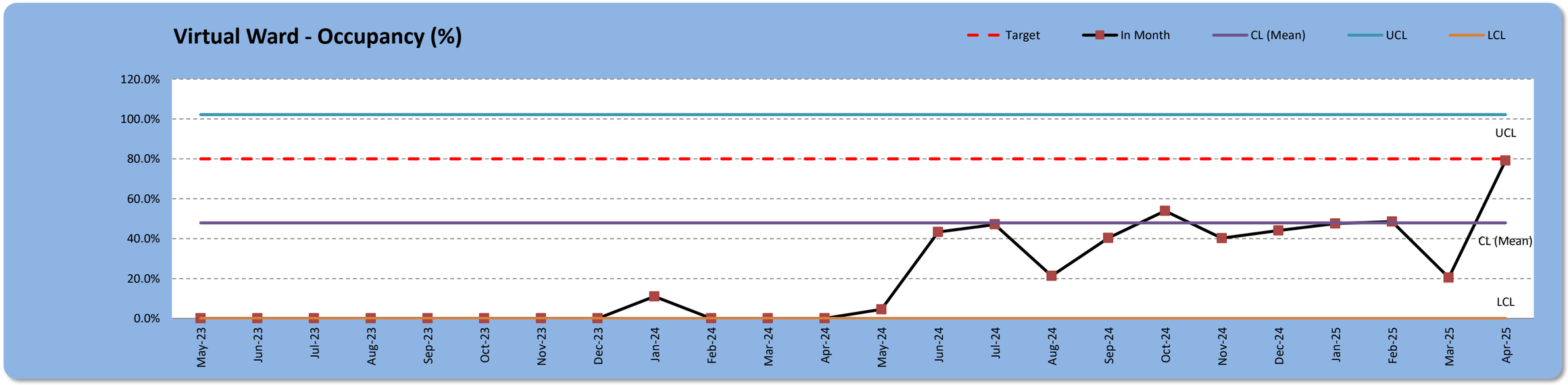
PI RETURN FORM 2025-26

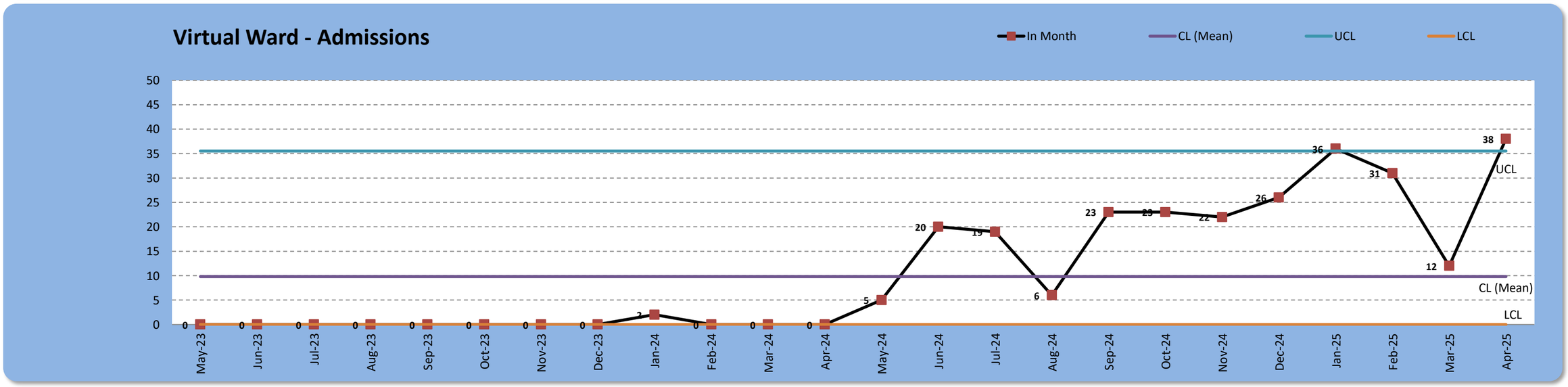
Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **April 2025**

Target:	Amber:	Current month stands at:
80%	75%	79.1%

Indicator Title	Description/Rationale		KPI Type
Virtual Ward	Virtual Ward Bed Occupancy Rate (Available Virtual Bed days vs Virtual Actual Bed Days)	Executive Lead Lynn Parkinson	VW 1





Please refer to the accompanying front sheet/report for any relevant commentary

PI RETURN FORM 2025-26

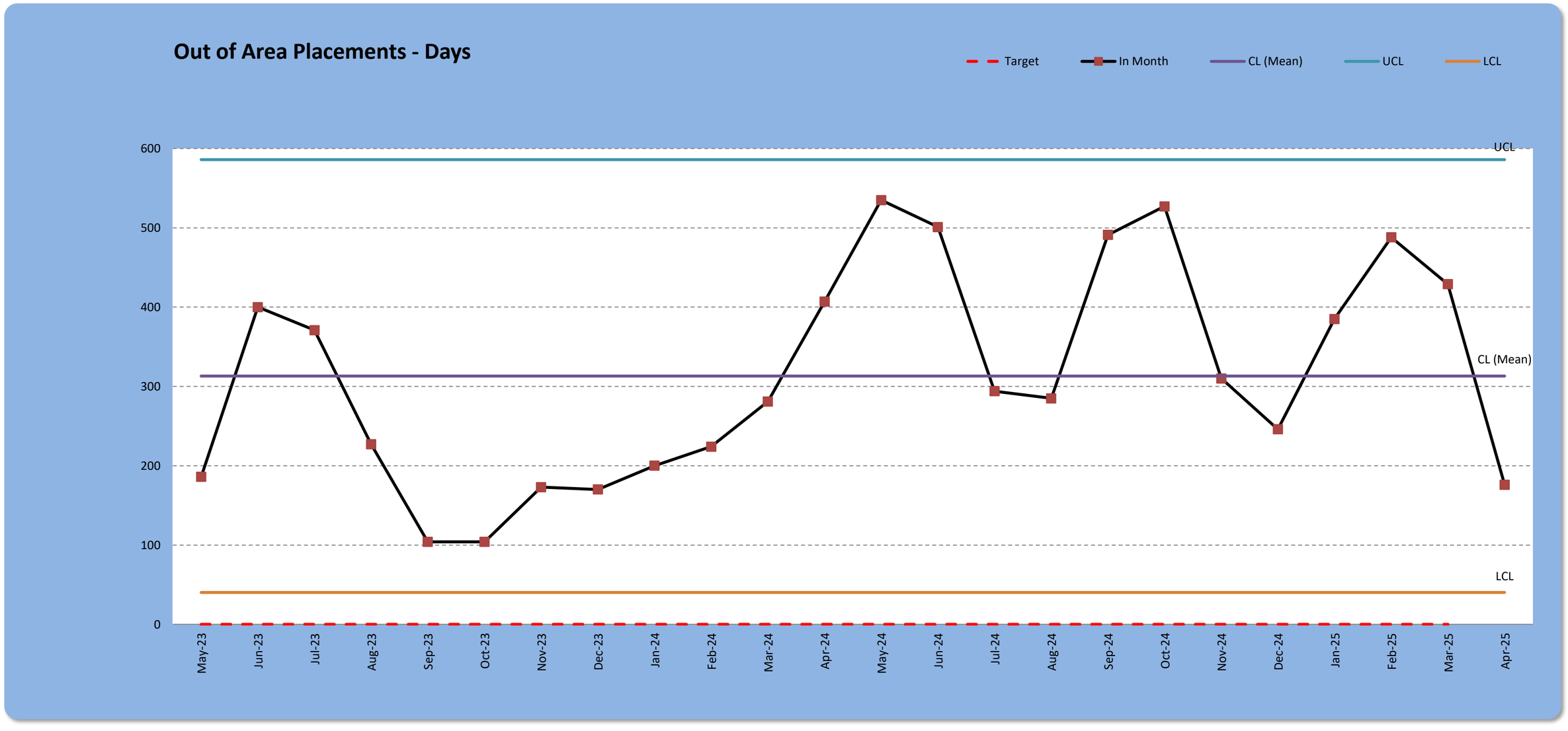
Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **April 2025**

Target:	Amber:	Patients OoA within month:
0	0	15

Split:	# days	# patients
Adult	69	8
OP	99	6
PICU	8	1

Indicator Title	Description/Rationale		KPI Type
Out of Area Placements	Number of days that Trust patients were placed in out of area wards	Executive Lead Lynn Parkinson	ST 4b



Please refer to the accompanying front sheet/report for any relevant commentary

PI RETURN FORM 2025-26

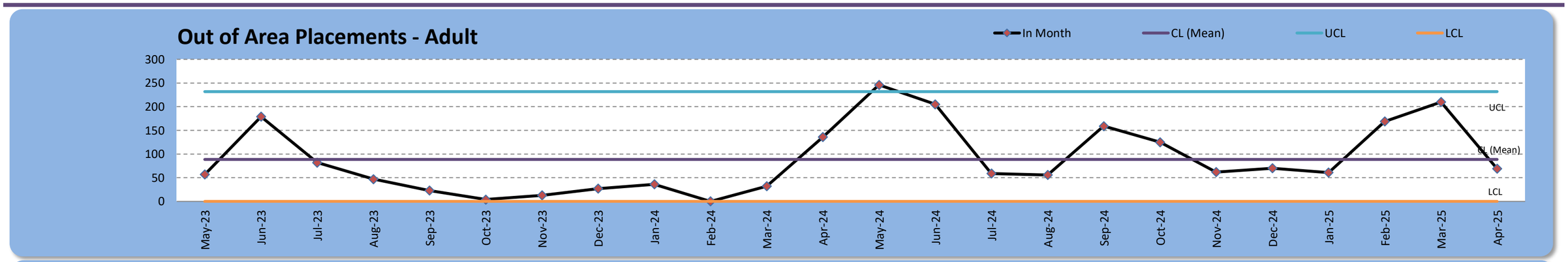
Goal 3 : Fostering Integration, Partnership and Alliances

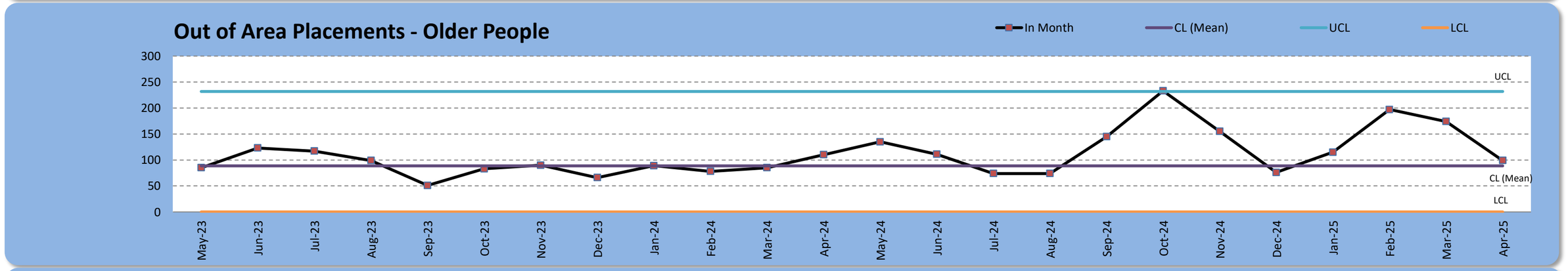
For the period ending: **April 2025**

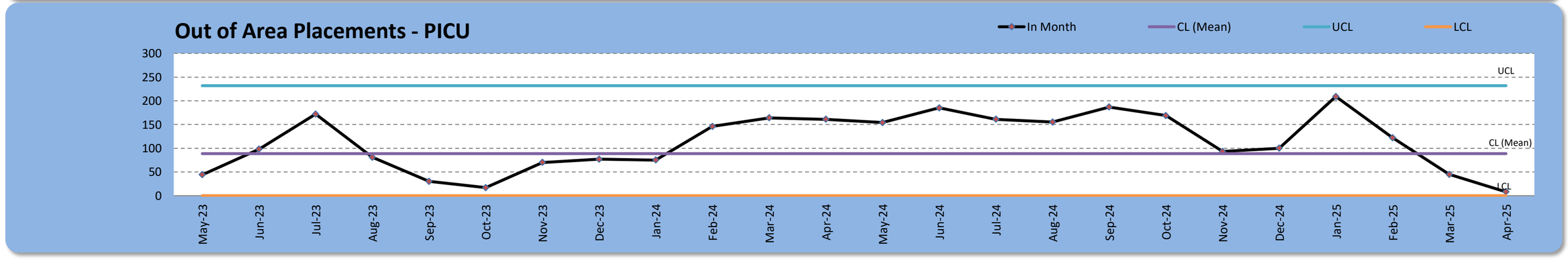
Split for Current month:

Apr-25	
69	Adult
99	OP
8	PICU
176	Total

Indicator Title	Description/Rationale		KPI Type
Out of Area Placements	Number of days that Trust patients were placed in out of area wards - split by service	Executive Lead Lynn Parkinson	ST 4 split







Please refer to the accompanying front sheet/report for any relevant commentary

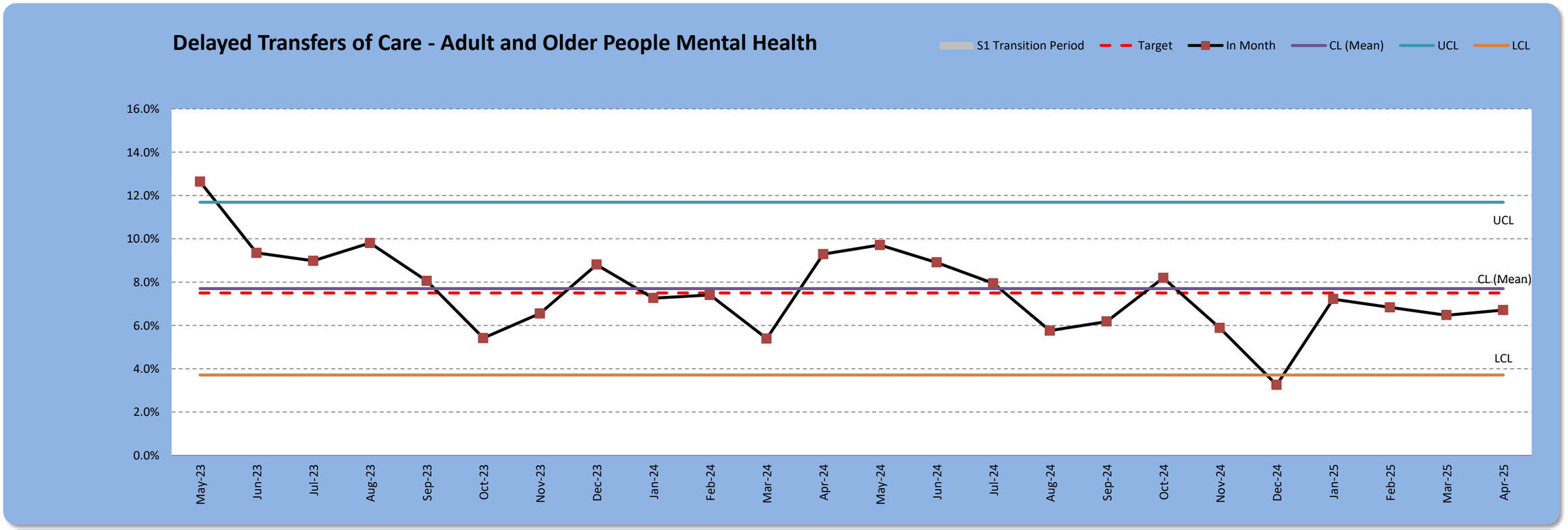
PI RETURN FORM 2025-26

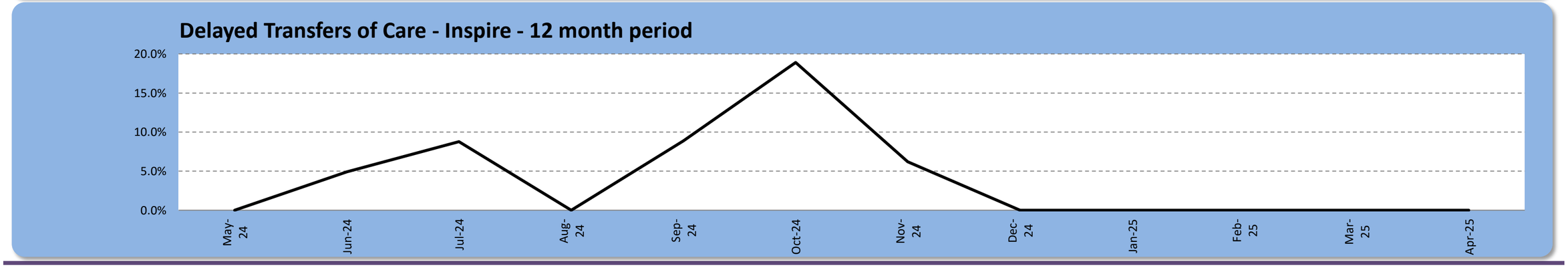
Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **April 2025**

Target:	Amber:	Current month stands at:
7.5%	7.0%	6.7%

Indicator Title	Description/Rationale		KPI Type
Delayed Transfers of Care	Results for the percentage of Mental Health delayed transfers of care	Executive Lead Lynn Parkinson	OP 14





Please refer to the accompanying front sheet/report for any relevant commentary

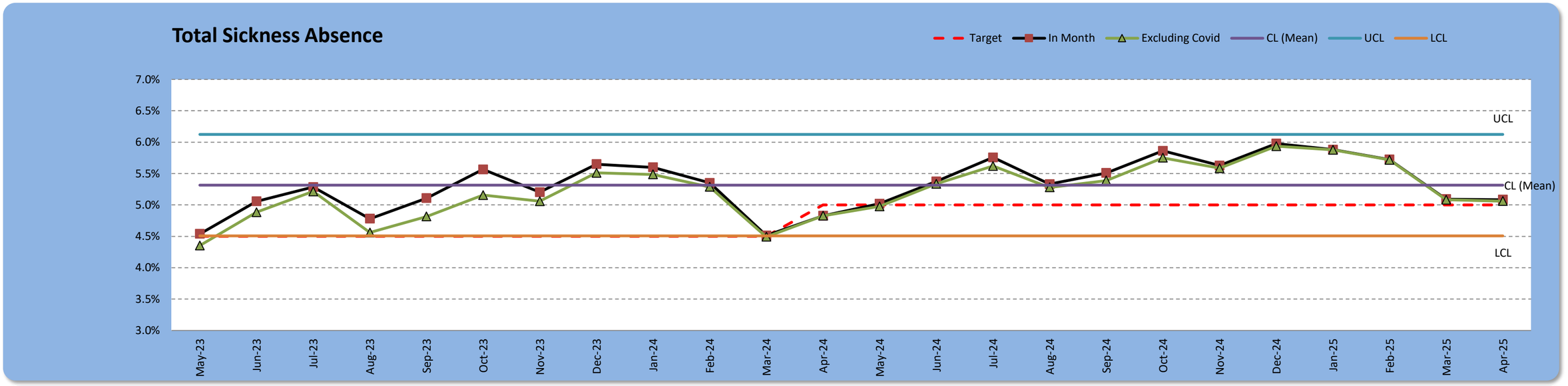
PI RETURN FORM 2025-26

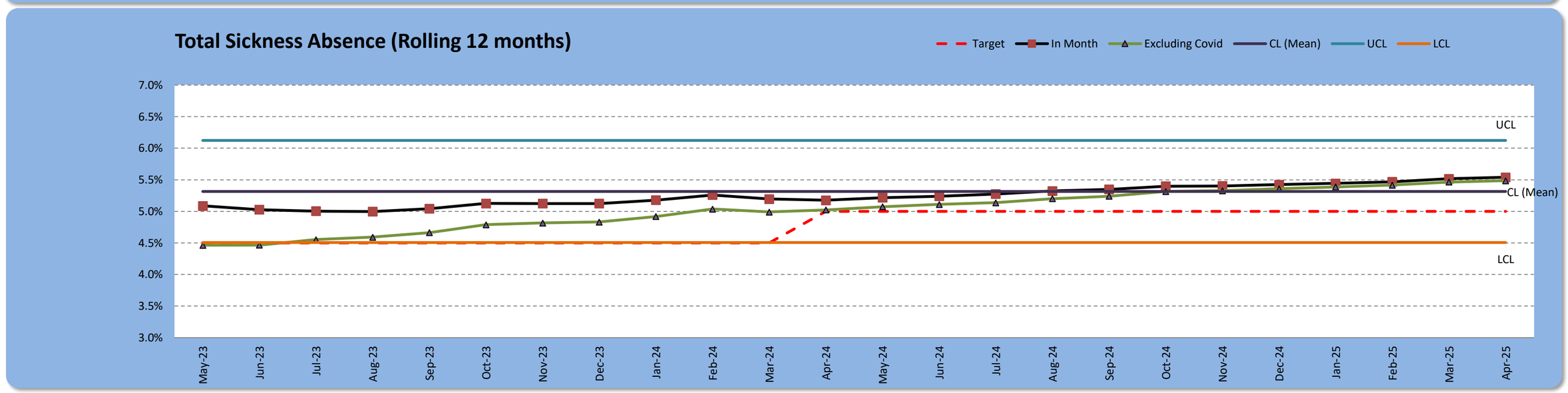
Goal 4 : Developing an Effective and Empowered Workforce

Target:	Amber:	Current month stands at:
5.0%	5.2%	5.1%

For the period ending: **April 2025**

Indicator Title	Description/Rationale		KPI Type
Sickness Absence	Percentage of staff sickness across the Trust (not including bank staff). Includes current month's unvalidated data	Executive Lead Karen Phillips	





Please refer to the accompanying front sheet/report for any relevant commentary

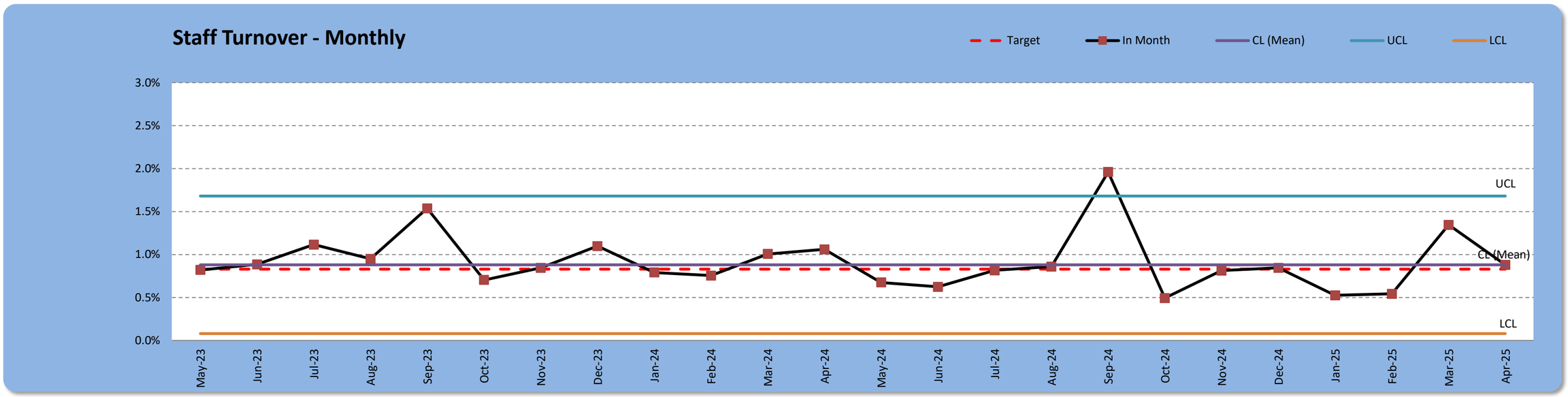
PI RETURN FORM 2025-26

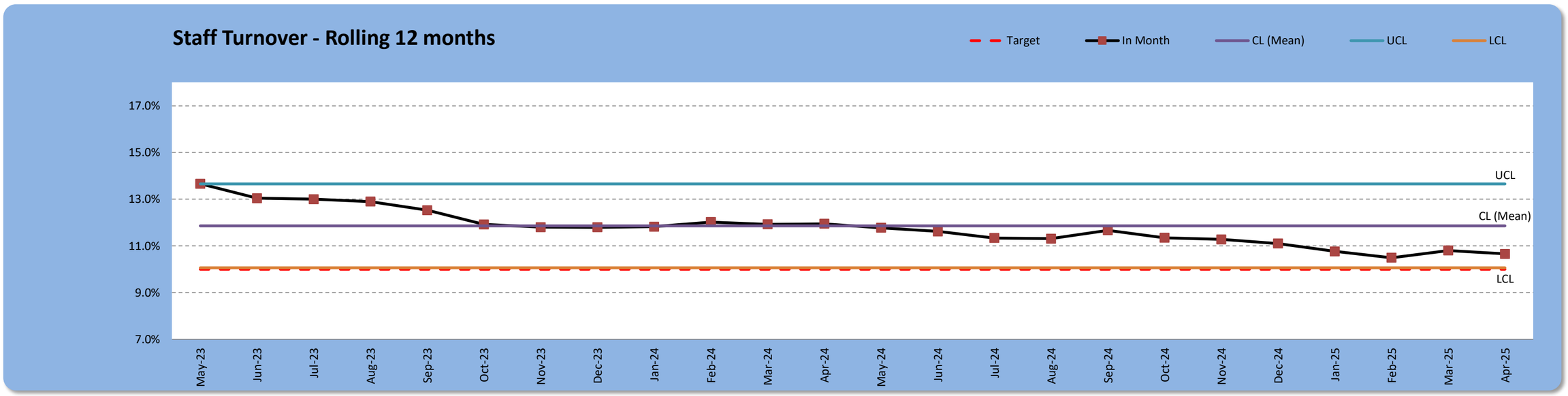
Goal 4 : Developing an Effective and Empowered Workforce

For the period ending: **April 2025**

Target:	Amber:	Current month stands at:	Target:	Amber:	Rolling figure stands at:
0.8%	0.7%	0.9%	10%	9%	11%

Indicator Title	Description/Rationale		KPI Type
Staff Turnover	The number of full time equivalent staff leaving the Trust expressed as a percentage of the overall full time equivalent workforce employed. Leavers include resignations, dismissals, transfers (up to Mar21), retirements and staff coming to the end of temporary contracts. It doesn't include junior doctors on rotation. Employee Transfers Out are excluded	Executive Lead Karen Phillips	WL 3 TOM Exc TUPE





Please refer to the accompanying front sheet/report for any relevant commentary

Humber Teaching NHS Foundation Trust

Trust Performance Report

GLOSSARY

ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
BLS	Basic Life Support
CAMHS	Child and Adolescent Mental Health Services
CHPPD	Care Hours per Patient Day
CL	Central Line
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CYP MH	Children and Young People's Mental Health
DToC	Delayed Transfer of Care
EIP	Early Intervention in Psychosis
FFT	Friends and Family Test
F2F	Face to Face
ILS	Immediate Life Support
LCL	Lower Control Limit
LD	Learning Disability
NHSER	National Health Service East Riding
OBD	Occupied Bed Days
PICU	Psychiatric Intensive Care Unit
RN	Registered Nurse
RTT	Referral to Treatment
SPC	Statistical Process Control
STaRS	Specialist Treatment and Recovery Service
TPR	Trust Performance Report
UCL	Upper Control Limit
WTE	Working Time Equivalent

NHS
Humber Teaching
NHS Foundation Trust

Executive Team:

Chief Executive: Michele Moran
Chair: Caroline Flint
Chief Operating Officer: Lynn Parkinson
Director of Finance: Peter Beckwith
Associate Director of People and Organisational Development: Karen Phillips
Medical Director: Kwame Fofie
Director of Nursing: Sarah Smyth

Caring, Learning
& Growing Together

Issue Date: 16/05/2025

Financial Year
2025-26

Humber Teaching
NHS Foundation Trust

NHS Prioritises Operational Planning Metrics

This document provides a high level summary of the performance against the NHS Priortises (Operational Planning) Mental Health and Community Services Operational Planning targets/objectives.

The purpose of this report is to present to EMT Members a review of the performance for a select number of indicators included in the Mental Health Long Term Plan, it includes data for the last 12 months.

Reporting Month:

Apr-25

Chief Executive: Michele Moran

Prepared by: Business Intelligence Team

Mental Health Operational Planning Metrics

NHS England

Humber Teaching NHS Foundation Trust

2025/26

13 May 2025

Humber Teaching NHS Foundation Trust

Entry	Indicator Definition	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
E.A.5	Inappropriate adult acute mental health **Out of Area Placement (OAP)** - SNAPSHOT at Reporting Month End	10	22	12	8	8	20	12	8	5	14	18	13	3
E.A.4a	Access to **NHS talking therapies** for anxiety and depression - reliable recovery	59%	59%	59%	58%	58%	58%	56%	61%	60%	54%	55%	59%	63%
E.A.4b	Access to **NHS talking therapies** for anxiety and depression - reliable improvement	75%	76%	72%	73%	74%	74%	74%	78%	79%	72%	73%	75%	79%
E.H.15	Women Accessing Specialist Community **Perinatal Mental Health Services** Rolling 12months **(ALL 4 PLACE AREAS)**	875	780	803	814	823	830	848	862	866	859	820	785	746
E.H.9	Access to **Children and Young People's** Mental Health Services Rolling 12months	6630	7110	6961	6740	6716	6683	6663	6618	6618	6640	6646	6844	6915
E.H.34	**Individual Placement Support access** Rolling 12months	220	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV

Community Services Operational Planning Metrics

NHS England
Humber Teaching NHS Foundation Trust
2025/26
13 May 2025

Humber Teaching NHS Foundation Trust

Entry	Indicator Definition	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
E.T.5	**Virtual Wards** - Number of Bed Occupancy	80%	25%	28%	21%	18%	27%	25%	30%	35%	42%	75%	56%	79%
E.T.8	UCR referrals (all). These are referrals to UCR services whether they require a 2-hour response or not.	115	93	82	100	91	80	108	113	121	116	95	97	77
E.T.10	Count of all attended care contacts in the period	43655	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV
E.T.9	Number of Adults (18+ years) >52 weeks on community waiting lists per system	8	2	1	0	1	2	4	4	4	3	8	6	15
E.T.9	Number of CYP (0-17 years) >52 weeks on community waiting lists	24	26	26	30	22	28	34	20	21	25	24	30	40

Mental Health
Long Term Plan Targets
Dashboard - PLACE data

NHS Improvement
Humber Teaching NHS Foundation Trust
2025/26
13 May 2025

Humber Teaching NHS Foundation Trust

Entry	Indicator Definition	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
E.A.5	Inappropriate adult acute mental health **Out of Area Placement (OAP)** bed days Rolling 3 months (HULL PLACE ONLY)	6	12	5	5	4	14	5	4	3	7	8	7	2
E.A.5	Inappropriate adult acute mental health **Out of Area Placement (OAP)** bed days Rolling 3 months(EAST RIDING PLACE ONLY)	4	7	5	2	2	4	5	4	2	7	10	6	1
E.H.9	Access to **Children and Young People's** Mental Health Services Rolling 12months (HULL PLACE ONLY)	3735	3870	3763	3634	3629	3589	3568	3541	3572	3558	3552	3613	3626
E.H.9	Access to **Children and Young People's** Mental Health Services Rolling 12months (East Riding PLACE ONLY)	2895	3008	2973	2876	2851	2858	2860	2846	2803	2835	2842	2981	3030
E.H.34	**Individual Placement Support access** Rolling 12months (HULL PLACE ONLY)	88	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV
E.H.34	**Individual Placement Support access** Rolling 12months (East Riding PLACE ONLY)	132	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV	IN DEV

Perinatal Dashboard - PLACE data

NHS Improvement
Humber Teaching NHS Foundation Trust
2025/26
13 May 2025

Humber Teaching NHS Foundation Trust

Entry	Indicator Definition	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
E.H.15	Women Accessing Specialist Community **Perinatal Mental Health Services** **Rolling 12months (HULL PLACE ONLY)**	294	273	283	291	294	298	304	304	309	300	287	268	253
E.H.15	Women Accessing Specialist Community **Perinatal Mental Health Services** **Rolling 12months (EAST RIDING PLACE ONLY)**	303	224	225	232	234	237	234	237	226	220	210	203	189
E.H.15	Women Accessing Specialist Community **Perinatal Mental Health Services** **Rolling 12months (NORTH LINCS PLACE ONLY)**	101	89	93	92	90	91	97	102	107	111	107	102	95
E.H.15	Women Accessing Specialist Community **Perinatal Mental Health Services** **Rolling 12months (NORTH EAST LINCS PLACE ONLY)**	177	194	202	199	205	204	213	219	224	228	216	212	209

NHS
Humber Teaching
NHS Foundation Trust

Executive Team:

Chief Executive:	Michele Moran
Chair:	Caroline Flint
Chief Operating Officer:	Lynn Parkinson
Director of Finance:	Peter Beckwith
Associate Director of People & Organisational Development:	Karen Phillips
Medical Director:	Kwame Fofie
Director of Nursing:	Sarah Smyth

Caring, Learning
& Growing Together

Issue Date: 21/05/2025

Humber Teaching NHS Foundation Trust

Agenda Item 20

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Report on the Use of the Trust Seal
Author/s:	Michele Moran Chief Executive
Recommendation:	

To approve		To discuss	
To note	☑	To ratify	
For assurance			

Purpose of Paper:	The purpose of this report is to inform the Trust Board of the use of the Trust Seal for the period 1st April 2024 to 31st March 2025.

Key Issues within the report:

Positive Assurances to Provide: • A register of the use of the seal is maintained	**Key Actions Commissioned/Work Underway:** • None
Key Risks/Areas of Focus: • None	**Decisions Made:** • None

Governance:

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

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership and alliances
	Developing an effective and empowered workforce
	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Use of the Trust Seal Report

1 Introduction and Purpose

The purpose of this report is to inform the Trust Board of the use of the seal for the period 1st April 2024 to 31st March 2025.

In line with the Trust Standing Orders (8.3.1) a report of all sealing's is made to the Trust Board on an annual basis**.**

2 Background

The common seal of the Trust is held in a secure place on behalf of the Chief Executive.

The Seal is used in order to execute a deed or agreement and when required to do so by law, for example during the conveyance of land

Where it is necessary to use the Trust Seal, the seal is affixed in the presence of a senior manager duly authorised by the Chief Executive and is attested by that person.

A register of the use of the seal is maintained which is available for review.

3 Use of Trust Seal

Over the period 1st April 2024 – 31st March 2025, the Trust Seal has been used 3 times. A register of the use of the seal is maintained which includes parties to the agreement which is available for review

Internal Ref Number	Date of Sealing	Description of Document
02/24	05/11/24	Deed of Grant Funding between the East Riding of Yorkshire Council & Humber Teaching NHS FT - Project name UK Shared Prosperity Fund People & Skills.
01/25	26/02/25	Health Stars (Humber Teaching NHS FT Charitable Funds) Charity Governing document.
02/25	27.03.25	Lease Agreement relating to Block H, East Riding of Yorkshire Council, County Hall, Cross Street, Beverley, HU17 9BA. Lessor ERYC, Lessee HTFT. Loan Agreement, Lender ERYC, Borrower HTFT.

4 Recommendation

The Board is asked to note the use of the Trust Seal

Humber Teaching NHS Foundation Trust

Agenda Item 21

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Changes to Standing Orders, Scheme of Delegation and Standing Financial Instructions
Author/s:	Stella Jackson, Head of Corporate Affairs Peter Beckwith, Director of Finance
Recommendation:	

To approve		To discuss	
To note		To ratify	X
For assurance			

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The purpose of this paper is to request Board ratification of changes to the Trust's Standing Orders, Scheme of Delegation and Standing Financial Instructions relating to the use of the Trust Seal and changes resulting from the introduction of the Procurement Regulations. The changes are outlined in this paper and through track changes in the Standing Orders (attached at Appendix A).

Key Issues within the report:

Positive Assurances to Provide:

- The Standing Orders, Standing Financial Instructions and Scheme of Delegation have served the Trust well.
- The proposed changes ensure the document remains fit for purpose in the future.
- The Trust's systems and processes for the procurement of goods, works and services have been reviewed and updated to reflect the Procurement Act.
- The revised section regarding use of the Trust Seal has been developed following advice received from Hill Dickinson, solicitors.

Key Actions Commissioned/Work Underway:

As a result of The Procurement Regulations, the following has been undertaken:

- The Trusts Standing Financial Instructions have been reviewed.
- Senior members of the Contracting and Procurement team have undergone training in the Procurement Regulations.
- The changes are being shared through divisional ODG meetings.

Key Risks/Areas of Focus:

- The key changes reflect the need to make a change in process when procuring goods and services.
- Clarification has been added to the document regarding the occasions when the Trust Seal will be used and the approval process for use of the Seal.

Decisions Made:

Recommendations in this paper have been approved at Trust ODG (28/4/25), EMT (13/5/25) and Audit Committee (19/5/25).

Governance: *Please indicate which committee or group this paper has previously been presented to:*				
		Date		Date
	Audit Committee	19/5/2025	Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	13/5/2025
	Mental Health Legislation Committee		Operational Delivery Group	28/4/2025
	Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
√	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership and alliances
	Developing an effective and empowered workforce
√	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Proposed changes to Standing Orders, Scheme of Delegation and Standing Financial Instructions

1. Introduction:

This document was last updated and approved by Trust Board in May 2024 and again in January 2025. The document has been further reviewed in 2025 and proposed changes are detailed below:

2. Proposed Changes

2.1 Changes resulting from the Procurement Regulations

a) General changes

References to the Public Contract Regulations 2015 have been updated throughout the document replacing with references to The Procurement Regulations.

b) Page 61: SECTION C PART G: Scheme of Budgetary Delegation

Currently, the Trust's local processes require contracts for goods and non-health care services with a financial value above £75k to be subject to tender.

It is proposed this threshold be increased to reflect the tender threshold set out in The Procurement Regulations which is £139,688. Contracts below this threshold will instead be subject to competitive quotes and the change will remove the requirement to undertake time and resource intensive tenders for relatively low value contracts.

The table outlining the Quotation, Tendering and Control Procedures to be replaced with the following:

Quotation, Tendering and Control Procedures – only applicable to goods, works and non-health care services		
Goods, works and non-health care services including Estates and Maintenance *(where this relates to contracts over more than one year, the lifetime contract value is delegated as per below)*		
Lifetime Value (including extension options) (excluding VAT)	**Minimum No**	**Authorised by**
Up to £9,999	At discretion of budget holder/Purchasing officer	Budget holder
£10,000 to £24,999 (Goods, Services & Works)	3 or more quotes or non-competitive quotation only in permissible circumstances	Division General Manager or for works Deputy Director of Estates and Facilities
£25,000 up to Procurement Act threshold (Goods & Services)	3 or more quotes or non-competitive quotation only in permissible circumstances	Director
£25,000 to £249,999 (Works)	3 or more quotes or non-competitive quotation only in permissible circumstances	Director of Finance
£250,000 up to Procurement Act threshold (Works)	Local tendering process	Chief Executive and Board if over £750k (annual value)

For any Goods, Services and Works above Procurement Act thresholds	Formal tendering process in accordance with Procurement Act	Director of Finance/Chief Executive/Board
The above applies to contracts for goods, works and non-health care services unless a framework agreement (SFI 21.1.2) applies in which case the above does not apply.		

c) Page 76: SECTION D – Standing Financial Instructions

The exceptions and instances where formal tendering need not be applied have been reworded to reflect the circumstances where formal tendering procedures need not be applied and where direct contract awards are justified in accordance with The Procurement Regulations.

2.2 Proposed changes to the Trust Seal

Paragraph 8.2 – Sealing of Documents

The existing Standing Orders do not currently specify when the Trust's Seal should be used or who should authorise use of the Seal.

The scheme of reservation and delegation (SORD) sets out that the use of the seal must be authorised by the Board of Directors. However, it is usual practice within the NHS for use of the Seal to be authorised by two directors and it is proposed that the Chief Executive (or their deputy) and the Director of Finance (or their deputy) authorise use of the Seal.

Proposed amendments have been made to paragraphs 8.1 to 8.3 of the Standing Orders outlining when the Seal should be used and who should authorise its use. Proposed amendments have been made to the SORD to remove the reference to the Board authorising use of the Seal (page 35, number 15). The Chief Executive's role in authorising and attesting the fixing of the Seal has been added to page 48 of the SORD.

The proposed amendments reflect advice received from Hill Dickinson, solicitors.

3. Recommendations

The recommendations in this paper have been approved by Trust ODG, EMT and Audit Committee. Trust Board is asked to ratify their approval with regard to the recommendations in this paper.

Appendix A:

Track changes to Standing Orders

Appendix A - Proposed changes to

Humber Teaching NHS Foundation Trust

Standing Orders,

Scheme of Delegation and Standing Financial Instructions

January 2025

Date Approved: 29 January 2025

Review Date: May 2025

Caring, Learning & Growing Together

1003847905.1

SECTION A:

INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

Introduction

Within the Terms of Authorisation issued by the Independent Regulator - NHS England (NHSE), the statutory entity that regulates NHS Foundation Trusts, NHS Foundation Trusts are required to demonstrate appropriate arrangements to provide comprehensive governance arrangements in accordance with the Health and Social Care (Community Health and Standards) Act 2008.

Standing Orders (SOs) regulate the proceedings and business of the Trust and are part of its corporate governance arrangements. In addition, as part of accepted Codes of Conduct and Accountability arrangements, boards are expected to adopt schedules of reservation of powers and delegation of powers. These schedules are incorporated within the Trust's Scheme of Delegation.

These documents, together with Standing Financial Instructions, Standards of Business Conduct and Managing Declarations of Interests Policy for NHS Staff, Budgetary Control Procedures, the Local Anti-Fraud, Bribery and Corruption Policy and the procedures for the Declaration of Interest provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation, Standing Financial Instructions and Budget Manual provide a comprehensive business framework that is to be applied to all activities, including those of the Charitable Foundation. Members of the Trust Board and all members of staff should be aware of the existence of and work to these documents.

These documents apply to all activities of the Trust and specifically including commissioning activities undertaken via the Provider Collaborative which should follow the same principles as the Trust who has the overall responsibility for the reporting arrangements.

Interpretation

Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Trust Board).

Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

"Accounting Officer" means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Associate Member" means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

“Associate Non-Executive Director” means a person appointed to support the Board succession strategy without the associated rights or liabilities. Associate Non-Executive Directors cannot participate in any formal vote at Board.

“Audit Committee" means a Committee whose functions are concerned with the scrutiny and review of Trust systems, risk management and internal control.

"Budget" means a resource, expressed in financial terms, proposed by the Trust Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

“Budget Holder” means the Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

"Chair of the Trust Board (or Trust)" is the person appointed to lead the Board and Council of Governors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole.

The expression “the Chair of the Trust” shall be deemed to include the Deputy Chair, if one is appointed, of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the Chief Officer of the Trust.

"Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

"Committee" means a Committee or sub-Committee created and appointed by the Trust Board.

“Collaborative Committee” – means a Committee whose functions are to hold delegated responsibility to provide commissioning leadership and monitoring functions on behalf of the Provider Collaborative.

"Committee members" means persons formally appointed by the Trust Board to sit on or to chair specific Committees.

"Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

“Council of Governors” means the body of persons elected and appointed, to fulfil the functions in accordance with the Constitution authorised to be members of the Council of Governors and act in accordance with the Constitution.

“Deputy Chair" means the Non-Executive Director appointed by the Council of Governors to take on the Chair’s duties if the Chair is absent for any reason.

"Director of Finance" means the Chief Financial Officer of the Trust.

“Finance & Investment Committee" means a Committee whose functions are to monitor, review and support the finance functions of the Trust.

“Funds held on trust” shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977.

“**Independent Regulator”** means the regulator for the purpose of Part 1 of the 2003 Act NHS England (NHSE), the statutory entity that remains the regulator of NHS foundation trusts.

"Member" means officer or non-officer member of the Trust Board as the context permits. Member in relation to the Trust Board does not include its Chair.

"Nominated Officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Non-Executive Director" means a Director who is not an officer of the Trust and who has been appointed in accordance with the Constitution. This includes the Chair member of the Trust Board who does not hold an executive office of the Trust.

"Officer" means employee of the Trust or any other person holding a paid appointment or office with the Trust.

"Officer Member" means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member).

"Provider Collaborative" – A group of providers who have agreed to work together to improve the care pathway for their local population.

"Provider Licence" – replaced the Terms of Authorisation and is how the Independent Regulator regulates providers of NHS Services.

"Quality Committee" means a Committee whose functions are to provide the strategic overview of and assurance against clinical and quality governance, clinical risk and patient and carer experience and engagement issues in the Trust.

"Secretary" means a person appointed by the Trust (the Trust Secretary) to act independently of the Trust Board and Council of Governors and monitor the Trust's compliance with the law, Standing Orders, Department of Health guidance, the Constitution and Provider Licence.

"Senior Employee" means an employee on Very Senior Manager pay and conditions

"Senior Manager" means an employee of band 8c and above.

"SFIs" means Standing Financial Instructions which regulate the conduct of the Trust's financial matters.

"SOs" means Standing Orders.

"Trust" means Humber Teaching NHS Foundation Trust.

"Trust Board" means the Chair, Chief Executive, Non-Executive Directors and Executive Directors of the Trust collectively as a body.

SECTION B: STANDING ORDERS

1. Introduction

Statutory Framework

Humber Teaching NHS Foundation Trust ("the Trust") came into existence on 1 February 2010 pursuant to authorisation of Monitor under the Health and Social Care (Community Health and Standards) Act 2008 ("the 2008 Act"). Prior to 1st April 2018 the Trust was known as Humber NHS Foundation Trust.

The principal place of business is:-

Trust Headquarters
Block A, Ground Floor,
Willerby Hill,
Beverley Road,
Willerby,
East Riding of Yorkshire
HU10 6FE

NHS Foundation Trusts are governed by the Health and Social Care Act 2012, its Constitution, Provider License, Governors and members.

As a Foundation Trust the Trust has specific powers to contract in its own name and to act as a corporate trustee. It is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals. The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

NHS Framework

In addition to the statutory requirements the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.

The Constitution requires that, inter alia, Trust Boards' draw up a Schedule of Matters Reserved to the Trust Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives.

The Constitution also requires the establishment of an Audit Committee and a Remuneration Committee with formally agreed terms of reference. The Trust also has a Code of Conduct for Directors.

Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make

arrangements for the exercise, on behalf of the Trust of any of their functions by a Committee, sub-Committee or joint Committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Independent Regulator may direct".

2. The Trust

All business shall be conducted in the name of the Trust.

The roles and responsibilities of the Trust Board are set out in Annex 8 of the Constitution

The powers of the Trust established under statute shall be exercised by the Trust Board except as otherwise provided for in Standing Order 4.

Directors acting on behalf of the Trust as corporate trustee of the NHS FT Charitable Funds are accountable for charitable funds held on trust to the Charity Commission.

2.1 Composition of the Membership of the Trust Board

2.1.1 In accordance with the Constitution the composition of the Board shall comprise both Executive and Non-Executive Directors. The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors.

The current composition consists of:

- The Chair of the Trust (appointed by the Council of Governors);
- 5 other Non-Executive Directors (appointed by the Council of Governors);
- 5 Executive Directors (but not exceeding the number of non-officer members) including;
    - a Chief Executive
    - a Finance Director
    - a Registered Medical Practitioner
    - a Registered Nurse
- A non-voting Director;
- Two Associate Non-Executive Directors (also non-voting)

The Trust may appoint other Executive, Non-Executive and Associate Non-Executive Directors as deemed necessary and in accordance with the Scheme of Delegation.

2.2 Appointment of Chair and Non-Executive Director Members of the Trust Board

2.2.1 The Chair and Non-Executive Directors shall be appointed and removed by the Council of Governors in accordance with the Constitution. The Chief Executive shall also be appointed and removed in accordance with the Constitution.

2.3 Terms of Office of the Chair

2.3.1 The provisions governing the period of tenure of office of the Chair and the termination of the office of the Chair are contained in the Constitution. The Chair and the Non-Executive Directors are to be appointed for a period of office in accordance with the Constitution. The terms and conditions of the office are decided by the Council of Governors at a General Meeting.

2.4 Appointment and Powers of Deputy Chair

2.4.1 The Council of Governors may appoint a Deputy Chair in accordance with the Constitution.

2.4.2 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair.

2.4.3 Where the Chair of the Trust has ceased to hold office or has been unable to perform their duties as Chair owing to absence through illness or any other cause, then the term Chair shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair, should a Deputy Chair have been appointed.

2.5 Appointment of Senior Independent Director

2.5.1 The Trust Board shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be their Senior Independent Director, using the procedure set out in the Constitution.

2.5.2 **Role of Trust Board**

The Board will function as a corporate decision-making body. Executive and Non-Executive Directors will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.6 Joint Directors

2.6.1 Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for Executive Directors, those persons shall become appointed as an Executive Director jointly and shall count for the purpose of Standing Orders as one person.

2.6.2 Where a post of Executive Director of the Trust Board is shared jointly by more than one person:

(a) either or both of those persons may attend or take part in meetings of the Trust Board;

(b) if both are present at a meeting they should cast one vote if they agree;

(c) in the case of disagreements no vote should be cast;

(d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.7 Role of Members

2.7.1 The Trust Board will function as a corporate decision-making body, Executive Directors and Non-Executive Directors will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.7.2 **Executive Members**

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

2.7.3 **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

2.7.4 **Director of Finance**

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.7.5 **Non-Executive Directors**

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

2.7.6 **Chair**

The Chair shall be responsible for the operation of the Trust Board and chair all Trust Board meetings when present. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with the representatives of the Council of Governors over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Trust Board in a timely manner with all the necessary information and advice being made available to the Trust Board to inform the debate and ultimate resolutions.

2.8 Corporate Role of the Trust Board

2.8.1 All business shall be conducted in the name of the Trust.

2.8.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.8.3 The Trust has the functions conferred on it by the Health and Social Care (Community Health and standards) Act 2003 and by its Provider Licence, which include the Constitution.

2.8.4 The Trust Board shall define and regularly review the functions it exercises on behalf of the Independent Regulator.

2.9 Schedule of Matters Reserved to the Trust Board and Scheme of Delegation

2.9.1 The Trust Board has resolved that certain powers and decisions may only be exercised by the Trust Board in formal session. These powers and decisions are set out in the Schedule of Matters Reserved to the Board in Section B of this document and shall have effect as if incorporated into the Standing Orders. Those powers

which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.10 Lead Roles for Trust Board Members

2.10.1 The Chair will ensure that the designation of lead roles or appointments of Board guidance will be made in accordance with that guidance or statutory requirement.

2.11 Relationship between the Trust Board and the Council of Governors

2.11.1 In summary the Trust Board manage the business of the Trust (in accordance with the Constitution) and the Council of Governors conduct a number of tasks amongst them, approving the appointment of Non-Executive Directors and deciding their remuneration, terms and conditions (following recommendations from the Appointments, Terms and Conditions Committee); appointing the external auditors (following recommendations made to the Council of Governors by any task and finish group established to progress the appointment ; and to review various periodic reports listed in the Constitution, presented to them by the Trust Board. The Council of Governors will represent the views of their constituencies so that the needs of the local health economy are taken into account when deciding the Trust's strategic direction.

2.11.2 In the event of any issues of conflict between the Trust Board and the Council of Governors, this should be raised with the Lead Governor and Senior Independent Director (SID). If a resolution cannot be found, the issue should be escalated to the Chair whose decision shall normally be final.

3. Meetings of the Trust Board

The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Trust Board but shall be required to withdraw upon the Board resolving as follows:

'That representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest' (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).'

The Chair shall give such direction as seen fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

It was **resolved** that members of the public would be excluded from the second part of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided above, shall be confidential to the members of the Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'in confidence' or minutes and papers headed 'private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

3.1 Calling Meetings

3.1.1 Ordinary meetings of the Trust Board shall be held on a bi-monthly basis at such times and places as the Trust Board may determine. Meetings of the Trust Board will be held in public.

3.1.2 The Chair of the Trust may call a meeting of the Trust Board at any time.

3.1.3 One third or more of the voting Directors of the Trust Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be Transacted

3.2.1 Before each meeting of the Trust Board a written notice specifying the business proposed to be transacted shall be delivered to every Director (by email or post to the usual place of residence of each Director) so as to be available to members at least five clear days before the meeting. Lack of service of such a notice on any member shall not affect the validity of a meeting. Details of meetings and the public agenda will be published on the Trust's website.

3.2.2 In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.

3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

3.2.4 A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

3.2.5 Before each meeting of the public Trust Board a notice of the time and place of the meeting shall be displayed on the Trust's website at least three clear days before the meeting. The public agenda and papers will be available on the Trust's website.

3.3 Agenda and Supporting Papers

3.3.1 The agenda will be sent to members 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda,

3.4 Petitions

3.4.1 Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

3.5.1 Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Trust Board

wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

3.5.2 The notice shall be delivered at least 14 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

3.6.1 Subject to the agreement of the Chair, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Trust Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.7 Motions: Procedure at and During a Meeting

3.7.1 i) **Who May Propose**

A motion may be proposed by the Chair of the meeting or any Director present. It must also be seconded by another Director.

3.7.2 ii) **Contents of Motions**

The Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the receipt of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Trust Board proceed to next business;
- that the Trust Board adjourn;
- that the question be now put.

3.7.3 iii) **Amendments to Motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Trust Board

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.7.4 iv) **Rights of Reply to Motions**

a) <u>Amendments</u>

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.7.5 v) **Withdrawing a Motion**

A motion, or an amendment to a motion, may be withdrawn.

3.7.6 vi) **Motions Once under Debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' Committee to deal with a specific item of business;
- that a Director be not further heard;

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Trust Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

3.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Directors, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such motion has been dealt with by the Trust Board it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chair of Meeting

3.9.1 At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy-Chair (if the Board has appointed one), if present, shall preside.

3.9.2 If the Chair and Deputy Chair are absent, such member (who is not also an Officer Member of the Trust) as the members present shall choose shall preside.

3.10 Chair's Ruling

3.10.1 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

3.11.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and Board members (including at least one Executive Director and one Non-Executive Director) is present.

3.11.2 An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.

3.11.3 If the Chair or another Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see Standing Order 7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

3.12.1 Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of Directors present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chair of the meeting) shall have a second, and casting vote.

3.12.2 At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.12.3 If at least one third of the Directors present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

3.12.4 If a Director so requests, their vote shall be recorded by name.

3.12.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

3.12.7 A manager attending the Trust Board meeting to represent an Executive Officer during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. A manager's status when attending a meeting shall be recorded in the minutes.

3.12.8 For the voting rules relating to joint directors see Standing Order 2.6.

3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any statutory provision or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Trust Board are present (including at least one member who is an Executive Director of the Trust and one member who is a Non-Executive Director) and that at least two-thirds of those Directors present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board' minutes.

3.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Trust.

3.13.3 No formal business may be transacted while Standing Orders are suspended.

3.13.4 The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and Amendment of Standing Orders

3.14.1 These Standing Orders shall not be varied except in the following circumstances:
- upon a notice of motion under Standing Order 3.5;
- upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;
- that two thirds of the Trust Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive Directors vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Record of Attendance

3.15.1 The names of the Chair and Directors/members present at the meeting shall be recorded.

3.16 Minutes

3.16.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

3.16.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

3.17 Admission of Public and the Press

3.17.1 Admission and Exclusion on Grounds of Confidentiality of Business to be Transacted

The public and representatives of the press may attend each meeting of the Trust Board, but shall be required to withdraw upon the Trust Board as follows:

It was resolved that members of the public would be excluded from the second part of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

The Trust Board meetings shall be held in public, at which members of the public and representatives of the press shall be permitted to attend. Members of the public are not permitted to ask questions during the meeting as it is a meeting held in public, not a public meeting. However, questions can be submitted to the Chair at the end of a meeting. Responses to the questions may be given at that time or in writing within 5 days of the meeting. Members of the public may be excluded from a meeting for special reasons and having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

3.17.2 General Disturbances

The Chair (or Deputy Chair) or the person presiding over the meeting

shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

`*That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'.*

3.17.3 Business Proposed to be Transacted when the Press and Public have been Excluded from a Meeting

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in 3.17.1 and 3.17.2 above, shall be confidential to the members of the Trust Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' "private" or minutes headed "strictly confidential, not for wider circulation" outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Trust Board meeting which may take place on such reports or papers.

3.17.4 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.17.5 Observers at Trust Board Meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

4. Appointment of Committees and Sub-Committees

4.1 Appointment of Committees

4.1.1 Subject to such directions as may be given by NHS England, the statutory entity that regulates NHS foundation trusts, the Trust Board may appoint Committees of the Trust.

4.1.2 The Trust Board shall determine the membership and terms of reference of Committees and Sub-Committees and shall if it requires, receive and consider reports of such Committees.

4.2 Joint Committees

4.2.1 Joint Committees may be appointed by the Trust Board by joining together with one or more other Trusts, Local Authorities or health service bodies consisting of, wholly or partly of the Chair and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

4.2.2 Any Committee or joint Committee appointed under this Standing Order may, subject to such directions as may be given by the Independent Regulator or the Trust or other health bodies in question, appoint sub-Committees consisting wholly or partly of members of the Committees or joint Committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the Committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

4.3.1 The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any Committees established by the Trust. In which case the term "Chair" is to be read as a reference to the Chair or other Committee as the context permits, and the term "member" is to be read as a reference to a member or other Committee also as the context permits. There is no requirement to hold meetings of Committees, established by the Trust in public.

4.4 Terms of Reference

4.4.1 Each such Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Trust Board), as the Trust Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Independent Regulator. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of Powers by Committees to Sub-Committees

4.5.1 Where Committees are authorised to establish sub-committees they may not delegate executive powers to the sub-Committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

4.6.1 The Trust Board shall approve the appointments to each of the Committees which it has formally constituted. Where the Trust Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a Committee the terms of such appointment shall be within the powers of the Trust Board as defined by the Independent Regulator. The Trust Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory Functions

4.7.1 Where the Trust Board is required to appoint persons to a Committee and/or to undertake statutory functions and where such appointments are to operate independently of the Trust Board such appointment shall be made in accordance with the regulations and directions made with the relevant authority.

4.8 Committees Established by the Trust Board

The Committees, sub-Committees, and joint-Committees established by the Board are:

4.8.1 Audit Committee

In line with the Standing Orders, the NHS Audit Committee Handbook, the Audit Code for NHS Foundation Trusts and the Code of Governance issued by the Independent Regulator, an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The terms of reference will be approved by the Trust Board and reviewed on a periodic basis.

The Committee will be comprised of not less than three Non-Executive Directors, unless the Trust Board decides otherwise, of which one must have significant, recent and relevant financial experience.

4.8.2 Quality Committee

In line with the Standing Orders, a Quality Committee will be established and constituted to provide the Trust Board with a strategic overview of and assurance against clinical and quality governance, clinical risk and patient and carer experience and engagement issues. The terms of reference will be approved by the Trust Board and reviewed on a periodic basis.

The Committee will be comprised of three Non-Executive Directors; the Director of Nursing, Allied Health and Social Care Professionals; the Medical Director; and the Chief Operating Officer.

4.8.3 Remuneration and Nominations Committee

In line with Standing Orders, the Audit Code for NHS Foundation Trusts and the Code of Governance issued by the Independent Regulator, a Remuneration and Nomination Committee will be established and constituted.

The Committee will provide assurance and advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors, other senior employees on a Very Senior Managers contract and conditions including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms.

The Committee will approve, to the levels outlined in the terms of reference, recruitment and retention premia awarded to any member of staff not covered by Agenda for Change where there are national recruitment and retention pressures (for example medical consultants).

The Committee will be comprised of all Non-Executive Directors (including the Chair).

4.8.4 Mental Health Legislation Committee

The Mental Health Legislation Committee is constituted as a sub-committee of the Trust Board.

The Committee will provide strategic leadership and assurance to the Trust Board pertaining to the Mental Health Act, the Mental Capacity Act and their respective Codes of Practice and other mental health related legislation and will;

- monitor, provide challenge and seek assurance of compliance with external standards relating to Mental Health Legislation.
- approve and review mental health legislation policies and protocols.
- promote and encourage joint working arrangements regarding the implementation of Mental Health Legislation with partner organisations including local authorities, clinical commission groups, acute hospital trusts, police and ambulance services.
- receive report regarding inspecting authorities and to monitor the implementation of action plans in response to any recommendations made

The Committee will be comprised of one Non-Executive Director (who is designated Chair); at least two other Non-Executive Directors (one of which is also a designated Associate Hospital Manager, if not the Chair); the Medical Director; the Chief Operating Officer; the Clinical Director; and the Director of Nursing, Allied Health and Social Care Professionals.

4.8.5 Finance Committee

The Finance and Investment Committee is constituted as a sub-committee of the Trust Board.

The Committee will provide strategic overview and provide assurance to the Trust Board that there is an effective system of governance and internal control across all financial areas and any potential investment decisions.

The Committee will;

- Scrutinise, review and endorse all financial plans prior to seeking Board approval.
- Approve the processes and timetable for annual budget setting, and budget management arrangements
- Monitor delivery of Trust's Capital Investment Programme
- Monitor progress and seek assurance on the progress against the Trust Digital Plan
- Scrutinise all business cases for new business and investment and review all tenders presented to the Committee
- Review and assess business cases to support and govern all investments, contracts and projects as set out in the committee's terms of reference.
- Review the robustness of the risk assessments underpinning financial forecasts
- Monitor delivery of the Trust's budget reduction strategy and other financial savings programmes

The committee is comprised of three Non-Executive Directors; the Director of Finance; Chief Operating Officer; and Chief Information Officer.

4.8.6 ~~Workforce and~~People and Organisational Development Committee

The Workforce and Organisational Development Committee is constituted as a sub-committee of the Trust Board.

The ~~Workforce and~~People and Organisational Development Committee exists to provide strategic overview and provide assurance to the Trust Board that there is an effective system of governance and internal control across workforce and

organisational development that supports the Trust to deliver its strategic objectives and provide high quality care.'

The Committee will be comprised of three Non-Executive Directors (one of whom will be the Committee Chair); the Associate Director of People and OD; the Chief Operating Officer; the Medical Director; and the Executive Director of Nursing, Allied Health and Social Care Professionals.

4.8.7 Provider Collaborative Committee

The Provider Collaborative Committee is constituted as a sub-committee of the Trust Board.

The Trust is the Lead Provider within the Humber and North Yorkshire Provider Collaborative and will hold the Lead Contract with NHS England. The Trust as Lead Provider will sub-contract with a range of healthcare providers in the delivery of:

- Child and Adolescent Mental Health In-Patient services
- Adult Low and Medium Secure services
- Adult Eating Disorder Services.

The Collaborative Committee has been established by the Trust as the Lead Provider and holds delegated responsibility to provide commissioning leadership and monitoring functions. On behalf of the Provider Collaborative and Lead Provider the Collaborative Committee will review any significant service proposals to ensure developments are in line with the assessed population needs and can be met from within the resources available within the Provider Collaborative. The Collaborative Committee will provide the Trust Board with a strategic overview of and assurance against provider collaborative issues.

The committee will be comprised of two Non-Executive Directors (one of whom will be the Committee Chair); the Associate Non-Executive Director; the Chief Executive; the Director of Finance; the Director of Nursing, Allied Health and Social Care Professionals; the Collaborative Planning Director; and the Clinical and Quality Assurance Director.

4.8.8 Other Committees

The Trust Board may also establish such other Committees as required to discharge the Trust's responsibilities.

5. Arrangements for the Exercise of Trust Functions by Delegation

5.1 Delegation of Functions to Committees, Officers or Other Bodies

5.1.1 Subject to the Constitution and directions as may be given by the Independent Regulator, the Trust Board may make arrangements for the exercise, on behalf of the Trust Board, or any of its functions

a) by a Committee, sub-Committee appointed by virtue of Standing Order 4, or by an officer of the Trust,

b) or by another body as defined in Standing Order 5.1.2 below,

c) in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to Committees, sub Committees or Officers, the Trust retains full responsibility.

5.2 Emergency Powers and Urgent Decisions

5.2.1 The powers which the Trust Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Trust Board shall agree from time to time to the delegation of executive powers to be exercised by other Committees, or sub-Committees, or joint-Committees, which it has formally constituted in accordance with directions issued by the independent regulator. The Constitution and terms of reference of these Committees, or sub-Committees, or joint Committees, and their specific executive powers shall be approved by the Trust Board in respect of its sub-Committees.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Trust Board or delegated to a Committee or sub-Committee or joint-Committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Trust Board subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Trust Board as indicated above.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Trust Board of the Director of Finance to provide information and advise the Board in accordance with statutory or independent regulator requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust Board and Scheme of Delegation of Powers

5.5.1 The arrangements made by the Board as set out in the "Scheme of Matters Reserved to the Board" in Section C shall have effect as if incorporated in these Standing Orders.

5.6 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

5.6.1 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Trust Board for action or ratification. All members of the Trust Board, Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. Overlap with Other Trust Policy Statements/Procedures, Regulations and Standing Financial Instructions

6.1 Policy Statements: General Principles

6.1.1 The Trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by Humber Teaching NHS Foundation Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy Statements

6.2.1 Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Managing Declarations of Interests Policy for NHS Staff
- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

6.3.1 Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific Guidance

6.4.1 Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Confidentiality: NHS Code of Practice 2003;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

7. Duties and Obligations of Trust Board Members/Directors and Senior Managers under the Standing Orders

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and Applicability to Trust Board

The Constitution, 2006 Act and the Code of Conduct and Accountability requires Trust Directors to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board Directors should declare such interests. Any Directors appointed subsequently should do so on appointment. It is a condition of employment that those holding director or director-equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to

hold such posts. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Trust's Provider Licence, the Health & Social Care Act 2012 (Regulated Activities) Regulation, and the Trust's Constitution.

7.1.2 Interests which are Relevant and Material

Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

d) A position of authority in a charity or voluntary organisation in the field of health and social care;

e) Any connection with a voluntary or other organisation contracting for NHS services;

f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to lenders and banks

g) Research funding/grants that may be received by an individual or their department;

h) Interests in pooled funds that are under separate management

Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 and elsewhere) has any pecuniary interest, direct or indirect, the Trust Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.1.3 Advice on Interests

If Trust Board members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust, or with the Trust Secretary.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 Recording of Interests in Trust Board Minutes

At the time Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 Publication of Declared Interests in Annual Report

Directors' Directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 Conflicts of Interest which Arise during the Course of a Meeting

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3)

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Trust Board. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both Executive and Non-Executive Trust Board members.

7.2.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public in accordance with the Constitution and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local population and to publicise arrangements for viewing it.

7.3 Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest

7.3.1 Definition of Terms used in Interpreting 'Pecuniary' Interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) "contract" shall include any proposed contract or other course of dealing.

(iii) "Pecuniary interest"
Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

For the purpose of this Standing Order the Chair or a director shall be treated, subject to SO 7.1 as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) he/she, or a nominee of his/her, is a Director of a company or other body (not being a public body), with which the contract was made, or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration, or

b) he/she is a partner, associate or employee of any person with whom the contract is made or proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

a) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or

b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2.

7.3.2 Exclusion in Proceedings of the Trust Board

(i) Subject to the following provisions of this Standing Order, if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(ii) The Board may exclude the Chair or a Director of the Trust Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

(iv) Any remuneration, compensation or allowance payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(v) This Standing Order applies to a Committee or sub-Committee and to a joint Committee or sub-Committee as it applies to the Trust and applies to a member of any such Committee or sub-Committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust.

7.4 Standards of Business Conduct

7.4.1 Trust Policy and National Guidance

All Trust staff must comply with the Trust's Standards of Business Conduct and Managing Conflicts of Interest Policy for NHS Staff and the national guidance produced by NHS England on Managing Conflicts of Interest.

7.4.2 Interest of Officers in Contracts

i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust Secretary as soon as practicable.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 Canvassing of and Recommendations by Members in Relation to Appointments

i) Canvassing of Members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Orders shall be included in application forms or otherwise brought to the attention of candidates.

ii) A Member shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

iii) Informal discussions outside appointments panels or Committees, whether solicited or unsolicited, should be declared to the panel or Committee.

7.4.4 Relatives of Members or Officers

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

ii) The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between himself/herself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

iii) On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust Board whether they are related to any other Director or holder of any office under the Trust.

iv) Where the relationship to a Director of the Trust is disclosed, the Standing Order headed 'Exclusion of Chair and Members in proceedings on account of pecuniary interest' (SO 7.3) shall apply.

8. Custody of Seal, Sealing of Documents and Signature of Documents

8.1 Custody of Seal

8.1.1 The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

8.2 Sealing of Documents

8.2.1 Where a document is to ~~it is necessary that a document shall~~ be sealed, the ~~seal shall be affixed~~ CEO (or their nominated deputy) and the Director of Finance~~CFO~~ (or their nominated deputy) shall authorise the use of the seal and the affixing of the seal shall be attested and signed by the CEO (or their nominated deputy) and the Director of Finance ~~CFO~~ (or their nominated deputy). ~~the presence of a senior manager duly authorised by the Chief Executive and shall be attested by them~~.

8.2.2 Where a document is required to be executed as a deed (this includes leases, transfers of land, the appointment of trustees and powers of attorney) or where the Trust determines that a contract or other document should be executed as a deed, the document must be executed under seal in accordance with the procedure in 8.2.1 above. All construction contracts and contracts for capital works shall be executed under seal.

8.2.3 For the avoidance of doubt, the requirements set out above in relation to the execution of deeds and the affixing of the seal do not affect, and operate in addition to, the delegated authorities set out in the Trust's Scheme of Reservation and Delegation.

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8.3 Register of Sealing

8.3.1 The Chief Executive or another manager authorised by the Chief Executive shall keep a register in which a record of the sealing of every document is entered. A report of all sealings shall be made to the Trust Board on an annual basis.

8.4 Signature of Documents

8.4.1 Where the signature of any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents may be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

8.4.2 Commercial opportunities - for example a joint venture, either contractual or corporate or a subsidiary company shall not be entered into or incorporated unless authorised by the Board.

8.4.3 The Executive Directors are authorised to develop commercial opportunities which may (or may not) lead to the establishment of a joint venture, either contractual or corporate or the formation of a subsidiary company. This includes authority to sign non legally binding documents that may be associated with the development of commercial opportunities prior to Board sign off, where this is required, for example Memorandum of Understanding or Articles of Association. The Executive Directors shall keep the Board apprised of the subject matter and of any non legally binding documents entered into via the Chief Executive (or nominated officer).

9. Miscellaneous

9.1 Joint Finance Arrangements

The Trust Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Trust Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

See overlap with Standing Financial Instruction No. 19.3.

SECTION C:

SCHEME OF MATTERS RESERVED TO THE TRUST BOARD AND DELEGATION

Part A: Decisions Reserved to the Board

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	**General Enabling Provision** The Trust Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers under the 2006 Act, its Constitution and its Provider Licence.
NA	THE BOARD	***Regulations and Control*** 1. Approve Standing Orders (SOs) of the Trust Board a Schedule of Matters Reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders under SO 3.13 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.2 5. Approve a Scheme of Delegation of powers from the Board to Committees**.** 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from Committees including those that the Trust is required by the Independent Regulator or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's Committees where the Committees do not have

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for charitable funds held on trust. 13. Establish terms of reference and reporting arrangements of all Committees and sub-Committees that are established by the Trust Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. ~~15. Authorise use of the Trust seal.~~ ~~16.~~15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6. ~~17.~~16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. ~~18.~~17. Authorisation of any long term loans to be taken out by the Board within the authorisation limits set out in SFI 20.1.6 ~~19.~~18. Approve the formation of any joint venture, either contractual or corporate or a subsidiary company. ~~20.~~19. The granting of loans to any subsidiaries will be subject to approval by the Board regardless of value.
NA	THE BOARD	**Appointments/ Dismissal** 1 Appoint the Senior Independent Director. 2 Subject to the Regulatory Framework, appoint and dismiss Committees (and individual members) that are directly accountable to the Board. 3 Appoint, appraise, discipline and dismiss Executive Directors based on recommendations of the Remuneration and Nomination Committee. (Chief Executive appointment requires Council of Governors approval)
NA	THE BOARD	***Strategy, Plans and Budgets*** 1. Set and define the strategic aims and objectives of the Trust. 2. Identify the key strategic risks, evaluate them and ensure adequate responses are in place and are monitored.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		3. Approve strategies covering all key areas of the Trust business. 4. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust. 5. Approve the Trust's Risk Management Strategy policies and procedures for risk management. 6. Approve Outline and Full Business Cases for Capital Investment. 7. Approve budgets. 8. Approve annually the Trust's proposed Organisational Development proposals. 9. Approve the Trust's Organisation Development Strategy and annual plans 10. Approve proposals for acquisition, disposal or change of use of land and/or buildings. 11. Approve Private Finance Initiative (PFI) proposals. 12. Approve the opening of bank accounts. 13. Approve proposals on individual contracts amounting to, or likely to amount to over £750~~0~~,000 14. Consideration of any proposal not to tender a contract opportunity for a new health care service or a significantly changed health care service. 15. Approve Executive Management Team's proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Trust Board. 16. Approve proposals for action on litigation against or on behalf of the Trust. 17. Review use of NHSLA risk pooling schemes (LTPS/CNST/RPST).
	THE BOARD	**Policy Determination** 1. Ratify management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. 2. Policies will be determined and approved by the Executive Management Team, exceptionally a policy may be referred to the Board for ratification, particularly if the issues are novel, contentious, contrary to guidance or breaking new ground of if the policy is a new one.
	THE BOARD	**Audit** 1. Receive the annual management letter received from the external auditor and taking account of the advice, where appropriate, of the Audit Committee. 2. Receive an annual report from the Internal Auditor and agree necessary actions taking account of

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		advice from the Audit Committee.
NA	THE BOARD	**Annual Reports and Accounts** 1. Receive and approval of the Trust's Annual Report and Annual Accounts. 2. Receive and approval of the Annual Report and Accounts for funds held on trust. 3. Receive and approve the Trust's Annual Quality Accounts
NA	THE BOARD	**Monitoring** 1. Receive such reports as the Board sees fit from Committees in respect of their exercise of powers delegated. 2. Continuously monitor the affairs of the Trust by means of the provision to the Board as the Board may require from Directors, Committees, and officers of the Trust as required. 3. Receive reports from the Director of Finance on financial performance against all internally and externally set targets and standards. 4. Approve and monitor the Board Assurance Framework 5. Approve the Annual Governance Statement based on the Audit Committee's recommendation 6. Approve the Trust's registration with the Care Quality Commission

PART B: DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 11.1.1	AUDIT COMMITTEE	The Committee will: 1. Advise the Trust Board on internal and external audit services; 2. Monitor compliance with Standing Orders and Standing Financial Instructions; 3. Review schedules of losses and compensations and make recommendations to the Board. 4. Review schedules of debtor/creditor balances 5. Review the annual financial statements prior to submission to the Board. 6. Review the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advise the Board accordingly.
	QUALITY COMMITTEE	The Committee will: 1 Provide a strategic overview of Clinical Governance, Risk and Patient Experience to the Trust Board. 2 Co-ordinate all activities relating to Quality, Patient Safety and Patient Experience on behalf of the Trust Board. 3 Provide an assurance to the Trust Board that risk and governance issues of all types are identified, monitored and controlled to an acceptable level. 4 Provide a regularly reviewed and appropriate risk register to the Trust Board identifying risks to achieving the Trust's strategic objectives 5 Ensure all areas/departments of the Trust produce a risk register that relates local risks to achieving the Trust's strategic objectives. 6 Advise the Trust Board on significant risks and governance issues, identifying recommendations, to enable it to take appropriate action. 7 Ensure that there is an effective mechanism for reporting significant risks and governance issues to the Trust Board in a timely manner. 8 Provide a strategic overview of patient and carer experience, regularly reviewing outcomes and satisfaction 9 Oversee the strategic direction of the Recovery College 10 Monitor and advise the work of the Research and Development Committee 11 Quality Committee will ensure that there is an integrated approach to quality and effectiveness, and patient and staff safety throughout the Trust.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		12 Ensure that work plans are produced, and a range of actions are undertaken by other committees and meetings, reporting to the Quality Committee to provide assurance to the Trust Board. 13 Monitor trust compliance with the required standards for regulation and registration with the Care Quality Commission and other national guidelines. 14 Implement and monitor any action required to achieve regulatory and registration standards.
	REMUNERATION AND NOMINATION COMMITTEE	The Committee will: 1. Advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors, other senior employees on a Very Senior Managers contract and conditions including: • All aspects of salary (including any performance-related elements/bonuses); • Provisions for other benefits, including pensions and cars; • Arrangements for termination of employment and other contractual terms; 2. Make recommendations to the Trust Board on the remuneration and terms of service of Executive Directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff; 3. Proper calculation and scrutiny of termination payments taking account of such national guidance and as is appropriate advise on and oversee appropriate contractual arrangements for such staff; 4. Approval of any special severance payments in accordance with HM Treasury guidance; 4 The Committee shall report in writing to the Trust Board the basis for its recommendations.
	MENTAL HEALTH LEGISLATION COMMITTEE	The Committee will: 1. Provide strategic leadership pertaining to the Mental Health Act, the Mental Capacity Act and their respective Codes of Practice and other mental health related legislation. 2. Monitor, provide challenge and seek assurance of compliance with external standards relating to Mental Health Legislation. 3. Approve and review Mental Health Legislation polices and protocols 4. Promote and encourage joint working arrangements regarding the implementation of Mental Health Legislation with partner organisations including local authorities, clinical commissioning groups, acute hospital trusts, police and ambulance services. 5. Receive reports regarding inspecting authorities and to monitor the implementation of actions plans in response to any recommendations made.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	FINANCE & INVESTMENT COMMITTEE	The Committee will: 1. Scrutinise, review and **e**ndorse all financial plans prior to seeking Board approval. 2. Approve the processes and timetable for annual budget setting, and budget management arrangements 3. Monitor delivery of Trust's Capital Investment Programme 4. Review the robustness of the risk assessments underpinning financial forecasts 5. Monitor delivery of the Trust's budget reduction strategy and other financial savings programmes 6. Review and assess business cases for: • Capital expenditure over £500k • New business development projects with an annual value in excess of £500k in total • Any reconfiguration project which has a financial and/or resource implication over £500k per annum • Leases, contracts or agreements with revenue, capital and/or resource investment/commitment in excess of £500k per annum • The purchase or sale of any property • The purchase or sale of any equipment above £250k • All Borrowing or investment arrangements • Horizon scanning regarding business opportunities. • To periodically consider strategic risks to business and ensure these are reflected and mitigated within any business cases.
	~~WORKFORCE AND~~PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE	The Committee will: 1. Provide oversight and assurance to the Board in relation to robust processes for the effective management of Workforce and Organisational Development; 2. Be assured on the management of the high operational risks on the corporate risk register which relate to workforce and organisational development and ensure the Board is kept informed of significant risks and mitigation plans, in a timely manner. 3. Be assured of the Trust's response to all relevant Directives, national standard, policies, reports, reviews and best practice as issued by the Department of Health, NHS Improvement and other regulatory bodies / external agencies to gain assurance that they are appropriately reviewed and actions are being undertaken and embedded. 4. To be assured that the views of staff are captured, understood and responded to. 5. Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for equality and diversity, staff health and well being, safe working for junior doctors and freedom to speak up.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	COLLABORATIVE COMMITTEE	The Committee will: 1. Provide commissioning leadership and monitoring functions 2. Provide assurance to the Board on matters of financial performance 3. Undertake contractual monitoring, financial and performance management of the Provider Collaborative to deliver the HCV aims 4. Monitoring performance including quality assurance on outcomes, experience, safety, activity and finance. 5. Contract management, including quality assurance across NHS and independent sector. 6. Appropriate reporting to Humber and North Yorkshire – Specialised Mental Health and Learning Disability - Provider Collaborative Oversight Group and NHSE/I (including nationally required returns)

PART C: SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

DELEGATED TO	DUTIES DELEGATED
CHIEF EXECUTIVE	Accountable through NHS FT Accounting Officer to Parliament for stewardship of Trust resources. NHS Foundation Trust Accounting Officer memorandum issued by the Independent Regulator is the reference document.
CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Independent Regulator. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Trust Board.
CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
CHIEF EXECUTIVE	Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers: • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
CHIEF EXECUTIVE	Implement requirements of corporate governance.
CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the Audit Commission and the National Audit Office (NAO).
DIRECTOR OF FINANCE	Operational responsibility for effective and sound financial management and information.
CHIEF EXECUTIVE	Primary duty to see that Director of Finance discharges this function.
CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
CHIEF EXECUTIVE and DIRECTOR OF FINANCE	The Chief Executive, supported by the Director of Finance, to ensure appropriate advice is given to the Trust Board and the Council of Governors on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.

DELEGATED TO	DUTIES DELEGATED
CHIEF EXECUTIVE	If the Chief Executive considers the Trust Board, the Council of Governors or the Chair is doing something that might infringe probity or regularity, the Chief Executive should set this out in writing to the Chair, the Council of Governors and the Trust Board. If the matter is unresolved, the Chief Executive should ask the Audit Committee to inquire and if necessary inform the Independent Regulator of the position, if possible before the decision is taken so that the Independent Regulator can intervene if appropriate.
CHIEF EXECUTIVE	If the Trust Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Trust Board and the Council of Governors. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform the Independent Regulator as appropriate. In such cases the Chief Executive should, as a member of the Trust Board, vote against the course of action rather than merely abstain from voting.

PART D: SCHEME OF DELEGATION

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
THE BOARD	Approve procedure for declaration of hospitality and sponsorship.
THE BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of the NHS Foundation Trust Code of Governance, the Code of Conduct, and other ethical concerns.
ALL BOARD MEMBERS	Subscribe to the NHS Foundation Trust Code of Governance and Code of Conduct.
THE BOARD	Board members share corporate responsibility for all decisions of the Trust Board.
CHAIR AND NON-EXECUTIVE MEMBERS	The Chair and Non-Executive Directors are responsible for monitoring the executive management of the organisation and are responsible to the Independent Regulator for the discharge of those responsibilities.
THE BOARD	The Trust Board has six key functions for which it is held accountable by the Independent Regulator:- 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation, the Council of Governors, members and the local community on its plans and performance and that these are responsive to the community's needs.
THE BOARD	It is the Trust Board's duty to: 1. act within the Regulatory Framework and other statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a Schedule of Decisions Reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish an Audit Committee and Remuneration and Nominations Committee on the basis of formally agreed terms of reference that set out the membership of the sub-Committee, the limit to their powers, and the arrangements for reporting back to the main Board.
CHAIR	It is the Chair's role to: 1. provide leadership to the Board, the Council of Governors and to ensure the two bodies work effectively together; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally appointed Remuneration and Nominations Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Council of Governors on the performance of Non-Executive Board members via the Appointments, Terms and Conditions Committee
CHIEF EXECUTIVE	The Chief Executive is accountable to the Chair and Non-Executive Directors of the Trust Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Trust Board. The other duties of the Chief Executive, as Accountable Officer, are laid out in the NHS Foundation Trust Accountable Officer Memorandum.
NON-EXECUTIVE DIRECTORS	Non-Executive Directors are appointed (and removed) by the Council of Governors to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers, the Independent Regulator and to the local community.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
CHAIR AND DIRECTORS	Declaration of conflict of interests.
THE TRUST BOARD	NHS Boards must comply with legislation and guidance issued by the Independent Regulator and the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.
ASSOCIATE HOSPITAL MANAGERS	Under Section 23(6) of the Mental Health Act 1983 the Trust delegates its power of discharge to individuals authorised by the Board for that purpose.
THE TRUST BOARD	Responsible for ensuring that the requirements of the Mental Health Act are fully met and that there are sufficient Associate Hospital Managers to fulfil the requirements in terms of consideration for discharge.
Non-Executive Director with responsibility for mental health legislation	Oversees the appointment, review, and termination of Associate Hospital Managers

PART E: SCHEME OF DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
3.10	CHAIR	Final authority in interpretation of Standing Orders (SOs).
2.2	COUNCIL OF GOVERNORS*	Appointment of Chair and other Non-Executive Directors
2.4	COUNCIL OF GOVERNORS*	Appointment of Deputy Chair
2.11.1	COUNCIL OF GOVERORS	Approve the appointment and dismissal of External Auditors
3.1	CHAIR	Call meetings.
3.9	CHAIR	Chair all Board meetings and associated responsibilities.
3.10	CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIR	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD	Variation or amendment of Standing Orders
4.5	BOARD	Formal delegation of powers to sub-committees, joint Committees and approval of their Constitution and terms of reference
4.6	BOARD	Approve appointments to each of the Committees it has formally constituted
5.2	CHAIR & CHIEF EXECUTIVE	The powers which the Trust Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive Directors.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	BOARD	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.
7.4	ALL STAFF	Comply with national guidance contained in *Managing Conflicts of Interest in the NHS - Guidance for staff and organisations"* (Publications Gateway Reference: 06419)
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (Chief Executive to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Authorse and attest fixing of the Seal, ~~K~~keep Seal in a safe place and maintain a register of Sealing.
8.4	CHIEF EXECUTIVE OR EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

**A full list of Statutory Roles and Responsibilities of the Council of Governors is appended to this document.*

PART F: SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS (SFIs)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	DIRECTOR OF FINANCE	Approval of all financial procedures.
10.1.4	DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
10.1.5	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
10.2.1	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.2	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.3	CHIEF EXECUTIVE DIRECTOR OF FINANCE	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of the Board and staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.4	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.5	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
10.2.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
11.1.2	CHAIR	Raise the matter at the Trust Board meeting where the Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	DIRECTOR OF FINANCE	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.) Ensure the annual report is prepared for consideration by the Audit Committee.
11.2.1	DIRECTOR OF FINANCE	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual Audit Code for NHS Foundation Trusts, NHS Foundation Trust Reporting Manual, the NHS Foundation Trust Accounting Officer Memorandum and best practice.
11.4		Ensure cost-effective External Audit and comply with the Audit Code for NHS Foundation Trusts.
11.5	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Monitor and ensure compliance with the Audit Code for NHS Foundation Trusts guidance on fraud and corruption including the appointment of the Local Counter Fraud Specialist (LCFS).
11.6	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
12.1.2 & 12.1.3	DIRECTOR OF FINANCE	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
12.1.6	DIRECTOR OF FINANCE	Ensure adequate training is delivered on an ongoing basis to budget holders.
12.2.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
12.2.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
12.3.1	DIRECTOR OF FINANCE	Devise and maintain systems of budgetary control.
12.3.2	CHIEF EXECUTIVE/ BUDGET HOLDERS	Ensure that a) any likely overspend or reduction of income that cannot be met from virement is incurred without prior consent of the Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment as approved by the Trust Board
12.3.4	CHIEF EXECUTIVE	Compile and submit to the Trust Board an Annual Plan which takes into account financial targets and forecast limits of available resources. This will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
12.3.4	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Strategic Plan
12.5.1	CHIEF EXECUTIVE	Submit monitoring returns
13.1	DIRECTOR OF FINANCE	Preparation of annual accounts and reports.
14.1	DIRECTOR OF FINANCE	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (The Board approves the arrangements.)
15.	DIRECTOR OF FINANCE	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
15.2.3	ALL EMPLOYEES	Duty to inform Director of Finance of money due from transactions which they initiate/deal with.
16.	CHIEF EXECUTIVE	Tendering and contract procedure.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
16.6.3	CHIEF EXECUTIVE	Waive formal tendering procedures.
16.6.3	CHIEF EXECUTIVE	Report direct contract award justifications to the Audit Committee. ~~waivers of tendering procedures to the Board.~~
16.7.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
16.7.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations dispatched.
16.7.4	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Where one tender is received will assess for value for money and fair price.
16.7.7	CHIEF EXECUTIVE CHAIR	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive and Chair
16.7.11	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
16.7.11	DIRECTOR OF FINANCE	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the Chief Executive.
16.8.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
16.8.4	CHIEF EXECUTIVE or DIRECTOR OF FINANCE	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
16.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
16.10	BOARD	All PFI proposals must be agreed by the Board.
16.11	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
16.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
16.17	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
16.17.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
17.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
17.2	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA
18.1.1	BOARD	Establish a Remuneration & Nomination Committee
18.1.2	REMUNERATION & NOMINATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the Chief Executive, Executive members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
18.1.3	REMUNERATION & NOMINATION COMMITTEE	Report in writing to the Trust Board its advice and its bases about remuneration and terms of service of Directors and senior employees.
18.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
18.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.
18.4.1 and 18.4.2	DIRECTOR OF FINANCE/DIRECTOR OF WORKFORCE & ORGANISATIONAL DEVELOPMENT	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 18.4.3).
18.4.4	NOMINATED MANAGERS	Submit time records in line with timetable. Submitting termination forms in prescribed form and on time.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
18.4.5	DIRECTOR OF FINANCE/DIRECTOR OF WORKFORCE & ORGANISATIONAL DEVELOPMENT	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
18.5	NOMINATED MANAGER	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
19.1.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
19.1.2	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
19.2.1	REQUISITIONER	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
19.2.2	DIRECTOR OF FINANCE	Shall be responsible for the prompt payment of accounts and claims.
19.2.2.1	DIRECTOR OF FINANCE	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
19.2.3	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
19.2.4	DIRECTOR OF FINANCE	Approve proposed prepayment arrangements.
19.2.5	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform the Director of Finance if problems are encountered).
19.2.6	CHIEF EXECUTIVE/DIRECTOR OF FINANCE	Authorise who may use and be issued with official orders.
19.2.7	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
19.2.8	CHIEF EXECUTIVE DIRECTOR OF FINANCE	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
19.3	DIRECTOR OF FINANCE	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
20.1.1	DIRECTOR OF FINANCE	The Director of Finance will advise the Board on the Trust's ability to pay dividend on PBC, and any proposed borrowing limits set by its Provider Licence and report, periodically, concerning the PDC debt and all loans and overdrafts.
20.1.2	BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the Chief Executive and Director of Finance.)
20.1.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
20.1.5	CHIEF EXECUTIVE OR	Be on an authorising panel comprising one other member for short term borrowing approval, following prior agreement of the board

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	DIRECTOR OF FINANCE	
20.2.2	DIRECTOR OF FINANCE	Will advise the Board on investments and report, periodically, on performance of same and report to Monitor on any major investments that will affect the financial risk rating of the Trust.
20.2.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions on the operation of investments held.
21.1.1	DIRECTOR OF FINANCE	Ensure that Board members are aware of the Financial Framework and ensure compliance
22	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
22.1.2	DIRECTOR OF FINANCE	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
22.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
22.1.4	DIRECTOR OF FINANCE	Assess the requirement for the operation of the construction industry taxation deduction scheme.
22.1.5	DIRECTOR OF FINANCE	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
22.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a Scheme of Delegation for capital investment management.
22.1.7	DIRECTOR OF FINANCE	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
22.2.1	DIRECTOR OF FINANCE	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
22.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
22.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from the Director of Finance).
22.3.5	DIRECTOR OF FINANCE	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
22.3.8	DIRECTOR OF FINANCE	Calculate and pay capital charges in accordance with Monitor requirements.
22.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
22.4.2	DIRECTOR OF FINANCE	Approval of fixed asset control procedures.
22.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to the Director of Finance, and reporting losses in accordance with Trust procedure.
23.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to Director of Finance responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.
23.2.1	DIRECTOR OF FINANCE	Responsible for systems of control over stores and receipt of goods.
23.2.1	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
23.2.1	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
23.2.2	NOMINATED OFFICERS	Security arrangements and custody of keys
23.2.3	DIRECTOR OF FINANCE	Set out procedures and systems to regulate the stores.
23.2.4	DIRECTOR OF FINANCE	Agree stocktaking arrangements.
23.2.5	DIRECTOR OF FINANCE	Approve alternative arrangements where a complete system of stores control is not justified.
23.2.6	DIRECTOR OF FINANCE	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
23.2.6	NOMINATED OFFICERS	Operate system for slow moving and obsolete stock, and report to Director of Finance evidence of significant overstocking.
23.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
24.1.1	DIRECTOR OF FINANCE	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
24.2.1	DIRECTOR OF FINANCE	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
24.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Executive and Director of Finance.
24.2.2	DIRECTOR OF FINANCE	Where a criminal offence is suspected, the Director of Finance must inform the police if theft or arson is involved. In cases of fraud and corruption the Director of Finance must inform the relevant LCFS and NHS Counter Fraud Authority.
24.2.2	DIRECTOR OF FINANCE	Notify NHS Counter Fraud Authority and External Audit
24.2.3	DIRECTOR OF FINANCE	Notify the Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
24.2.4	BOARD	Approve write off of losses (within limits delegated by H M Treasury's Managing Public Money).
24.2.6	DIRECTOR OF FINANCE	Consider whether any insurance claim can be made.
24.2.7	DIRECTOR OF FINANCE	Maintain a losses and special payments register.
25.1.1	DIRECTOR OF FINANCE	Responsible for accuracy and security of computerised financial data.
25.1.2	DIRECTOR OF FINANCE	Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
25.2.1	RELEVANT OFFICERS	Send details of the outline design of the computer system to the Director of Finance.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.3	DIRECTOR OF FINANCE	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
25.4	DIRECTOR OF FINANCE	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
25.5	DIRECTOR OF FINANCE	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists; c) Director of Finance and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
25.1.3	DIRECTOR OF NURSING	Shall publish and maintain a Freedom of Information (FOI) Scheme.
26.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
26.3	DIRECTOR OF FINANCE	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
26.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
27.1	DIRECTOR OF FINANCE	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
28	CHIEF EXECUTIVE	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
29	CHIEF EXECUTIVE	Ensure retention of document procedures in accordance with NHS Records Management: Code of Practice
30.1	CHIEF EXECUTIVE	Ensure a Risk Management programme is in place
30.1	BOARD	Approve and monitor Risk Management programme.
30.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
30.4.1	DIRECTOR OF FINANCE	Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Trust Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
30.4.1	DIRECTOR OF FINANCE	Ensure documented procedures cover management of claims and payments below the deductible.

PART G: SCHEME OF BUDGETARY DELEGATION

~~Value (annual)~~ ~~Note: If total contract value exceeds the relevant Procurement Act threshold then formal tendering procedures must be followed~~	~~Process~~
~~Up to £9,999~~	~~At discretion of budget holder/Purchasing officer~~
~~£10,000 to £74,999 (Goods & Services)~~	~~3 or more quotes or non-competitive quotation only in permissible circumstances~~
~~£10,000 to £249,999 (Works)~~	~~3 or more quotes~~
~~£75,000 up to Procurement Act threshold (Goods & Services)~~	~~Local tendering process~~
~~£250,000 up to Procurement Act threshold (Works)~~	~~Local tendering process~~
~~For any Goods, Services and Works above Procurement Act threshold~~	~~Formal tendering process in accordance with Procurement Act~~

~~**The above applies to contracts for goods, non-health care services and works unless using a framework agreement (SFI 21.1.2 applies) compliantly in which case the above do not apply.**~~

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Quotation, Tendering and Control Procedures – only applicable to goods, works and non-health care services		
Goods, works and non-health care services including Estates and Maintenance *(where this relates to contracts over more than one year, the lifetime contract value is delegated as per below)*		
Lifetime Value (including extension options) (excluding VAT)	**Minimum No**	**Authorised by**
Up to £9,999	At discretion of budget holder/Purchasing officer	Budget holder
£10,000 to £24,999 (Goods, Services & Works)	3 or more quotes or non-competitive quotation only in permissible circumstances	Division General Manager or for works Deputy Director of Estates and Facilities
£25,000 up to Procurement Act threshold (Goods & Services)	3 or more quotes or non-competitive quotation only in permissible circumstances	Director
£25,000 to £249,999 (Works)	3 or more quotes or non-competitive quotation only in permissible circumstances	Director of Finance
£250,000 up **to Procurement Act threshold** (Works)	Local tendering process	Chief Executive and Board if over £750k (annual value)
For any Goods, Services and Works above Procurement Act thresholds	Formal tendering process in accordance with Procurement Act	Director of Finance/Chief Executive/Board
The above applies to contracts for goods, works and non-health care services unless a framework agreement (SFI 21.1.2) applies in which case the above does not apply.		

Non-Pay Revenue and Capital Expenditure/Requisitioning/Ordering/Payment Of Goods. Contracts (Including Income) and Non Pay Revenue. Stock/Non-stock requisitions	
Financial Limit *(where this relates to contracts over more than one year, the annual value is delegated as per below)*	Delegated to
Up to £9,999	Senior Manager/other staff on authorised signatory list up to their delegated limit
£10,000 to £24,999	Divisional General Manager
£25,000 to £49,999	Director
£50,000 to £249,999	Director of Finance
£250,000 to £750,000	Chief Executive*
Over £750,000	Trust Board

*during periods of absence of the Chief Executive (planned and unplanned) the authorisation limits will be delegated to the Director of Finance in the first instance, and then to the Deputy Chief Executive (in any instances where both the Chief Executive and Director of Finance are absent at the same time).

Authorisation of Losses and Special Payments		
Delegated Matter	Up to £5,000	£5,000 to £49,999
Losses of cash	Director of Finance or Trust Secretary	Chief Executive and Director of Finance

Drawing Down of Pre-Arranged Loans		
	1st Signatory	**2nd Signatory**
Any pre-arranged loan	Chief Executive or Director of Finance (or person acting up*)	Deputy Director of Finance or Executive Director

Short term loans		
Short term borrowing up to £499,000	With the authority of two members of an authorised panel, one of which must be the Chief Executive or Director of Finance	The Board must be made aware of all short term borrowings at the next Board meeting.

Expenditure on Charitable and Endowment Funds	
Up to £4,999	Fund Manager, Health Stars Charity/Fundraising Manager
Over £5,000* *Any expenditure over £5,000 is subject to procurement rules and budgetary delegation set out above and elsewhere in the SFIs	Fund Manager, Director of Finance and Executive Management Team
Over £25,000	Fund Manager, Director of Finance and Trust Board as Corporate Trustee
Over £100,000	Trust Board as Corporate Trustee

Humber Teaching NHS Foundation Trust

SECTION D –

STANDING FINANCIAL INSTRUCTIONS

SECTION D - STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

These standing financial instructions (SFIs) refer to both the Trust as provider and any activities the Trust undertakes via the Provider Collaborative. SFIs for the provider collaborative are subject to the same principles as the Trusts as set out in this document.

10.1 General

10.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its Directors and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with the requirements of the Independent Regulator in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Matters Reserved to the Trust Board and the Scheme of Delegation adopted by the Trust.

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

10.1.6 The Trust is considered as a commercial organisation under the terms of the Bribery Act 2010. As such all employees of the Trust are required to comply with these SFIs.

10.1.7 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All Directors of the Trust Board and officers have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

10.2 Responsibilities and Delegation

10.2.1 The Board

The Board exercises financial supervision and control by:

(a) approving the financial strategy; following formulation by the Finance & Investment Committee
(b) requiring the submission and approval of budgets within approved allocations/overall income;
(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);
(d) defining specific responsibilities placed on Board members and employees as indicated in the Scheme of Delegation

10.2.1.1 The Board has resolved that certain powers and decisions may only be exercised by the Board in a formal session. These are set out in the Scheme of Matters Reserved to the Trust Board document. All other powers have been delegated to such other Committees as the Trust has established.

10.2.2 The Chief Executive and Director of Finance

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Independent Regulator, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.2.1 It is a duty of the Chief Executive to ensure that Directors, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.3 The Director of Finance

The Director of Finance is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.4 Board Members and Employees

All Board members and officers, individually and collectively, are responsible for:

(a) the security of the property of the Trust;
(b) avoiding loss;
(c) exercising economy and efficiency in the use of resources;
(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.5 Contractors and their Employees

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

10.2.6 For Board members and any officers employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board members and officers discharge their duties must be to the satisfaction of the Director of Finance.

11. Audit

11.1 Audit Committee

11.1.1 In accordance with Standing Orders, the Constitution, the 2006 Act (and as set out in the Audit Code for NHS Foundation Trusts, issued by the Independent Regulator) the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2014), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments.

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board;

(f) reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

The Audit Committee can delegate some of their detailed responsibilities to the but they remain accountable for the independent and objective view of all internal controls.

11.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health. In the first instance this should be referred to the Director of Finance

11.1.3 It is the responsibility of the Director of Finance to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

11.2 Director of Finance

11.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

11.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or Board members or officer of the Trust;

(c) the production of any cash, stores or other property of the Trust under a Board member and or an officer's control; and

(d) explanations concerning any matter under investigation.

11.3 Role of Internal Audit

11.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other in scope management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and the Constitution, the 2006 Act (and as set out in the Audit Code for NHS Foundation Trusts, issued by the Independent Regulator)

11.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

11.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

11.3.4 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.4 External Audit

11.4.1 The External Auditor is appointed by the Council of Governors and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Council of Governors if the issue cannot be resolved.

11.5 Fraud and Corruption

11.5.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance

shall monitor and ensure compliance with Service Condition 24 of the NHS Standard Contracton fraud and corruption.

11.5.2 The Director of Finance shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified at NHS Requirement 9 of the Government Functional Standard (GOVS 013: Counter fraud).

11.5.3 The LCFS shall report to the Trust's Director of Finance and shall work with staff in NHS Counter Fraud Authority in accordance with the NHS Counter Fraud Manual.

11.5.4 The LCFS will provide a written report, at least annually, on counter fraud work within the Trust.

11.6 Security Management

11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

11.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

12. Allocations, Planning, Budgets, Budgetary Control and Monitoring

12.1 Preparation and Approval of Plans and Budgets

12.1.1 The Chief Executive will compile and submit to the Board an annual budget which takes into account financial targets and forecast limits of available resources. The Strategic Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;
(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

12.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan
(b) accord with workload and manpower plans;
(c) be produced following discussion with appropriate budget holders;
(d) be prepared within the limits of available funds;
(e) identify potential risks.

12.1.3 The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

12.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

12.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

12.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

12.2 Budgetary Delegation

12.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

12.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

12.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

12.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

12.3 Budgetary Control and Reporting

12.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

12.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

12.3.3 (a) Where an employee has more than one post with Humber Teaching NHS Foundation Trust then for the purposes of approval of expenses on-line the budget holder for the primary post will be the person designated to approve expenses claims for all posts held by the individual staff member.

12.3.4 The Chief Executive is responsible for ensuring the Trust identifies and implements cost improvements and income generation initiatives in accordance with the requirements of the Strategic Plan and a balanced budget.

12.4 Capital Expenditure

12.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure.

12.5 Monitoring Returns

12.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

13. Annual Accounts and Reports

13.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by Monitor, the Trust's accounting policies, and generally accepted accounting practice;

(b) prepare and submit annual financial reports to Monitor certified in accordance with current guidelines;

(c) submit financial returns to the Independent Regulator for each financial year in accordance with the timetable prescribed by the Independent Regulator.

13.2 The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors. The Trust's audited annual accounts must be presented to the Board for approval and received at a public meeting of the Council of Governors.

13.3 The Trust will publish an annual report, in accordance with the Constitution and present it to the Council of Governors. The document will comply with the Independent Regulator's Annual Report Guidance for NHS Foundation Trusts

14. Bank Accounts

14.1 General

14.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued from time to time by the Monitor. In line with 'Cash Management in the NHS' the Trust's banking arrangements should be in line with the guidelines set out in the Trust's Treasury Management policy.

14.1.2 The Board shall approve the banking arrangements.

14.2 Bank Accounts

14.2.1 The Director of Finance is responsible for:

a) the control and internal administration of the Trust's bank accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with Department of Health guidance on the level of cleared funds.

14.3 Banking Procedures

14.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts which must include:

(a) the conditions under which each bank account is to be operated.

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

14.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

14.4 Tendering and Review

14.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

14.4.2 The results of the tendering exercise should be reported to the Board. This review is not necessary for Government Banking Service accounts.

15. Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments

15.1 Income Systems

15.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

15.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

15.2 Fees and Charges

15.2.1 The Trust shall follow the Department of Health's advice in the "Costing Manual" in setting prices for NHS service agreements.

15.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Trust's Standards of Business and Managing Conflicts of Interest Policy for NHS Staff shall be followed.

15.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

15.3 Debt Recovery

15.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

15.3.2 Income not received should be dealt with in accordance with losses procedures.

15.3.3 Controls should be in place to prevent overpayments arising. If there are incidences of such overpayments there need to be controls and processes in place to detect them and to initiate recovery.

15.4 Security of Cash, Cheques and other Negotiable Instruments

15.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

15.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

15.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

15.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

16. PROCUREMENT OF GOODS, WORKS AND NON-HEALTH CARE SERVICES

This procedure is used for when the Trust is procuring goods, works and non-health care services

16.1 Duty to Comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Financial Instructions (except where SO 3.13 is applied).

16.2 Legislation Governing Public Procurement (Goods and non-health care services)

(a) The Trust shall comply with The Procurement Regulations 2024~~the Public Contracts Regulations 2006~~ (the "Regulations") ~~and any EU Directives relating to EU procurement law having direct effect in England (the "Directives") and any other duties derived from the EU Treaty ("Treaty Obligations")~~ and any duties derived from the UK common law ("Common Law Duties") (the Regulations, Directives, Treaty Obligations and Common Law Duties together are referred to elsewhere in these SFIs as "Procurement Legislation"). The Procurement Legislation as from time to time amended shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

(b) The Trust should consider obtaining support from any suitably qualified professional advisor (including where appropriate legal advisors to ensure compliance with Procurement Legislation when engaging in tendering procedures.

(c) The Trust shall consider the application of any applicable duty to consult or engage the public or any relevant Overview and Scrutiny Committee of a Local Authority prior to commencing any procurement process for a contract opportunity.

16.3 Guidance on Public Procurement and Commissioning

a. The Trust should have regard to all relevant guidance issued by the NHS England in relation to the conduct of procurement practice and the commissioning of health care services, including but not limited to:

b. All off payroll engagements of more than six months in duration, for more than a daily rate of £220 should be referred to the Trust Procurement department before commitment to contract is given. This is to ensure contractual provisions are explicit that allow the Trust to seek assurance regarding the income tax, NIC obligations and IR35 status of the engagement – and to terminate the contract if that assurance is not provided. The general provision in relation to tendering 16.6.1 and quotations 16.8.1 also apply in addition to this requirement.

16.4 Decision to Tender and Exceptions to Requirement to Tender

16.4.1 Presumption to Tender

Where:

(a) a contract opportunity that is required to be tendered under The Procurement Regulations 2024~~the Public Contract Regulations~~ i.e. the contract opportunity is governed by The Procurement Regulations 2024~~the Public Contract Regulations~~ and the value of the contract opportunity as calculated pursuant to The Procurement Regulations 2024~~the Public Contract Regulations~~ exceeds the relevant financial threshold ~~excluding VAT~~ for the requirement to run a formal tender process; then ~~subject to SFI 16.7.5~~ the Trust shall ensure that contract opportunities with the Trust are advertised in accordance with SFI 16.6.6~~9~~ and ~~where more than one response is received that~~ competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of non-health care services including all forms of management consultancy services;
- the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and
- subject to SFI 16.16 for disposals.

16.5 Capital Investment Manual and Other Department of Health Guidance

The Trust shall comply with the requirements of the Department of Health's Capital Investment Manual and Estate code in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply with the Independent Regulator's Management Consultancy spending approval process.

16.6 Formal Competitive Tendering

16.6.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of non-health care services including all forms of management consultancy services;
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

16.6.2 Circumstances ~~Exceptions and Instances~~ where Formal Tendering Need Not be Applied and Justifications for Direct Award

Circumstances where f~~F~~ormal tendering procedures **need not be applied** ~~where~~:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the threshold for tendering as set out in the Scheme of Delegation;

(b) where the supply is proposed under special arrangements negotiated by NHS England in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in SFI 24;

d**)** the Trust is entitled to call off from a Framework Agreement and the

requirements of SFI 21.1.2 (Use of Framework Agreements) have been followed and have been approved in accordance with the Scheme of Delegation

Direct contract awards are justified in the following circumstances (subject to Director of Finance/Chief Executive approval):

(e) Prototypes and development

The public contract concerns the production of a prototype, or supply or other novel goods or services, for the purpose of:

i. Testing the suitability of the goods or services,

ii. Researching the viability of producing or supplying the goods or services at scale and developing them for that purpose, or

iii. Other research, experiment, study or development.

(f) Single suppliers (applies in three situations)

i. The public contract concerns the creation or acquisition of a unique work of art or artistic performance, or

ii. The following conditions are met in relation to the public contract:
   (a) Due to a particular supplier having intellectual property rights or other exclusive rights, only that supplier can supply the goods, services or works required, and
   (b) There are no reasonable alternatives to those goods, services or works, or

iii. The following conditions are met in relation to the public contract:
   (a) Due to an absence of competition for technical reasons, only a particular supplier can supply the goods, services or works required, and
   (b) There are no reasonable alternatives to those goods, services or works.

(g) Additional or repeat goods, services or works

The public contract concerns the supply of goods, services or works by the existing supplier which are intended as an extension to, or partial replacement of, existing goods, services or works in circumstances where:

i. a change in supplier would result in the contracting authority receiving goods, services or works that are different from, or incompatible with, the existing goods, services or works, and

ii. the difference or incompatibility would result in disproportionate technical difficulties in operation or maintenance, or

A contract has previously been awarded under a competitive tendering procedure and the tender notice or tender documents set

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out the authority's intention to carry out a subsequent procurement of similar goods, services or works.

(h) Commodities

The public contract concerns goods purchased on a commodity market.

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(i) Advantageous terms on insolvency

The award of the public contract to a particular supplier will ensure terms particularly advantageous to the contracting authority due to the fact that a supplier, whether or not the one to whom the contract is to be awarded, is undergoing insolvency proceedings.

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(j) Urgency

Where –

i. The goods, services or works to be supplied under the public contract are strictly necessary for reasons of extreme and unavoidable urgency, and

ii. As a result the public contract cannot be awarded on the basis of a competitive tendering procedure.

Urgent is not unavoidable if it is attributable to any act or omission of the authority or could have been foreseen by the authority. The situation must be so urgent that the authority cannot comply with the timescales required for a competitive tender (even the shortened timescales permitted for urgency).

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(k) User choice contracts

This refers to situations where an authority is required by law to consider the views of a third party in the choice of supplier (for example, a parent or a carer).

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(l) Defence and security

In certain circumstances, some defence and security contracts can be awarded without a competitive tendering procedure.

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Where a direct contract award request is submitted to the Contracting and Procurement Team, the requestor should be confident they have evidence to support the request (as outlined in paragraphs (e) to (l) above) and need to complete a Direct Award Justification template. The Direct Award Justification request needs to be authorized by either Director of Finance (direct awards with an annual value upto £249,999) or Chief Executive (direct awards with an annual value of £250,000 or above). All direct award justifications will be reported to the Audit Committee.

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(e) for a contract opportunity for goods and non-health care services that it is not reasonably expected to exceed £49,999 as requirements of SFI 16.8 Quotations: Competitive and Non-Competitive thence apply;

Formal tendering procedures **may be waived** in the following circumstances:

f) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(g) where the requirement is covered by an existing contract;

(h) where a Consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the Consortium members;

(i) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(j) where specialist expertise is required and is available from only one source;

(k) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

when the goods required by the Trust are a partial replacement for, or in addition to, existing goods and to obtain the goods from a supplier other than the supplier who supplied the existing goods would oblige the Trust to acquire goods with different technical characteristics and this would result in:

- incompatibility with the existing goods; or
- disproportionate technical difficulty in the operation and maintenance of the existing goods;

but no such contract may be entered in for a duration of more than three years;

(l) there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

when works or services required by the Trust are additional to works or services already contracted for but for unforeseen circumstances such additional works or services have become necessary and that such additional works or services:

- cannot for technical or economic reasons be carried out separately from the works or services under the original contract without major inconvenience to the Trust; or

- can be carried out or provided separately from the works or services under the original contract but are strictly necessary to the latest stages of performance of the original contract; provided that the value of such

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~~additional works or services does not exceed 50% of the value of the original contract.~~

(m) ~~for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.~~

~~The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.~~

~~(n) where allowed and provided for in the Capital Investment Manual.~~

~~The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.~~

~~Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded on a Tender waiver form which must be completed by Procurement, signed by the Chief Executive and reported to the Audit Committee at each meeting.~~

~~(o) Where subcontracting arrangements arise following successful joint tender applications with partner organisations or where contracting arrangements/requirements are inherited under a Lead Provider arrangement.~~

~~16.6.3 Fair and Adequate Competition~~

~~Where the exceptions set out in SFI Nos. 16.1 and 16.8.3 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate having regard to their capacity to supply the goods or materials or to undertake the services or works required.~~

~~The appropriate numbers are set out in the Scheme of Delegation~~

16.6.~~3~~4 Equality of Treatment

The Trust shall ensure that no sector of any market (public, private, third sector/social enterprise is given an unfair advantage in the design or conduct of any tender process.

16.6.~~4~~5 Non-Discrimination

(a) The subject matter and the scope of the contract opportunity should be described in a non-discriminatory manner. The Trust should utilise generic and/or descriptive terms, rather than the trade names of particular products or processes or their manufacturers or their suppliers.

(b) All participants in a tender process should be treated equally and all rules governing a tender process must apply equally to all participants.

~~16.6.6 Building and Engineering Construction Works~~

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~~The Trust shall ensure that firms/individuals invited to tender for building and engineering construction work, where this is not contrary to the Directives by the Council of the European Union (see Scheme of Delegation) are among those on approved lists or have been openly advertised in accordance with EU Procurement and UK legislation.~~

~~Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.~~

16.6.~~5~~7 Items which Subsequently Breach Thresholds after Original Approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive and be recorded in an appropriate Trust record.

16.6.~~6~~8 Advertisement of Contract Opportunities

Where a formal tender process is required under SFI 16.4 then:

(a) where a contract opportunity falls within the Regulations and a process compliant with the Regulations is required, a relevant notice should be utilised; or

(b) Where a contract opportunity does not fall within the Regulations the Trust shall utilise a form of advertising for such contract opportunity that is sufficient to enable potential providers to access appropriate information about the contract opportunity so as to be in a position to express an interest; and

16.6.~~7~~9 Choice of Procedure

(a) Where a contract opportunity falls within The Procurement Regulations 2024 ~~the Public Contract Regulations~~ and a process compliant with The Procurement Regulations 2024 ~~the Public Contract Regulations~~ is required then the Trust shall utilise an available tender procedure under The Procurement Regulations 2024~~ the Public Contract Regulations~~.

(b) In all other cases the Trust shall utilise a tender procedure proportionate to the value, complexity and risk of the contract opportunity~~ and shall ensure that invitations to tender are sent to a sufficient number of providers to provide fair and adequate competition (in any event no less than two)~~.

16.7 Tendering Procedure

16.7.1 Invitation to Tender

(a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(b) All invitations to tender shall state that no tender will be accepted unless:

(i) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(ii) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not

identify the sender on the envelope or on any receipt so required by the deliverer.

(iii) or are submitted electronically through the appropriate process using the Trust's e-tendering service, as instructed within the tender documentation;

(c) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

Every invitation to tender must require each bidder to give a written undertaking not to engage in collusive tendering or other restrictive practice and not to engage in canvassing the Trust, its employees or officers concerning the contract opportunity tendered.

(d) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

16.7.2 Receipt and Safe Custody of Tenders

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

16.7.3 Opening Tenders and Register of Tenders

(a) Tenders are received electronically and the Procurement team will be responsible for the unlocking of the e-tendering portal to allow bids to be opened with an audit trail kept on the accessing of the electronic tender submissions.

(b) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 16.7.5 below).

16.7.4 Admissibility of Tenders

(a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(b) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

16.7.5 Late Tenders

(a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.

(b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

16.7.6 Accountability where In-house Bid

(a) In all cases where the Trust determine that in-house services (which term includes Trust community services) should be subject to competitive tendering the following groups shall be set up:

- Specification group, comprising the Chief Executive or nominated officer/s and specialist officer whose function shall be to draw up the specification of the service to be tendered.
- In-house tender group, comprising a nominee of the Chief Executive and technical support to draw up and submit the in-house tender submission.
- Evaluation group, comprising normally a specialist officer, a supplies or commissioning officer and a Director of Finance representative whose function is to shortlist expressions of interest received and evaluate tenders received. For services having a likely annual expenditure exceeding £100,000, a non-officer member should be a member of the evaluation team.

(b) No officer or employee of the Trust directly engaged or responsible for the provision of the in-house service subject to competitive tendering may be a member of any of the specification or evaluation group established under SFI 16.7.12(a) but the specification group may consult with and take into account information received from such officers or employees in drawing up the Trust's specification subject at all times to observing the duty of non-discrimination at SFI 16.7.6. No member of the in-house tender group may participate in the evaluation of tenders.

(c) The evaluation group shall make recommendations to the Board.

(d) The Chief Executive shall nominate an officer to oversee and manage the contract awarded on behalf of the Trust.

16.7.7 Acceptance of Formal Tenders (See overlap with SFI No. 16.7)

(a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(b) Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders (see SFI 16.7.5 above).

(c) Where examination of tenders reveals errors which would affect the tender figure, the tenderer may be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.

(d) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(i) experience and qualifications of team members;

(ii) understanding of client's needs;

(iii) feasibility and credibility of proposed approach;

(iv) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(e) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(i) No tender shall be accepted by the Trust which is obtained contrary to these SFIs except with the authorisation of the Chief Executive or Director of Finance.

(ii) All tenders should, subject to compliance with the provisions of the Freedom of Information Act 2000, be kept confidential and should be retained for 12 months from the date set for the receipt of tenders for inspection.

(f) The use of these procedures must demonstrate that the award of the contract was:

(i) not in excess of the going market rate / price current at the time the contract was awarded;

(ii) that best value for money was achieved.

(g) All tenders should be treated as confidential and should be retained for inspection.

(h) All tendering activity carried out through e-tendering should be compliant with Trust policies and procedures. Issue of all tender documentation will be done electronically through a secure website with controlled access using secure login, authentication and viewing rules. All tenders will be received into a secure vault so that they cannot be accessed until an agreed opening time.

16.7.8 Tender Reports to the Board

Reports to the Board will be made on an exceptional circumstance basis only.

16.7.9 Monitoring and Audit of Decision to Tender

(a) The waiving of competitive tendering procedures should not be used with the object of avoiding competition or solely for administrative convenience or subject to SFIs 16.8.2 to award further work to a provider originally appointed through a competitive procedure.

(b) Where it is decided that competitive tendering need not be applied or should be waived, the fact of the non application or waiver and the reasons for it should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

(c) Where the Trust proposes not to conduct a tender process in relation to a contract opportunity for a new health care service or a significantly changed health care service then the Trust shall consider such proposal at a meeting of the Board as recommended by the Trust Procurement Guide

16.7.10 List of Approved Firms for Building and Engineering Construction Works

The Trust does not hold a physical approved contractors list as it uses general open tendering principles the same as for all other tenders created. Where relevant the Trust may use the services of construction industry standards such as Constructionline or YORBuild to pre approve contractors to bid for work.

16.7.11 Checks to be Undertaken When Not Using Approved Lists

Where a contract (and where appropriate a quote) is to be awarded to a contractor who is not on an approved list there should be appropriate checks to ensure that the Contractor is technically competent, financially secure and where appropriate that they comply with any appropriate equalities and health and safety legislation.

16.7.12 Contracts for Building or Engineering Works

(a) Subject to SFIs 16.7.9(b) inclusive, every contract for building or engineering works shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode.

(b) When the content of the work is primarily engineering every contract shall embody or be in the terms of:

- the General Conditions of Contract recommended by the Institution of Mechanical Engineers; and/or
- the Association for Consultancy and Engineering (Form A);

(c) In the case of civil engineering work every contract shall embody or be in the terms of the General Conditions of Contract recommended by:

- the Institution of Civil Engineers; and/or

- the Association for Consultancy and Engineering; and/or
- the Civil Engineering Contractors Association.

(d) Each of the documents referred to in SFI 16.7.12 (a) to (c) inclusive may be modified and/or amplified to accord with Department of Health guidance and, with appropriate professional advice (including legal advice if necessary), to cover special features of individual projects.

16.8 Quotations: Competitive and Non-Competitive

16.8.1 General Position on Quotations
Quotations for goods and non-health care services are required where formal tendering procedures are not adopted and where the intended expenditure exceeds the threshold set out in the Scheme of Delegation.

16.8.2 Competitive Quotations

(a) Quotations should be obtained from up to 3~~5~~ firms/individuals based on Scheme of Delegation prepared by the Trust.

(b) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(c) All quotations should be treated as confidential and should be retained for inspection.

(d) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

16.8.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(a) the supply of proprietary or other goods of a special character and the rendering of non-health care services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) miscellaneous services, supplies and disposals;

(d) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (a) and (b) of this SFI) apply.

16.8.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

16.9 Evaluation of Tenders and Quotations

16.9.1 Overriding Duty to Achieve Best Value

The Trust shall ensure that it seeks to obtain best value for each contract opportunity.

16.9.2 Choice of Evaluation Methodology

The Trust must for each contract opportunity which is subject to a tender or a competitive quotation choose to adopt evaluation criteria based on either:

(a) the lowest price; or

(b) the most economically advantageous tender, based on criteria linked to the subject matter of the contract opportunity including but not limited to some or all of:

- quality;
- price;
- technical merit;
- aesthetic and functional characteristics;
- environmental characteristics;
- running costs;
- cost effectiveness;
- after sales service;
- technical assistance;
- delivery date;
- delivery period; and/or
- period of completion

c) Each invitation to tender or invitation to supply a competitive quotation must state the evaluation criteria to be used to evaluate the tender or quotation and the relative weightings of each such criteria.

16.9.3 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract will be decided as specified in Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Board this shall be recorded in their minutes.

16.9.4 Form of Contract: General

Subject to the remainder of SFI 16.9.5 below the Trust shall consider the most applicable form of contract for each contract opportunity (including to the extent appropriate any NHS Standard Contract Conditions available) and should consider obtaining support from a suitably qualified professional advisor (including where appropriate legal advisors).

16.9.5 Statutory Requirements

The Trust must ensure that all contracts that are governed by mandatory statutory requirements (whether contained in Statute, Regulations or directions) comply with such requirements. Such contracts include, but may not be limited to:

(a) GMS contracts;
(b) PMS agreements;
(c) SPMS contracts;
(d) APMS contracts;
(e) PCTMS contracts;

(f) PDS agreements;
(g) PCTDS contracts;
(h) GDS contracts;
(i) GOS contracts (mandatory and/or additional services contract)

16.10 Alternative Finance for Capital Procurement (See also SFI 22.2)

The Trust should normally market-test for different finance options (Including PFI *Private Finance Initiative funding*) when considering a capital procurement. When the Trust Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

16.11 Compliance Requirements for all Contracts

The Trust Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b)

(c) any relevant directions including the Capital Investment Manual, Estate code and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

(h) In all contracts made by the Trust, the tendered value of the winning contract should not be exceeded. If, in the course of the contract, the tendered value is required to be exceeded then, prior to any agreement to vary the value, authorisation must be obtained by the relevant Director in charge of the business area. In the case of a capital contract, this agreement must be provided from the Capital and Redesign Group prior to any agreement being made. In all

instances this agreement should only be sought when all other mitigating options have been explored.

16.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

16.13 Disposals (See overlap with SFI 24)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value below the threshold detailed in Scheme of Delegation;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which Department of Health guidance has been issued but subject to compliance with such guidance.

16.14 In-house Services

16.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

16.14.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £750,000 a Non-Executive Trust Board member should be a member of the evaluation team.

16.14.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

16.14.4 The evaluation team shall make recommendations to the Board.

16.14.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

16.15 Applicability of SFIs on Tendering and Contracting to Funds Held in Trust (see also SFI 27)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

17. PROCUREMENT OF HEALTH CARE SERVICES

17.1 Duty to Comply with Standing Orders and Standing Financial Instructions.

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Financial Instructions (except where SO 3.13 is applied).

17.2 Legislation Governing Procurement of Health Care Services

(a) The Trust shall comply with the Health and Care Act 2022 and The Health Care Services (Provider Selection Regime) Regulations 2023. The Procurement Legislation as from time to time amended shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

(b) The Trust should consider obtaining support from any suitably qualified professional advisor (including where appropriate legal advisors to ensure compliance with Procurement Legislation when engaging in tendering procedures.

(c) The Trust shall consider the application of any applicable duty to consult or engage the public or any relevant Overview and Scrutiny Committee of a Local Authority prior to commencing any procurement process for a contract opportunity.

17.3 The Provider Selection Regime (PSR)

17.3.1 How does the PSR work?

The PSR applied to the arrangement of health care and public health services arranged by relevant authorities and irrespective of who the provider is (i.e., whether the service is provided by NHS providers, other public sector bodies, local authorities, or providers within the voluntary, community, social enterprise (VCSE) and independent sectors). The PSR will not apply to goods and non-health care services (such as medicines, medical equipment, cleaning, catering, business consultancy services and social care), unless arranged as part of mixed procurement.

The Trust can follow three different provider selection processes to award contracts for health care services under the PSR:

1. direct award processes (direct award process A, direct award process B and direct award process C)
2. most suitable provider process
3. competitive process.

17.3.2 Making decisions under the PSR

The PSR decision-making processes are set out in Regulation 6. This regime must be applied whenever relevant authorities are making decisions about awarding contracts for health care services. The first step for relevant authorities applying this regime is to identify which of the following provider selection processes are applicable.

Direct award process A must be used when all of the following apply:

- there is an existing provider of the health care services to which the proposed contracting arrangements relate
- the relevant authority is satisfied that the health care services to which the proposed contracting arrangements relate are capable of being provided only by the existing provider (or group of providers) due to the nature of the health care services.

Direct award process A must not be used to conclude a framework agreement.

Direct award process B must be used when all of the following apply:

- the proposed contracting arrangements relate to health care services in respect of which a patient is offered a choice of provider
- the number of providers is not restricted by the relevant authority
- the relevant authority will offer contracts to all providers to whom an award can be made because they meet all requirements in relation to the provision of the health care services to patients
- the relevant authority has arrangements in place to enable providers to express an interest in providing the health care services.

Where relevant authorities are required to offer choice to patients under regulation 39 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, they cannot restrict the number of providers and therefore direct award process B must be followed.

Direct award process B must not be used to conclude a framework agreement.

Direct award process C may be used when all of the following apply:

- the relevant authority is not required to follow direct award processes A or B
- the term of an existing contract is due to expire and the relevant authority proposes a new contract to replace that existing contract at the end of its term
- the proposed contracting arrangements are not changing considerably
- the relevant authority is of the view that the existing provider (or group of providers) is satisfying the existing contract and will likely satisfy the proposed contract to a sufficient standard.

Direct award process C must not be used to conclude a framework agreement.

The most suitable provider process may be used when all of the following apply:

- the relevant authority is not required to follow direct award processes A or B
- the relevant authority cannot or does not wish to follow direct award process C
- the relevant authority is of the view, taking into account likely providers and all relevant information available to the relevant authority at the time, that it is likely to be able to identify the most suitable provider (without running a competitive process).

The most suitable provider process must not be used to conclude a framework agreement.

The competitive process must be used when all of the following apply:

- the relevant authority is not required to follow direct award processes A or B
- the relevant authority cannot or does not wish to follow direct award process C, and cannot or does not wish to follow the most suitable provider process.

The competitive process must be used if the relevant authority wishes to conclude a framework agreement.

Once the relevant authority has identified which of these circumstances applies and has identified the appropriate provider selection process to follow, it will then need to follow that provider selection process as set out in detail in the sections below.

Relevant authorities are expected to identify which provider selection process is applicable sufficiently in advance of a contract coming to an end. The fact that a particular decision-making approach was used to select a provider in the past does not mean the same approach must be used for that service in future.

It is permitted to make certain modifications during the term of a contract to allow for changes to services or circumstances. The section on contract modifications sets out the conditions and transparency requirements for these modifications. In limited circumstances relevant authorities may need to act rapidly, for example, to address immediate risks to patient or public safety, within which it would be impractical to follow the steps required under this regime. The section on urgent awards or contract modifications sets out these circumstances and how relevant authorities must act if they arise.

17.4 Provider Selection Processes

17.4.1 Direct award process A

The process that must be followed when awarding a contract under direct award process A is set out in Regulations 6(3) and 7.

The type of service means there is no realistic alternative to the current provider. This process must not be used to award contracts when establishing a new service.

Direct award process A must be used to award contracts to the existing provider (or group of providers) when the nature of the service means there is no realistic alternative to the existing provider (or group of providers). Even when there are alternative providers in the market, as long as these are not considered to be realistic alternatives for the relevant authority's specific requirements, direct award process A must be used to award a contract.

Such services may include, but are not limited to:

- Type 1 and 2 urgent and emergency services and associated emergency inpatient services
- 999 emergency ambulance services
- NHS urgent mental health crisis services
- services established as a commissioner requested services (CRS)*
- services provided by NHS trusts designated as 'essential services' in their NHS Standard Contract
- a service that is interdependent with, and cannot realistically be provided separately from, another service which only that provider can realistically provide (e.g., because of a need for cross-specialty or cross-service working).

*A service is established as a commissioner requested services (CRS) by following the processes set out in the provider licence (for foundation trusts or independent sector providers) or designated an 'essential service' under an NHS contract (for trusts). Relevant authorities are expected to periodically review CRS designations, in line with the Guidance for commissioners on ensuring the continuity of health care services, as markets and alternative

provision may evolve. Providers that have been designated to provide CRS can still be replaced if the relevant authority considers this to be appropriate.

Direct award process A must not be used to conclude a framework agreement or to award a contract based on a framework agreement.

17.4.2 Direct award process B

The process that must be followed when awarding a contract under direct award process B is set out in Regulations 6(4) and 8.

People have a choice of providers, and the number of providers is not restricted by the relevant authority.

Direct award process B must be used to award contracts to providers where people are offered a choice between providers and where the number of providers is not restricted by the relevant authority through provider selection. Services arranged using direct award process B may include, but are not limited to:

- elective services led by a consultant or mental health care professional where patients have a legal right to Choice (as set out in Part 8 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012)
- other elective services where patients do not have a legal right to Choice, but for which relevant authorities voluntarily offer patients a choice of providers and where the number of providers is not restricted by the relevant authority through provider selection (e.g., mandatory eye health services, audiology, podiatry services, NHS continuing health care services, public health services such as over-forty health checks).

For some services where the number of providers is not restricted or cannot be restricted, the qualification criteria, which providers must meet, will apply, before a provider can be offered a contract. These criteria (which only apply to ICBs and NHS England) sit outside the PSR decision-making processes and are set out in the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended) and are explained in NHS England's Choice guidance.

When awarding a contract using direct award process B, relevant authorities must ensure that:

- arrangements are in place to enable providers to express an interest in providing the required services
- all providers that meet the requirements in relation to the provision of the health care services are offered contracts.

Relevant authorities must consider the exclusions in Regulation 20 and apply as appropriate.

Direct award process B must not be used to conclude a framework agreement or to award a contract based on a framework agreement.

The relevant transparency steps (see transparency section and Annex B) must be followed before contracts are awarded under this approach.

If relevant authorities are seeking to voluntarily establish other pools of providers from which patients can choose (i.e., for services where there is no legal right to choice) and they intend to select a limited number of providers to be available, they must use the most suitable provider process or the competitive process to make this selection.

17.4.3 Direct award process C

The process that must be followed when awarding a contract under the direct award process C is set out in Regulations 6(5) and 9.

The existing provider is satisfying the existing contract and likely to satisfy the new contract, and the proposed contracting arrangements are not changing considerably from the existing contract.

Direct award process C may be used to award a new contract to the existing provider (or group of providers), to replace an existing contract that is coming to an end, when all the tests below are met:

- the relevant authority is not required to follow direct award processes A or B
- the term of an existing contract is due to expire, and the relevant authority is proposing a new contract to replace that existing contract at the end of its term
- the proposed contracting arrangements are not changing considerably from the existing contract (see establishing that a proposed contracting arrangement is not changing considerably)
- the relevant authority is of the view that the existing provider is satisfying the existing contract to a sufficient standard, according to the detail outlined in the contract, and also taking into account the key criteria and applying the basic selection criteria
- the relevant authority is of the view that the existing provider will likely satisfy the proposed contract to a sufficient standard taking into account the key criteria and applying the basic selection criteria
- the procurement is not to conclude a framework agreement or to award a contract based on a framework agreement.

Once the relevant authority has ascertained that it can use direct award process C, it must follow the below steps:

1. Publish a notice containing its intention to award the contract to the chosen provider (see transparency) and observe the standstill period (see standstill period).
2. Enter into a contract with the chosen provider after the standstill period has concluded.
3. Publish a notice confirming the award of the contract within 30 days of the contract being awarded.

Even where the proposed contracting arrangements are not changing considerably from the existing contract and the provider is satisfying the existing contract and will likely be able to satisfy the new contract, relevant authorities do not have to use direct award process C. Relevant authorities may still choose to follow the most suitable provider process or the competitive process, for example because they wish to test the market.
Relevant authorities must consider the exclusions in Regulation 20 and apply them as appropriate.

Establishing that the proposed contracting arrangements are not changing considerably from the existing contract

The considerable change threshold is set out in Regulation 6(10). Circumstances where a change does not meet the considerable change threshold are set out in Regulations 6(11) and 6(12).

To use direct award process C, the relevant authority must be satisfied that the requirements for the provision of health care services are not changing considerably, i.e., they don't meet the considerable change threshold as set out in Regulation 6(10).

Under this regime, the threshold for considerable change is met where the change:

a. renders the proposed contracting arrangements materially different in character to the existing contract when that existing contract was entered into

or:

b. meets all the following:

- the change, (to the proposed contracting arrangements as compared with the existing contract), is attributable to a decision made by the relevant authority
- the lifetime value of the proposed new contract is at least £500,000 higher (i.e., equal to or exceeding £500,000) than the lifetime value of the existing contract when it was entered into
- the lifetime value of the proposed new contract is at least 25% higher (i.e., equal to or exceeding 25%) than the original lifetime value of the existing contract when it was entered into.

The considerable change threshold is not met, where either:

- The material difference in character from the existing contract (when that existing contract was entered into) applies solely as a result of a change in the identity of the provider due to succession into the position of provider following corporate changes including takeover, merger, acquisition or insolvency and the relevant authority is satisfied that the provider meets the basic selection Additionally, all of the following three conditions do not apply:
    - attributable to a decision of the relevant authority
    - the lifetime value of the proposed contracting is at least £500,000 or higher than the lifetime value of the existing contract when it was entered into
    - the lifetime value of the proposed new contract is at least 25% or higher than the original lifetime value of the existing contract when it was entered into.
- The proposed contracting arrangements are not materially different in character to the existing contract when that existing contract was entered into, and the following three points all apply:
    - the changes in the relevant health care services to which the proposed contracting arrangements relate (compared with the existing contract) are attributable to a decision of the relevant authority; however, that decision had to be made due to external factors beyond the control of the relevant authority or the provider, such as changes in patient or service user volume or changes in prices in accordance with a formula provided for in the contract document
    - the lifetime value of the proposed contracting arrangement is £500,000 or higher than the lifetime value of the existing contract when it was entered into
    - the lifetime value of the proposed new contract is 25% or higher (i.e., equal to or exceeding 25%) than the original lifetime value of the existing contract when it was entered into).

Lifetime value of a contract means the total value of the contract over the full length of the contract. If there is an option to extend stated explicitly in the contract, then the value of the extension should also be considered in the lifetime value. For example, a contract may be worth £1 million per year and is for a duration of three years; the lifetime value of that contract when it was entered into would be £3 million. If there was an option to extend for an additional 2 years, worth £1 million per year, then the lifetime value of the contract when it was entered into would be £5 million. Unplanned modifications made to the contract during its term are not to be included in this calculation.

Establishing that the existing provider is satisfying the existing contract, and is likely able to satisfy the new contract to a sufficient standard
Once the relevant authority has established that the proposed contracting arrangements are not changing considerably, it must assess whether the existing provider is both:

- satisfying the existing contract to a sufficient standard, according to the detail outlined in the existing contract, and taking into account the key criteria and applying the basic selection criteria
- will likely be able to satisfy the new contract to a sufficient standard, according to the detail outlined in the new contract, taking into account key criteria and applying the basic selection criteria.

To do this, the relevant authority must decide the relative importance of the key criteria for the service in question, before assessing the existing provider in relation to each of the key criteria.

The relevant authority must be of the opinion, based on its assessments, that the existing provider is satisfying the existing contract and will likely be able to satisfy the new contract to a sufficient standard. The relevant authority must also assess whether the existing provider is continuing to meet the basic selection criteria.

If direct award process C is not applicable because the proposed contracting arrangements are changing considerably from the existing contract, or the existing provider is not satisfying the existing contract or is not likely to be able to satisfy the new contract, then the relevant authority must follow the most suitable provider process or the competitive process.

Relevant authorities must keep records of these considerations (see transparency) and the resultant decisions, as they may need to disclose information on the rationale for their decision if a representation is made (see standstill period).

17.4.4 The most suitable provider process

The process that must be followed when awarding a contract under the most suitable provider process is defined in Regulations 6(6) and 10.

The relevant authority is able to identify the most suitable provider without running a competitive exercise.

This provider selection process is designed to allow relevant authorities to make an assessment on which provider (or group of providers) is most suitable to deliver the proposed contracting arrangements based on consideration of the key criteria and the basic selection criteria, and to award a contract without running a competitive exercise.

This provider selection process gives relevant authorities a mechanism for reasonable and proportionate decision-making without running a competitive exercise. It is suitable for circumstances where a relevant authority is of the view, taking into account likely providers and all relevant information available to it at the time (see provider landscape), that it is likely to be able to identify the most suitable provider to deliver the health care services to the relevant population (local/regional/national). Relevant authorities are advised to follow this provider selection approach only when they are confident that they can, acting reasonably, clearly identify all likely providers capable of providing the health care services and passing any key criterion or sub-criterion which has been designated as pass/fail.
The most suitable provider process must not be used to conclude a framework agreement or to award a contract based on a framework agreement.

Following this provider selection process

This provider selection process may be followed where any of the following apply:

- the relevant authority is not required to follow direct award processes A or B

- the relevant authority is changing an existing contracting arrangement considerably (such that it must not be continued under direct award process C)
- a new service is being arranged
- the existing provider no longer wants to provide the services
- the relevant authority wants to consider potential providers (even where the proposed contracting arrangements are not changing considerably or otherwise), as this is in the best interest of people who use the service, but there is no benefit to running a competitive process or it is disproportionate to do so.

When following the most suitable provider process, the relevant authority:

1. Is advised to take account of any relevant existing contractual provisions relating to termination and contract exit where there is an existing contract with an existing provider in place, whether the existing provider no longer wants to or is no longer able to provide the services,
2. Is advised to consider undertaking a pre-market engagement exercise (see provider landscape) to help identify all suitable providers and develop the service specification.
3. Must decide the relative importance of each of the key criteria for the service in question (see key criteria); carefully considering the relative importance of the value criterion. It is advised that for provider selection processes with higher contract values, greater focus is given to value for money and the quality and efficiency of the services to be provided, unless this means the service does not best meet the needs of the population it is serving.
4. Must be of the view that by considering providers it understands are likely to have the ability to deliver services to the relevant (local/regional/national) population, and all relevant information available at the time (see provider landscape), it is likely able to identify the most suitable provider.
5. Must publish a notice setting out its intention to follow the most suitable provider process (see transparency). The relevant authority must not proceed to the assessment of likely providers until at least 14 days after the day on which the notice of intention is submitted for publication. The relevant authority is also advised to make potential providers aware that they are being considered for the award of the contract.
6. Is advised to ask the providers it identified as likely to have the ability to deliver services to the relevant (local/regional/national) population, and any provider(s) that responded to the notice publishing the intention to follow the most suitable provider process, for further information that would help decision-making, as necessary.
7. Must identify potential providers that may be the most suitable provider, taking into account the providers it understands are likely to have the ability to deliver services to the relevant (local/regional/national) population and any provider(s) that responded to its notice publishing the intention to follow the most suitable provider process, with reference to the key criteria and the basic selection criteria.
8. Must assess the potential providers identified, considering the key criteria and applying the basic selection criteria in a fair way across them (i.e., on the same basis), and choose the most suitable provider(s) to which to make an award.
9. Must publish a notice containing its intention to award the contract to the chosen provider (see transparency) and observe the standstill period (see standstill period).
10. May enter into a contract with the chosen provider after the standstill period has concluded.
11. Must publish a notice confirming the award of the contract within 30 days of the contract being awarded.

Relevant authorities are expected to use their established knowledge of potential providers (see provider landscape). Relevant authorities may approach providers and ask for information as necessary but are advised to take a proportionate approach.

Relevant authorities must be able to demonstrate that they have understood the alternative providers and reached a reasonable decision when selecting a provider – but this does not need to be via a formal competitive exercise. Relevant authorities must keep robust records of these considerations and follow the relevant transparency requirements (see transparency). They may need to disclose information on the rationale for their decision if a representation is made (see standstill period).

If at any point in the most suitable provider process the relevant authority has insufficient information to make an assessment under the most suitable provider process, for example, because it did not receive sufficient information to help its decision-making, it is advised to use the competitive process. If the relevant authority fails to identify the most suitable provider (or a group of providers), then it must follow the approach for the competitive process to select a provider or abandon the selection process all together if appropriate.

If the relevant authority decides to switch provider selection approach after it published its intended approach notice, then it must abandon the selection process before switching provider selection approach.

Relevant authorities must consider the exclusions in Regulation 20 and apply as appropriate.

Further information

Relevant authorities are expected to develop and maintain a sufficiently detailed knowledge of relevant providers that have the capability to meet the needs of patients within the relevant geographical footprint, which can be used to identify suitable providers (see provider landscape). Relevant authorities may identify suitable providers through market research, regular engagement with providers, registers of relevant providers or responses to their intention to follow the most suitable provider process notice.

17.4.5 The competitive process

Regulations 6(7) and 11 set out the process that relevant authorities must follow when awarding a contract under the competitive process.

Conducting a competitive procurement exercise

This provider selection process must be followed when the relevant authority is not required to follow direct award processes A or B, and the relevant authority cannot or does not wish to follow direct award process C or the most suitable provider process (for example, because it has not been able to identify a most suitable provider or because it wishes to test the market).

This provider selection process must be used when concluding a framework agreement and may be used when awarding a contract based on a framework agreement, in accordance with the terms of that framework agreement (see framework agreements).

Following this provider selection process

The steps outlined in the Regulations and the transparency requirements must be adhered to. Relevant authorities may determine additional procedures to be applied in selecting a provider using the competitive process, taking into account the specificities of the services in question to design a bespoke procedure.

When following the competitive process, relevant authorities:

1. Will need to develop a service specification setting out the relevant authority's requirements for the service. In doing so, relevant authorities may consider undertaking a pre-market engagement exercise.
2. Must determine the contract or framework award criteria for the service in question, taking into account the key criteria and applying the basic selection criteria (see key criteria and basic selection criteria).

3. Must formally advertise the opportunity to bid (see transparency) and ensure providers are given a reasonable timeframe to respond. The advertisement must include information relating to how bids will be assessed, including whether the different award criteria will be assessed in stages.
4. Must assess any bids received by following the assessment process – that is, against the award criteria, and the exclusion criteria set out in Regulation 20, in a fair way across all bids (i.e., on the same basis). This may be done in stages, in accordance with step 3 above.
5. Must identify the successful provider (or group of providers).
6. Must inform in writing the successful provider (or group of providers) of its intention to award a contract or conclude a framework agreement, and must also inform in writing each unsuccessful provider that its bid has been unsuccessful.
7. Must publish a notice of its intention to award the contract to or conclude a framework agreement with the chosen provider (or group of providers) (see transparency) and observe the standstill period (see standstill period).
8. May enter into a contract or conclude a framework agreement with the chosen provider (or group of providers) after the standstill period has concluded.
9. Must publish a notice confirming the award of the contract within 30 days of the contract being awarded.

The award criteria referred to above consist of the basic selection criteria, the key criteria and any other elements of the contract award. These components can be assessed in stages – for example, a provider that does not meet the basic selection criteria may be discounted without further assessment.

Relevant authorities may engage in dialogue or negotiate with all bidders or with shortlisted bidders prior to determining who to award a contract and with a view to improving on initial offers, provided that they do so in a fair and proportionate way and treat all bidders equally.

Relevant authorities must keep records of the procedure followed to select a provider (including details of the bespoke procedure), of how each bid performed against the award criteria and the rationale for selecting the successful bidder (see transparency).
Relevant authorities must consider the exclusions in Regulation 20 and apply as appropriate.

The Trust should follow the tendering procedure described in SFI 16.71 to 16.7.7 when implementing the PSR Competitive Process.

17.5 Framework agreements

Framework agreements are defined in Regulation 16.
Relevant authorities may establish framework agreements under the PSR to arrange health care services in scope of the regime (or that are categorised as mixed procurements within the regime).

What is a framework agreement?

Framework agreements for the purposes of this regime are agreements in relation to health care services in scope of this regime between one or more relevant authorities and one or more providers. Framework agreements set out the terms and conditions based on which the provider will enter into one or more contracts with a relevant authority, during the period the framework agreement is in place.

The relevant authority (or relevant authorities) that may award contracts based on the framework agreement must be identified in the framework agreement (either by name or by describing the type of relevant authority), and contracts awarded based on a framework agreement must only be between the relevant authority (or relevant authorities) identified in the framework agreement and a provider that is party to the framework agreement.

The length of a framework agreement must not exceed four years, other than in exceptional cases where the relevant authority is satisfied that the subject-matter of the framework agreement justifies a longer term.

The terms and conditions of a framework agreement may be modified in line with the requirements for contract modification for this regime (see contract modifications).

Concluding a framework agreement

The process that must be followed when concluding a framework agreement is set out in Regulation 16.

The process that must be followed when adding providers to an existing framework agreement is set out in Regulation 17.
When concluding a framework agreement, relevant authorities must use the competitive process to select provider(s) to be party to the framework agreement.

During the term of a framework agreement, providers may be added to a framework agreement. Relevant authorities are advised to set out how and when this might be done in the terms and conditions of that framework agreement. Relevant authorities must use the approach for the competitive process to add providers to the framework agreement, and relevant authorities are advised to use the same award criteria as when setting up the original framework agreement.

When concluding a framework agreement, relevant authorities must set out the duration of the framework agreement and which relevant authorities can award contracts based on the framework agreement. Relevant authorities are expected to set out:

- the terms for awarding a contract based on the framework agreement
- how the framework agreement will operate
- how the call-off procedures will operate (see below)
- how new providers or relevant authorities can be added to the framework agreement at a later date (if applicable).

Relevant authorities must not conclude a framework agreement with a provider and may exclude a provider from the procurement process if the provider meets the exclusion criteria detailed in Regulation 20. Relevant authorities are advised to set out in the terms and conditions of their framework agreement that they may remove a provider from the framework agreement if that provider meets the exclusion criteria.

Awarding contracts based on a framework agreement

The processes that must be followed when awarding a contract based on a framework agreement are defined in Regulation 18.

Only relevant authorities that are identified as being able to award contracts under the framework agreement may award contracts to providers that are party to that same framework agreement. Relevant authorities may decide that the award criteria for awarding contracts under a framework agreement are different from those for concluding the framework.

Relevant authorities must award a contract under a framework agreement in accordance with the terms and conditions of that framework agreement.

If awarding a contract based on a framework agreement, relevant authorities may do so in one of the following ways:

- without competition if the framework agreement only includes one provider (via a ‘direct award’)
- if the framework agreement includes more than one provider, choose whether to award the contract:

- without a further competition (via 'direct award'), or
- by following the competitive process (via a 'mini-competition').

In all these scenarios, relevant authorities must make decisions in accordance with the framework agreement.

If awarding a contract based on a framework agreement without competition (via a 'direct award'), relevant authorities must:

- publish a notice confirming the decision notice within 30 days of the contract being awarded (see transparency section and Annex B).

If awarding a contract based on a framework agreement following a competitive process (via a 'mini-competition'), relevant authorities must:

- follow the process for the competitive process, substituting step 2 (the step advertising the opportunity to the market' with 'invite providers party to the framework to submit an offer'
- follow the terms and conditions of the framework agreement, including how competitions must run when awarding a contract based on that framework agreement (if this is set out)
- follow the relevant transparency requirements (see transparency section and Annex B)
- observe the standstill period as required for the competitive process (see standstill period).

When awarding a contract from a framework agreement, the term of the contract may exceed the length of the framework agreement.

Contracts awarded from a framework agreement are expected to not exceed the total value of the framework agreement.

17.6 Key criteria

Overview

The PSR key criteria are defined in Regulation 5.
Five key criteria must be considered when making decisions about provider selection under direct award process C, the most suitable provider process, and the competitive process of this regime. Annex D to this guidance provides detail on what each criterion covers. In summary, these criteria are:

- **Quality and innovation**, that is the need to ensure good quality services and the need to support the potential for the development of new or significantly improved services or processes that will improve the delivery of health care or health outcomes.
- **Improving access, reducing health inequalities and facilitating choice**, that is ensuring accessibility to services and treatments for all eligible patients, improving health inequalities and the ensuring that patients have choice in respect of their health care.
- **Social value**, that is whether what is proposed might improve economic, social and environmental well-being in the geographical area relevant to a proposed contracting arrangement.

Application of key criteria

Relevant authorities must consider each of the key criteria in the regime when making decisions under direct award process C, the most suitable provider process and the competitive process (including when concluding a framework agreement and when awarding a contract based on a framework agreement using the competitive process). Under these

processes, relevant authorities must be able to justify their decisions when following a provider selection process in relation to the key criteria and keep a record of this. Further detail on recording decision-making and transparency can be found in the transparency section.

How relevant authorities assess providers against the key criteria, including what evidence they consider, may vary according to the service they want to procure. A relevant authority may wish to address specific priorities; these are expected to be described as part of the key criteria and can be considered when deciding the relative importance of the key criteria.

Relevant authorities must be aware that equalities duties in the Equality Act 2010, including the Public Sector Equality Duty, are relevant to all criteria and due regard to these requirements must be given when considering each criterion.

Balancing the key criteria

The relative importance of the key criteria is not predetermined by the Regulations or this guidance and there is no prescribed hierarchy or weighting for each criterion. Relevant authorities must decide the relative importance of the key criteria for each decision they make under this regime, based on the proposed contracting arrangements and what they are seeking to achieve from them/the services, including scenarios where a particular criterion is 'pass/fail', or where certain key criteria are of equal importance. All criteria must be considered, and none is expected to be discounted when following a provider selection process.

The regime does not specify how relevant authorities must balance the key criteria; however, relevant authorities are expected be aware of wider requirements or duties when considering procurement decisions. For example, NHS England, ICBs, NHS trusts and NHS foundation trusts are expected to adhere to NHS England's net zero ambitions and its social value commitment, and the need to ensure value for money when arranging health care services (this list is not exhaustive). The flexibilities offered by the regime do not mean that relevant authorities are exempt from complying with their other obligations.

Relevant authorities are advised to consider particularly carefully the relative importance of the value criterion when making assessments under the most suitable provider process.

It is advised that for provider selection processes with higher contract values, greater focus is given to value for money and the quality and efficiency of the services to be provided, unless this means the service does not best meet the needs of the population it is serving.

When making assessments against the key criteria under direct award process C and the most suitable provider process, relevant authorities are expected to use information and evidence from a range of sources, as well as their knowledge and experience of working with providers. They can ask providers for further information to assist with this assessment if they wish. The explanation of each criterion in Annex D includes examples of relevant sources where appropriate.

When following the competitive process relevant authorities must only use the information contained in the bid to assess the bid. Relevant authorities may set out in their tender documents that wilful misrepresentation of a bid by a provider will result in exclusion from the provider selection process.

Relevant authorities must justify and record how they have given relative importance to each of the key criteria for the service they are arranging. Further detail on recording decision-making can be found in the transparency section.

Relevant authorities must ensure they meet other relevant statutory duties when deciding the relative importance of each of the criteria, including normal public law decision-making principles around reasonableness of decisions. Relevant authorities are also expected to consider other national and local policies and non-statutory guidance when deciding the relative importance of each of the criteria.

17.7 Transparency

The relevant information keeping requirements are detailed in Regulation 24.

The requirements for the transparency notices, including the content of the notices, are detailed in Schedules 2 to 15.

Relevant authorities are required to evidence that they have properly exercised the responsibilities and flexibilities conferred on them by the regime, to ensure that there is proper scrutiny and accountability of decisions made about health care services. This section sets out the steps that relevant authorities must take to be transparent in their decision-making under this regime.

There are several elements to the transparency process under this regime – these apply differently according to which decision-making process is being applied. Annex B provides detailed information about the transparency requirements for all processes under the PSR.

Relevant authorities must follow the transparency process relevant to the approach being followed.

In all circumstances, relevant authorities must keep internal records of their decision-making processes and must publish notices confirming their decision to award a contract.

When following the most suitable provider process relevant authorities must also make their intentions clear in advance by issuing a notice.

When following direct award process C, the most suitable provider process and the competitive process (including when concluding a framework agreement and when awarding a contract based on a framework agreement using the competitive process) relevant authorities must also communicate their decision to award a contract publicly and observe a standstill period during which representations can be made. The standstill period must end before contracts can be awarded.

All transparency notices referred to in this section must be published using the UK e-notification service, the Find a Tender Service (FTS). The information that must be included in the transparency notices is set out in Annex B and relevant authorities should refer to the separate guide to publishing these notices on FTS.

Relevant authorities can publish information on their decision-making in other places as well if they wish, such as Contracts Finder.

In addition to the transparency notices required under the various provider selection processes, relevant authorities must publish transparency notices when they are abandoning a provider selection process, when making an urgent award or contract modification or when undertaking certain non-urgent contract modifications.

17.8 Keeping records of decision-making

The relevant information requirements are detailed in Regulation 24.
Relevant authorities must make and keep clear records detailing their decision-making process and rationale. This must be done for all provider selection processes (direct award process A, B and C, the most suitable provider process, and the competitive process), when concluding a framework agreement, when awarding a contract based on a framework agreement without competition, and when awarding a contract based on a framework agreement following the competitive process. This includes where a provider selection process was abandoned or where the relevant authority decided to return to an earlier step in the process. Records must include:

- name of the provider to which the contract has been awarded or the name of any provider who is a party to a framework agreement and the address of their registered office or principal place of business

- the decision-making process followed to select a provider(s), including details of the procedure used when the competitive process is followed
- the reasons for these decisions
- details of the individual/individuals making the decision
- any declared or potential conflicts of interest for individuals involved in decision-making and how these were managed
- where a procurement is abandoned, the date on which it is abandoned.

We expect that records are kept when contracting for mixed procurements, including how the procurement meets the requirements for mixed procurements under this regime.

When following direct award process C or the most suitable provider process, records must also include:

- a description of the way in which the key criteria (e.g., weighting, hierarchy, or more informal description of importance) were taken into account, and how the basic selection criteria were assessed when making decisions. We expect that this includes the relative importance of the key criteria that the relevant authority used to make a decision, the rationale for the relative importance of the key criteria, and the rationale for choosing the provider with reference to the key criteria.

When following the competitive process (including when concluding a framework agreement or when awarding a contract based on a framework agreement following the competitive process), records must also include:

- a description of the way in which the key criteria were taken into account, the basic selection criteria were assessed, and contract or framework award criteria were evaluated when making a decision. We expect that this includes the relative importance of the key criteria that the relevant authority used to make a decision, the rationale for the relative importance of the key criteria, and the rationale for choosing the provider with reference to the key criteria.

When concluding a framework agreement, we expect that records include the terms and conditions that will be laid down by the framework agreement, and include which relevant authorities are part of the framework agreement. When awarding a contract from a framework agreement, we expect that records include which framework agreement the contract is being awarded from.

Relevant authorities must be aware that they may need to disclose information on the rationale for their decision making under the Regulations if a representation is made (see standstill period). We expect relevant authorities to keep their records for a period of time that is in line with their organisation's record keeping policies and any applicable legislation. Relevant authorities are also expected to keep records of their decisions and decision-making processes when modifying a contract.

Keeping records of decision-making in urgent circumstances

When awarding or modifying a contract in an urgent circumstance, relevant authorities must make and keep clear records detailing their decision-making process and rationale. Records must include:

- justification for using the urgent circumstances exemption
- name of the provider(s) to which the contract has been awarded and the address of its registered office or principal place of business
- the approach taken to select a provider and the process followed (i.e., urgent circumstance)
- details of the individual/individuals making the decision
- any declared or potential conflicts of interest of individuals making the decision (not including individual names) and how these were managed.

We expect that records are kept when contracting for mixed procurements, including how the procurement meets the requirements for mixed procurements under this regime.

17.9 Annual summary

The annual summary requirements are set out in Regulation 25.

Relevant authorities must publish a summary of their application of the PSR annually online (e.g., via the relevant authority's annual reports or annual governance statement). We expect the first annual summary to relate to contracts awarded using the PSR between 1 January 2024 – 31 March 2025, and we expect this to be published no later than six months following the end of 2024/2025 financial year. Following the first annual summary, all other annual summaries must be published no later than six months following the end of the financial year it relates to.

This must include, in the year to which the summary relates, the:

- number of contracts directly awarded under direct award processes A, B or C
- number of contracts awarded under the most suitable provider process
- number of contracts awarded under the competitive process
- number of framework agreements concluded
- number of contracts awarded based on a framework agreement
- number of urgent contracts awarded and urgent modifications (in line with the urgent awards or contract modifications section)
- number of new providers awarded contracts
- number of providers who ceased to hold any contracts with the relevant authority
- details of representations received, including:
    - the number of representations received in writing and during the standstill period in accordance with Regulation 12(3)
    - summary of the outcome of all representations received and of the nature and impact of those representations.

In addition, relevant authorities are expected to publish:

- total number of providers the relevant authority is currently contracted with
- details of any PSR review panel reviews:
    - number of requests for consideration received by the PSR review panel
    - number of requests accepted and rejected by the PSR review panel for consideration
    - number of times where the PSR review panel advised the relevant authority to re-run or go back to an earlier step in a provider selection process under the PSR, and the number of times the advice was followed.

17.10 Monitoring requirements

The monitoring requirements are set out in Regulation 26.

Relevant authorities must monitor their compliance with the Regulations. The results of the monitoring must be published online annually (and may be integrated into other annual reporting requirements) and include processes, decisions made under the PSR, contract modifications, and declaration and management of conflicts of interests. Relevant authorities may use internal auditors to fulfil these requirements.

If a compliance report finds instance(s) of non-compliance, relevant authorities must put in place actions to address this issue and to improve adherence with the regime.

18. Terms of Service, Allowances and Payment of Members of the Board and Employees

18.1 Remuneration and Terms of Service (see also SO 4)

18.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Nominations Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

18.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors employed by the Trust, and other senior employees (if any) as it is designated to consider, including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of Executive Trust Board members (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such Board members and staff where appropriate;

(c) ensure in consultation with the Chief Executive, that the performance of individual Executive Directors is regularly monitored and evaluated

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

18.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board's meetings should record such decisions.

18.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

18.1.5 The Trust will pay allowances to the Chair and Non-Executive Directors in accordance with instructions issued by the Council of Governors.

18.1.6 The Committee will approve recruitment and retention premia awarded to any member of staff not covered by Agenda for Change where there are national recruitment and retention pressures (for example medical consultants).

18.2 Funded Establishment

18.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

18.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

18.3 Staff Appointments

18.3.1 No Trust Board member or officer may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive

(b) within approved Scheme of Delegation

18.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

18.4 Processing Payroll

18.4.1 The Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

18.4.2 The Director of Finance will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employees;

(h) procedures for payment by cheque, bank credit, or cash to employees, liaising as necessary with the Finance Directorate;

(i) procedures for the recall of cheques and bank credits, liaising as necessary with the Finance Directorate;

(j) pay advances and their recovery, liaising as necessary with the Finance Directorate;

(k) separation of duties of preparing records and handling cash;

(l) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

18.4.3 The Director of Finance will issue instructions regarding maintenance of regular and independent reconciliation of pay control accounts

18.4.4 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

18.4.5 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

18.5 Contracts of Employment

18.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

19. Non Pay Expenditure

19.1 Delegation of Authority

19.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

19.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

19.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

19.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (See also SFI 16)

19.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement department should be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

19.2.2 System of Payment and Payment Verification

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

19.2.2.1 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Financial Instructions and regularly reviewed

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of officers and Board members (including specimens of their signatures) authorised to certify invoices should be submitted to Finance and Purchasing by each Business Unit/HQ Directorate. It is the responsibility of the Assistant or Deputy Director /Departmental Director to re-submit specimen signatures where staff changes occur.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

- Email authorisation of invoices is allowable up to the thresholds within the Scheme of Delegation

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI 19.2.4 below.

19.2.3 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

19.2.4 **Official Orders**

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised under the Scheme of Delegation

19.2.5 Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement; (current thresholds are detailed in the Scheme of Delegation)

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health (The Procurement and Management of Consultants within the NHS)

(d) where the item being procured is a capital investment or an estate or property transactions, the procurement must be in accordance with guidance issued by the Department of Health (Capital Investment Manual and Estatecode)

(e) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with SO 7 and 7.4.1)

(f) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(g) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, purchases from petty cash or purchases made using the Trust purchasing card process ;

(h) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of officers authorised to certify invoices are notified to the Director of Finance ;

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance ;

(m) petty cash records are maintained in a form as determined by the Director of Finance .

19.2.6 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Concode and Estatecode. The technical audit of these contracts shall be the responsibility of the relevant Director.

19.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

19.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act **shall** comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts. (See also SO 9.1)

20. External Borrowing

20.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividend on and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

20.1.2 The Board will agree the list of officers (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

20.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

20.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health.

20.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

20.1.6 All long-term borrowing must be consistent with the plans outlined in the current Strategic Plan and be approved by the Board.

20.2 Investments

20.2.1 Temporary cash surpluses must be held only in such public or private sector investments in accordance with the conditions set out in the Trust's Treasury Management Policy and the Independent Regulator's guidance "Managing Operating Cash in NHS Foundation Trusts"

20.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

20.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained The Trust will comply with all the relevant guidance published in relation to investments.

21. Financial Framework

21.1.1 The Director of Finance should ensure that Board members are aware of the Financial Framework. This document contains directions which the Trust must follow. The Director of Finance should also ensure that the direction and guidance in the framework is followed by the Trust.

. The Board will ensure that funds are available for short term cashflow management and this maybe by negotiating an irrevocable working capital facility. The value of this facility shall not exceed 30 days worth of normal operating expenditure.

21.1.2 Use of Framework Agreements

The Trust may utilise any available framework agreement to satisfy its requirements for works, services or goods but only if it complies with the requirements of Procurement Legislation in doing so, which include (but are not limited to) ensuring that:

(a) the framework agreement was procured on its behalf. The Trust should satisfy itself that the original procurement process included the Trust within its scope;

(b) the framework agreement includes the Trust's requirement within its scope. The Trust should satisfy itself that this is the case;

(c) where the framework agreement is a multi-operator framework agreement, the process for the selection of providers to be awarded call-off contracts under the framework agreement is followed; and

(d) the call-off contract entered into with the provider contains the contractual terms set out by the framework agreement.

22. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

22.1 Capital Investment

22.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

22.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the Capital Investment Manual) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

22.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Estatecode.

22.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

22.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

22.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see also SFI 16.9);

(c) approval to accept a successful tender (see also SFI 16.9).

The Chief Executive will issue a Scheme of Delegation for capital investment management in accordance with Estatecode guidance and the Trust's Standing Orders.

22.1.7 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 246.

22.2 Private Finance (See also SFI 16.10)

22.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Board.

22.3 Asset Registers

22.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

22.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual or later guidance as issued by the Department of Health.

22.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

22.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

22.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

22.3.6 All assets are initially measured at cost and subsequently at fair value. For specialised buildings this involves a valuation based on modern equivalent assets (see accounting policies)

22.3.7 The value of each asset shall be depreciated using methods and rates as specified in the Independent Regulator's Financial Reporting Manual and IFRS.

22.3.8 The Director of Finance of the Trust shall calculate and pay capital charges as specified in the Capital Accounting Manual issued by the Department of Health.

22.4 Security of Assets

22.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

22.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

22.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

22.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

22.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

22.4.6 Where practical, assets should be marked as Trust property.

23. Stores and Receipt of Goods

23.1 General Position

23.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

23.2 Control of Stores, Stocktaking, Condemnations and Disposal

23.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an officer by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

23.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

23.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

23.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

23.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

23.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also SFI 23). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

23.3 Goods Supplied by NHS Supply Chain

23.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

24. Disposals and Condemnations, Losses and Special Payments

24.1 Disposals and Condemnations

24.1.1 **Procedures**

The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

24.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

24.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

24.1.4 The Condemning Officer shall satisfy himself/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

24.2 Losses and Special Payments

24.2.1 Procedures

The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

24.2.2 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved if this has not already been done. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the LCFS and the NHS Counter Fraud Authority.

The Director of Finance must notify NHS Counter Fraud Authority, the External Auditor and the Independent Regulator of all frauds.

24.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Board,

(b) the External Auditor.

24.2.4 Within limits delegated to it by the Managing Public Money guidance the Board shall approve the writing-off of losses.

24.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

24.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

24.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

24.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

24.2.9 All losses and special payments must be reported to the Audit Committee annually

25. Information Technology

25.1 Responsibilities and Duties of the Director of Finance

25.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

25.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

25.1.3 The Director of Nursing shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

25.2 Responsibilities and Duties of Other Directors and Officers in Relation to Computer Systems of a General Application

25.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance :

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

25.3 Contracts for Computer Services with Other Health Bodies or Outside Agencies

The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

25.4 Risk Assessment

The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

25.5 Requirements for Computer Systems which have an Impact on Corporate Financial Systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

26. Patients' Property

26.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as property) handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

26.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

a) notices and information booklets;

b) hospital admission documentation and property records;

c) the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

26.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

26.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

26.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

26.6 Officers should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

26.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

27. Funds Held on Trust

27.1 Corporate Trustee

a) The Trust Board Acts as the Corporate Trustee for the Trust's charity Healthstars.

b) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

c) The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

27.2 Accountability to Charity Commission and Secretary of State for Health

(a) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(b) The Schedule of Matters Reserved to the Trust Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust Officers must take account of that guidance before taking action.

27.3 Applicability of Standing Financial Instructions to Funds held on Trust

a) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. See also SFI No 16.18).

b) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

28. Acceptance of Gifts by Staff and Link to Standards of Business Conduct (See also SO 6 and SO 7.4.1)

The Director of Finance shall ensure that all officers are made aware of the Trust's Standards of Business and Managing Conflicts of Interest policy for NHS Staff on acceptance of gifts and other benefits in kind by officers. This policy follows the guidance published by NHS England) and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions.

29. Retention of Records

29.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

29.2 The records held in archives shall be capable of retrieval by authorised persons.

29.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

30. Risk Management and Insurance

30.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

(f) a clear indication of which risks shall be insured;

(g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by current Monitor guidance.

30.2 Insurance: Risk Pooling Schemes Administered by NHSLA

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

30.3 Insurance Arrangements with Commercial Insurers

30.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(b) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(c) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

30.4.1 Arrangements to be Followed by the Trust Board in Agreeing Insurance Cover

(a) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

(b) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Trust Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(c) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Statutory Roles and Responsibilities of the Council of Governors

Subject always to provisions of the Constitution, the Governors shall have the following statutory roles and responsibilities:-

- Appoint and, if appropriate, remove the chair (Constitution paragraph 26);
- Appoint and, if appropriate, remove the other non-executive directors (Constitution paragraph 26);
- Decide the remuneration and allowances, and the other terms and conditions of office, of the chair and the other non-executive directors (Constitution paragraph 33);
- Approve (or not) the appointment of the chief executive (Constitution paragraph 28);
- Appoint and, if appropriate, remove the NHS foundation trust's auditor (Constitution paragraph 38);
- Receive the NHS foundation trust's annual accounts, any report of the auditor on them and the annual report at a general meeting of the Council of Governors (Constitution paragraph 44);
- Hold the non-executive directors, individually and collectively, to account for the performance of the Trust Board (Constitution paragraph 16);
- Represent the interests of the members of the Trust as a whole and the interests of the public (Constitution paragraph 12);
- Approve 'significant transactions' (Constitution paragraph 46);
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution (Constitution paragraph 46);
- Decide whether the Trust's non-NHS work would significantly interfere with its principle purpose, which is to provide goods and services for the health service in England or performing its other functions (Constitution paragraph 41);
- Approve amendments to the Trust's constitution (Constitution paragraph 44).

Humber Teaching NHS Foundation Trust

Agenda Item 22

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Compliance with the Provider License – Annual Review
Author/s:	Pete Beckwith, Director of Finance Stella Jackson, Head of Corporate Affairs
Recommendation:	

To approve		To discuss	x
To note		To ratify	
For assurance			

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	This report provides evidence of how the Trust continues to meet the terms of its Provider Licence, elements of the NHS Act and its Constitution. Trust Board is asked to: • Consider whether the information in Appendix A provides evidence that the Trust is meeting its licence conditions. • Note updates to the evidence are highlighted in yellow in appendices A and B. • Note that the Executive Management Team has reviewed the evidence. • Note the report will be shared with Governors for information at the July Council of Governors meeting.

Key Issues within the report:

This report provides evidence of how the Trust continues to meet the terms of its Licence, elements of the NHS Act and its Constitution.

Positive Assurances to Provide: • High level of assurance provided in June 2022 by Audit Yorkshire regarding the annual declarations process.	**Key Actions Commissioned/Work Underway:** • The evidence which outlines how the Trust continues to meet the terms of the Provider Licence is reviewed on annual basis and was last approved by the Board in May 2024.
Matters of Concern or Key Risks: • None	**Decisions Made:** • N/A

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	22.4.2025
Mental Health Legislation Committee		Operational Delivery Group	

	Collaborative Committee		Other (please detail)	Trust Board 28.2.25

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
√	Innovating Quality and Patient Safety
√	Enhancing prevention, wellbeing and recovery
√	Fostering integration, partnership and alliances
√	Developing an effective and empowered workforce
√	Maximising an efficient and sustainable organisation
√	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Compliance with the Provider Licence
Annual Review

1 Introduction

Up until the financial year 2023/24, NHS Providers were required to publish a declaration of compliance against the NHS provider licence. This requirement was removed from the Provider Licence which came into force on 1 April 2023.

The new licence does not require licence holders to publish a declaration of compliance, but they are expected to self-assess their compliance against the conditions.

NHS England will not be monitoring compliance with the Licence and Integrated Care Boards will decide if and how they want to monitor compliance.

However, NHS England will use the licencing framework to take action against an NHS provider should a breach occur.

The Code of Governance for Provider Trusts provides that when holding to account, the governors should `ensure the board of directors acts so that the trust does not breach the conditions of its licence'. The report will be shared with governors at the July Council of Governors meeting in order to appraise them of how the Trust is meeting its licence conditions.

2 Declarations

In previous years the Trust has made the following declarations:

Declaration	Details
G6 (3)	Providers must certify that their Board has taken all necessary precautions to comply with the licence, NHS Act and NHS Constitution.
FT4 (8)	Providers must certify compliance with required governance standards and objectives
CoS7 (3)	Providers providing Commissioner Requested Services (CRS) have to certify that they have a reasonable expectation that required resources will be available to deliver designated services.

Evidence to support the above declarations is attached at Appendix A and B and updates to the evidence are highlighted in yellow for ease of reference.

Appendix A
Licence Conditions:

Condition	Explanation	Comments
Trust Working in Systems (WS)		
WS1. Cooperation	Requirement for NHS providers to carry out their legal duties to co-operate with NHS bodies and with local authorities, having regard to any guidance produced regarding cooperation.	• The Trust CEO is a member of the ICB Board • The Trust has active participation across the ICB in various groups
WS2. The Triple Aim	Obliged, when making decisions, to comply with the Triple Aim duty and any guidance published by NHS England regarding this.	• The Trust consider all aspects of the Triple aim when making decisions (Improving Patient Experience, Improving Value for Money, Improving Population Health). • The Trust will comply with any guidance issued by NHS England
WS3. Digital Transformation	Requirement to comply with required levels of digital maturity as set out in guidance published by NHS England	• The Trusts Data Quality Maturity Index (DQMI) score at 99% (National Average 95%). • The Trust digital governance has been updated to reflect what good looks like framework. • The Trust are identified as having a level 2 Electronic Patient Record and have procured a second-generation Electronic Patient Record as part of the Front Line Digitisation Programme.
General licence conditions (G)		
G1. Provision of information	Obligation to provide NHS England with any information it requires for its licensing functions.	• The Trust complies with any NHS England requests for information and complies with the reporting requirements as set out in the Single Oversight Framework. • The Trust has robust data collection and validation processes. • Accurate, complete and timely information is produced and submitted to third parties to meet specific requirements. • The Trust makes monthly submissions to NHS England

Condition	Explanation	Comments
G2. Publication of information	Obligation to publish such information as NHS England may require regarding the health care services it provides for the purposes of the NHS.	• The Trust Board of Directors continues to meet in public with digital access available to view meetings. • Agendas, minutes and papers are published on the Trust's website. • Public Board meetings include updates on operational performance, quality and finance. • The Trust's website contains a variety of information and referral point information should the public require further information. • The Trust Publishes Quality Accounts and an Annual Report. • The Trust responds to Freedom of Information requests • The Board Assurance Framework and Trust Wide Risk Register are reported to the Board quarterly. • The Council of Governors receives regular communication about the work of the Trust. • The Trust complies with its obligations under Duty of Candour.
G3. Fit and proper persons as Governors and Directors	Prevents licensees from allowing unfit persons to become or continue as governors or directors.	• Governors and Members of the Board of Directors are required to make an annual declaration to ensure that they continue to meet the Fit and Proper Persons Test. • The Trust complies with NHS England Fit and Proper Person Test framework requirements.
G4. NHS England guidance	Requires licensees to have regard to NHS England guidance.	• The Trust responds to guidance issued by NHS England. • Submissions and information provided to NHS England are approved through relevant and appropriate authorisation processes. • The Trust has regard to NHS England guidance with reports to Board and Council of Governors providing assurance.
G5. Systems for compliance with licence conditions and related obligations	Requires providers to take reasonable precautions against risk of failure to comply with the licence.	• The Trust's Internal Auditors (Audit Yorkshire) considered the Board Assurance Framework and Risk Management as part of the 2020/21 audit work programme; the outcome provided 'High' assurance. • Previously governance arrangements (Board & Committee Effectiveness) were reviewed as part of the 2018/19 internal audit programme, providing 'good' assurance. Governance arrangements in relation to Board & Committee Effectiveness remain in place and follow the process which was audited in 2018/19. • Previously governance arrangements (Board & Committee Effectiveness) were reviewed as part of the 2018/19 internal audit programme, providing 'good' assurance. • The Board Assurance Framework and Trust Wide Risk Register are reported to the Board quarterly as well as relevant parts to the sub-committees of the Board and Executive Management Team.

Condition	Explanation	Comments
		• Annual Governance Statement • The 2024/25 Annual Head of Internal Audit Opinion is expected to provide 'Significant' Assurance
G6. Registration with the Care Quality Commission (CQC)	Requires providers to be registered with the CQC and to notify NHS England if their registration is cancelled.	• The Trust is registered with the Care Quality Commission (CQC). • The Trust's last full CQC inspection was in 2019 and assessed the Trust as 'Good'
G7. Patient eligibility and selection criteria	Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.	• Details of Services the Trust provides are published on the Trust's website • Patients referred to the Trust are not selected on any eligibility grounds. • Eligibility is defined through commissioner contracts and patient choice • Treatment decisions are made on clinical grounds and treatment options (risks and benefit) are discussed with the patient through the consent to treatment process.
G8. Application of section 6 (Continuity of Services)	Sets out the conditions under which a service will be designated as a CRS	• CRS are defined in the Trusts contracts with the Integrated Care Board
Costing conditions (P)		
C1. Obtaining, recording and maintaining sufficient information about expended costs	Obligation of licensees to record information, particularly about costs consistent with the guidance in NHS England's Approved Costing Guidance.	• The Trust has well established systems for coding, collection, retention and analysis of activity and cost information. • The 2020/21 Internal Audit Programme undertook an audit of the National Cost Collection which provided 'High' assurance
C2. Provision of information	Obligation to submit the above to NHS England.	• The Trust responds to guidance and requests from NHS England.
C3. Assurance regarding the accuracy of pricing and costing information.	Obliges Providers to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England.	• The Trust Board have signed off the process in relation to National Cost Collection (July 2024).

Condition	Explanation	Comments
Pricing Condition (P)		
P1. Compliance with the NHS payment scheme	Obligation to comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England	• All Trust contracts are agreed annually and are in line with the NHS payment scheme where applicable.
Integrated care condition (IC)		
IC1. Provision of integrated care	Requires Licensee to act in the interests of people who use healthcare services by ensuring service provision is integrated with the provision of such services by others and enables co-operation with other providers.	• The Trust actively works with its partners, through formal and informal mechanisms to foster and enable integrated care, including lead provider arrangements where appropriate. • A number of services provided are done so through partnership working with other local stakeholders. • The Trust has become the lead provider in the Humber Coast and Vale Geography for the following specialised Mental Health Services o Adult Secure inpatient care (Low/Medium Secure) o Children's and Adolescent Mental Health Inpatient Services o Adult Eating Disorders Inpatient Services
IC2. Personalised Care and Patient Choice	Obligation to: Support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance. Offer service users information, choice and control to manage their own health and wellbeing to meet their own needs, working in partnership with other services as required. Ensure service users are informed, as applicable, when they have a choice of provider and that the information assists them in making well informed choices. Not offering gifts, benefits or pecuniary or other advantages to clinicians, other health professionals, commissioners or their staff as inducements to refer patients or commission services.	• The Trust has in place a service directory setting out the services available. • Commissioners monitor the Trust's compliance with the legal right of choice as part of contract monitoring in line with NHS Standard Contract requirements.

Condition	Explanation	Comments
Continuity of service (CoS)		
CoS1. Continuing provision of Commissioner Requested Services (CRS)	Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners.	• The Current Contracts with commissioners require agreement with commissioners on the ways CRS services are provided.
CoS2. Restriction on the disposal of assets	Licensees must keep an up-to-date register of relevant assets used in commissioner requested services (CRS) and to seek NHS England's consent before disposing of these assets **if** NHS England has concerns about the licensee continuing as a going concern.	• The Trust maintains a full capital asset register. • Any disposals are reported to and approved by the Trust Board
CoS3. Standards of corporate governance, financial management and quality governance	Licensees are required to adopt and apply systems and standards of corporate governance, quality governance and financial management, which would be regarded as appropriate for a provider of NHS services, enable the Trust to continue as a going concern and provide reasonable safeguards against the licensee being unable to deliver services due to quality stress.	• The Trust has Standing Orders, Standing Financial Instructions and a Scheme of Delegation in place, and these are reviewed on an annual basis. • The Board of Directors/Executive Management Team receive regular performance reports aligned to the Trust Strategic Goals. • The Trust has a Board Assurance Framework and Risk Register which are reviewed at Board meetings and each Committee meeting • The Trust's Internal Auditors review risk management processes as part of the strategic audit plan. • The Trust has a current CQC rating of 'Good' for Well Led
CoS4. Undertaking from the ultimate controller	Requires licensees to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to breach its licensing conditions.	• The Trust does not operate and is not governed by an Ultimate Controller arrangement, so this Licence Condition does not apply.
CoS5. Risk pool levy	Obliges licensees to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails).	• The Trust currently contributes to the NHS Litigation Authority (NHS Resolution) risk pool for clinical negligence and public liability schemes.
CoS6. Co-operation in the event of financial or quality stress	Applies when a licensee receives notice from NHS England regarding the ability of the licensee to continue to provide commissioner requested services due to a quality stress or carry on as a going concern.	• The Trust has not received any such notices from regulators • The Trust would full comply with this condition if required.

Condition	Explanation	Comments
CoS7. Availability of resources*	Requires licenses to act in a way that secures resources to operate commissioner requested services (CRS).	• The Trust has maintained a bank balance of circa £25m+ • The Trust has an approved budget. • The Trust continues to complete its accounts on a going concern basis and there are no indications this will change
Foundation Trust conditions (FT)		
NHS1. Information to update the register of NHS foundation trusts	Obliges foundation trusts to provide information to NHS England.	• The Trust has provided NHS England with a copy of its NHS Foundation Trust Constitution • The Trust has provided NHS England with a copy of its Board approved Annual Report and Accounts.
NHS2.NHS Foundation Trust governance arrangements	Obliges the Licensee to apply principles, systems and standards of good corporate governance.	• The Trust reports, via its Annual Report, on its compliance against the NHS Foundation Trust Code of Governance. • Succession planning on the Board is considered on an annual basis. • The Board has an Annual workplan which ensures decisions are made in a timely way • Evidence regarding the Trust's compliance with its Licence conditions is considered on an annual basis. **** Evidence against this submission is detailed in* appendix B.**

Appendix B –
Condition FT4 (8): the provider has complied with required governance arrangements

	Statement	Sources of Evidence and Assurance
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Scheme of Delegation, Reservation of Powers and Standing Financial Instructions have been updated and refreshed – January 2025 Board. Constitution is reviewed and, if appropriate, updated on an annual basis
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Trust Wide Risk Register Board Assurance Framework Board Performance Reports Finance Report
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Committee Structures well established Committee Effectiveness reviews are reported to Trust Board Annually Clear Accountability through EMT and Executive Directors Portfolios. Level 3 performance reports and 'ward to board' reporting. Well Led Review has taken place and all recommendations have been implemented.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory	*External Audit Opinion on VFM (ISA260)* *Going Concern review to Trust Board in May* *Annual Governance Statement* All Statutory requirements met Delivered Financial Targets in 2024/25 Previous use of Resource Score of 2 *(currently not recorded)* Trust plan agreed to meet its financial targets for 2025/26 Regular Performance report to Trust Board and EMT Quality Report to Quality Committee Monthly returns to NHS Improvement via ICB

	Statement	Sources of Evidence and Assurance
	regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Risk Register and Board Assurance Framework Annual Report on non-clinical safety presented to Trust Board *Annual Report and Accounts* *Annual Quality Report*

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:
	(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
	(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
	(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
	(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
	(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
	(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.
		Board Skill Mix
		
		CQC well led rating of Good
		
		Board Development Programme
		
		Standing Items to Board
		• Performance Report
		• Finance
		• Chief Executive Update including
		  ○ Nursing, Allied Health and Social Care Professional Update
		  ○ Operations Update
		  ○ Medical Update
		  ○ HR Update
		Refreshed Trust Strategic Objectives
		
		Patient and Staff Stories reported to Board
		Programme of Exec Visits (Virtual and Physical)
		Friends and Family Test
		Quality Standards Group Work plan
		Midday Mail/Midweek Global
		EMT New Headlines
		Board Talk
		Meet with Michele

	Statement	Sources of Evidence and Assurance
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Trust Board undertake Fit and Proper Persons Test Board Secretary maintains declarations of interest register Staffing Figures reported to the Board regularly. Trust Workforce Strategy Workforce included in Service Plans The Trust has an established People and Organisational Development Committee

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 23

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Board Assurance Framework Update
Author/s:	Executive Lead: Michele Moran, Chief Executive Oliver Sims Corporate Risk and Incident Manager
Recommendation:	

To approve		To discuss	
To note	√	To ratify	
For assurance			

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The report provides the Trust Board with the Q4 2024/25 version of the Board Assurance Framework (BAF) allowing for the monitoring of progress against the Trust's six strategic goals.

Key Issues within the report:

Positive Assurances to Provide:

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

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

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

Key Actions Commissioned/Work Underway:

- Following review of the newly developed Board Assurance Framework template by the Strategic Board meeting in April, the Trust will transition to the new template for Q1 2025/26 reporting.

- Review of the Trust Board and assuring committee workplans is underway to ensure, where able, that the committees can review the first iteration of the new BAF template ahead of Trust Board reporting. Where this is not possible due to existing meeting dates, the version of the BAF sections pertinent to the committees will be circulated to its membership and chair for comment.

Key Risks/Areas of Focus:

- Trust Board is asked to review the current iteration of the Board Assurance Framework and to identify any further elements for consideration as part of the ongoing development of the new Board Assurance Framework template going into 2025/26 reporting arrangements.

Decisions Made:

Current assurance ratings for each section of the Board Assurance Framework:

Strategic Goal – Innovating for Quality and Patient Safety

- Current rating 8 – High for Quarter 4 2024/25

	Strategic Goal – Enhancing prevention, wellbeing, and recovery. - Current rating 12 - High for Quarter 4 2024/25 **Strategic Goal – Fostering integration, partnerships, and alliances.** - Current rating 8 - High for Quarter 4 2024/25 **Strategic Goal – Promoting people, communities, and social values.** - Current rating 6 - Moderate for Quarter 4 2024/25 **Strategic Goal – Developing an effective and empowered workforce.** - Current rating 8 - High for Quarter 4 2024/25 **Strategic Goal – Optimising an efficient and sustainable organisation.** - Current rating 8 - High for Quarter 4 2024/25

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

	Date		Date
Audit Committee	05/2025	Remuneration & Nominations Committee	
Quality Committee	05/2025	Workforce & Organisational Development Committee	05/2025
Finance & Investment Committee	04/2025	Executive Management Team	04/2025
Mental Health Legislation Committee	05/2025	Operational Delivery Group	04/2025
Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
√	Innovating Quality and Patient Safety
√	Enhancing prevention, wellbeing and recovery
√	Fostering integration, partnership and alliances
√	Developing an effective and empowered workforce
√	Maximising an efficient and sustainable organisation
√	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Humber Teaching
NHS Foundation Trust

Board Assurance Framework

Quarter 4 2024/2025

Humber Teaching NHS Foundation Trust Strategic Goals / Objectives

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

RISK APPETITE

Strategic Goal	Executive Lead	Risk Appetite (Agreed by Trust Board June 2024)	Threshold Risk Score
Innovating for quality and patient safety	Director of Nursing	SEEK	15
Enhancing prevention, wellbeing, and recovery	Chief Operating Officer	SEEK	15
Fostering integration, partnerships, and alliances	Chief Executive	MATURE	15+
Promoting people, communities, and social values	Chief Executive	SEEK	15
Developing an effective and empowered workforce	Director of Workforce and OD	MATURE	15+
Optimising an efficient and sustainable organisation	Director of Finance	SEEK	15

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

BOARD ASSURANCE FRAMEWORK SUMMARY

Strategic Goal	Risk	Executive Lead	Assuring Committee	Initial Risk Rating (Before Mitigation)			Current Risk Rating (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Movement (From last Quarter)
				I	L	Rating I X L	I	L	Rating I X L			
Innovating for quality and patient safety	Quality and patient safety underpins all that we do. Failure to innovate for quality improvement and patient safety could result in service delivery not meeting required quality standards resulting in substandard care which could impact on patient safety and outcomes, trust reputation and CQC rating.	Director of Nursing	Quality Committee	**4**	**3**	**12 HIGH**	**4**	**2**	**8 HIGH**	**SEEK**	**IN**	⟷
Enhancing prevention, wellbeing, and recovery	Failing to enhance prevention, wellbeing and recovery could result in patients not accessing support and services that will address their health and care needs leading to poorer health outcomes and adversely widening health inequalities for our populations.	Chief Operating Officer	Quality Committee	**4**	**4**	**16 SIGNIFICANT**	**4**	**3**	**12 HIGH**	**SEEK**	**IN**	⟷
Fostering integration, partnerships, and alliances	Failure to foster integration, partnerships and alliance could result in the Trust not being able to influence the delivery of health and social care regionally, which could impact on the development of system-wide solutions that enhance ability to deliver excellent services.	Chief Executive	Audit Committee	**4**	**3**	**12 HIGH**	**4**	**2**	**8 HIGH**	**MATURE**	**IN**	⟷
Promoting people, communities, and social values	Failure to promote people, communities and social values may result in Trust services not having a measurable social impact which could affect the health of our population and cause increased demand for services.	Chief Executive	Quality Committee	**3**	**3**	**9 HIGH**	**3**	**2**	**6 MODERATE**	**SEEK**	**IN**	⟷
Developing an effective and empowered workforce	Failure to recruit and retain high-quality workforce could result in service delivery not meeting national and local quality standards resulting I substandard care being delivered which could impact on patient safety and outcomes	Director of Workforce and OD	Workforce and OD Committee	**4**	**3**	**12 HIGH**	**4**	**2**	**8 HIGH**	**MATURE**	**IN**	⟷
Optimising an efficient and sustainable organisation	Failure to optimise efficiencies in finances, technology and estates will inhibit the longer-term efficiency and sustainability of the Trust which will reduce any opportunities to invest in services where appropriate and put at risk the ability to meet financial targets set by our regulators.	Director of Finance	Finance and Investment Committee	**4**	**3**	**12 HIGH**	**4**	**2**	**8 HIGH**	**SEEK**	**IN**	⟷

Innovating for quality and patient safety

Lead Director:	Lead Committee:
Dir. Nursing	Quality Committee

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

Risk Score: 8

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

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	8 HIGH	8 HIGH	8 HIGH	8 HIGH
Risk Appetite Threshold	15	15	15	15

Positive Assurance

- The Trust's current CQC rating is 'Good' (2019 assessment). Peer review process in place aligned to CQC fundamental standards. Quality Standards meeting established to oversee CQC inspection preparation
- Well led compliance overseen by EMT
- PSIRF implemented successfully. Quarterly performance reports in place.
- No incidents relating to medicine safety, safer staffing or relating to waiting lists that have caused harm moderate and above
- Significant assurance given by Audit Yorkshire for Trust Patient Safety Governance audit and Safer Staffing audit.
- QI training increased with 1241 total places delivered.
- Trust is rated green for 24 of 29 aspects of statutory and mandatory training and amber for the remaining 5.
- 337 recorded Quality Improvement (QI) activities of which 212 were complete, 3 at idea stage/awaiting charters and 66 underway. 175 (62%) QI activities underway or complete have indicated that they have included Patients and Carers in the planning and delivery of the work.
- 60.9% of staff said they strongly agreed/agreed to the statement 'I am able to make improvements happen in my area of work' (compared to the benchmark of 60.4%).
- FFT response rate and feedback mechanisms in place
- 86 (30%) QI activities have indicated that they have collaborated with organisations outside the Trust
- Waiting Time position – Trust exceeding target for RTT – Early Interventions (93.3% against target of 60%), RTT – IAPT 18 weeks (98.7% against target of 95%) and RTT – IAPT 6 weeks (78.5% against Trust target of 75%)
- Annual NICE implementation report and Clinical Audit Report indicates high level of compliance with NICE.
- Annual Research Report indicates high level of research activity in the Trust.

Negative Assurance / Gaps in Assurance

- Trust CQC rating for 'Safe' domain remains requires improvement (2019 assessment)
- Annual Medicine Administration compliance rate 76% (December 2024) improved from initial risk assessed position of 17.74% in May 2023, but with target of 85% Trust compliance *(Risk NQ56)*
- Internal audit to audit PSIRF implementation 2024/25
- Patient surveys for community mental health services and services require actions to improve. High number of patient complaints in one primary care practice.
- Trust Waiting Time position for neurodiversity services remains high

Mitigating Actions to Address Gaps	Target Date	Action Lead	Quarterly Update on Actions
Waiting list Capacity and Demand work ongoing to identify areas for further support. (Neuro diversity and Adult ADHD)	June 2025	Lynn Parkinson	Adult ASD/ADHD Assessment waiting times are improving
Neuro diversity services work at ICB level to determine how processes can be standardised / streamline to reduce system pressures	June 2025	Lynn Parkinson	ICB aware of top priorities around waiting time and considering system pathways to remedy pressures.
Adult ADHD Options paper to be developed to consider options as it is not a fully commissioned service for the Trust and to determine level of service delivery going forward.	June 2025	Lynn Parkinson	Multi-disciplinary pathway for adult ADHD under development with pathway re-design. Waiting list for adult ADHD paused to limit current demand and halt additional referrals.
Patient Safety Priorities identified for 2025/26 following thematic review of incidents.	June 2025	Hilary Gledhill	Monitoring in place with reports to QC.

Enhancing prevention, wellbeing, and recovery

Lead Director: Chief Operating Officer

Lead Committee: Quality Committee

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

Risk Score: 12

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

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	12 HIGH	12 HIGH	12 HIGH	12 HIGH
Risk Appetite Threshold	15	15	15	15

Positive Assurance

- For the reporting period of October 2022 – March 2023, the Recovery College has seen:
  403 new sign ups
  147 course completions
- The current budget (2022/23) for the Recovery & Wellbeing College is £163,459. The Children's & LD Division have also invested £33,374 into the Children's Recovery College, with the addition of £7,080 from Digital.
- For the reporting period of September 2022 – February 2023, the IAPT Employment Advisers have started 277 people on employment support and the service has delivered a total of 1046 employment support sessions.
- For the reporting period of April 2022 – March 2023, the Wellbeing Recovery Employment Service (WRES) service have reported that 32 people referred to them have moved into employment.
- The results of the overall surveys completed where patients would recommend the Trust's services to their family and friends is currently at 90.1% (February 2023).
- At the end of Quarter 3 22/23, 134 (62%) of QI activities underway or complete have indicated that they have included Patients and Carers in planning and delivery of the work.
- The Trust currently has 17 panel volunteers. Data on panel volunteer representation at interviews is not currently collected, but this is being discussed with HR.
- The Trust currently has 2 Patient Safety Partners. The Involving Patients and Families Subgroup of the PSIRF has recently been set up; this is a new project which will help the Trust to look at ways it can recruit more Patient Safety Partners.

Negative Assurance / Gaps in Assurance

- The Recovery College full review of courses and prospectus
- Mental Health Division to apply the principles to the Trauma Service.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Quarterly Update on Actions
The Recovery College is currently going through a full review of courses and prospectus, with a transition back to more face-to-face sessions.	June 2025	Lynn Parkinson	Future reporting will capture both face-to-face and online attendance, and feedback will be captured more accurately. A new focus group is also being set up to help develop and co-produce future courses/sessions.
Development of Trauma in Care Strategy Task and Finish group.	June 2025	Lynn Parkinson	Trauma in Care Strategy Task and Finish group has been set up. The group is in its early stages and is currently in the process of producing an action plan for key pieces of work.
Development of trauma service principles within Mental Health Division	June 2025	Lynn Parkinson	Work is ongoing in the Mental Health Division to apply the principles to the Trauma Service.

Promoting people, communities, and social values

Lead Director: Chief Executive

Lead Committee: Quality Committee

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

Risk Score: 6

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

Risk Analysis	Q1 (2024/25))	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	6 MODERATE	6 MODERATE	6 MODERATE	6 MODERATE
Risk Appetite Threshold	15	15	15	15

Positive Assurance

Trust Health Inequalities (HI) Programme:

In April 2024, the HI Operational Group agreed a delivery plan for the coming year covering:

- Communications and Knowledge Transfer - Building on the successful launch of the HI intranet pages by delivering a programme of webinars and communications to increase staff awareness of HI
- Data analysis - Working with clinical/operational teams to develop action plans in response to data published in the annual report on HI in access to mental health services, use of the Mental Health Act and restrictive interventions. A clinical and operational workshop is scheduled for 26th June 2024.
- Supporting teams to address HI - Running reflective workshops to help teams identify potential inequalities of access, outcomes, and experience within their services.
- Integrating HI into Trust strategies/policies inc the new Access Policy and associated SOPs and EIAs.
- Ensuring that approaches to HI are embedded in clinical practice via the implementation of Person-Centred Planning and the Culture of Care standards for mental health inpatient services. Incorporating content on HI in revised service specs for CAMHS, Children's Therapies and Mental Health services.
- System working to address the wider determinants of health including reviewing the impact of housing issues on service users, patients', and Trust services.

Inclusion Groups Programme of the East Riding Health and Care Committee:

- Work continues the ERYC inclusion health needs assessment and Smile VCSE mapping exercise. A delivery plan for 2024-25 has been agreed which focuses on completing the needs assessment and developing a system wide Inclusion Champions scheme.
- 17 VCSE organisation representatives are part of the Humber Co-production Network (June 2024)
- No significant change in the demographic 'profiles (see table). EDI data for governors is still not yet collected as they are external to the organisation.

	% BAME	% disabled	% LGBTQ+	% female	% part-time	% aged 50+
Q3 24/25	8.44%	9.52%	4.54%	79.09%	33.32%	34.50%
Q2 24/25	7.35%	9.30%	4.55%	79.36%	33.50%	34.83%

- EDI data for governors is not yet collected as they are external to the organisation, however discussions are being held about the feasibility of doing this moving forward.
- The demographic profile of SCOPEs has not changed by any significance since Q4 23/24.
- EMT reviewed the ToR for each staff network. Changes include a provision of an Executive Sponsor to support the group in escalating areas of concern. Additionally, network chairs have protected time to attend meetings. EMT now receive regular activities reports and will review their impact later in the year. Substantial budgets are allocated to each network to facilitate engagement and activities and are currently working on plans to support Hull PRIDE in July, and Black History Month in October.
- The Trust continues to host several forums for patients, service users, carers, staff, and partner organisations to attend. The Trust continues to attend 'A Good Experience' steering group of which provides assurance to oversee the Communications Charter project. York St John University have produced a project proposal to support the initiative.

Positive Assurance (continued)

- The Trust's Five-Year Estate Strategy 2022-2025 continues and is shared with ICB members and informs the ICB Estate Strategy. Priorities include redesigning MH Inpatient Services. Estate Plans are refined on a locality basis. Current areas of focus are Hull, Beverley and Driffield. The Estate Strategy and CDG provides a forum at which progress is monitored and reviewed against service need. The Estate Strategy is influenced by the organisational Green Plan which focuses on carbon reduction and use of local suppliers where appropriate and within procurement guidelines. The Trust aids the ongoing delivery of healthcare to the region inc coordinating as a landlord organisation for partner Trusts and third sector organisations. This is evident in the ongoing Hull Place Pilot, following the One Public Estate projects.
- Since Jan 2024, the Trust has embraced new regulations of the Social Value Agenda. The PSR regulations require commissioning bodies to apply key criteria when assessing suppliers for their suitability to deliver health care. These criteria include an assessment as to whether what is proposed might improve economic, social, and environmental well-being in relevant the geographical area.
- The Trust now considers the extent to which suppliers have acted to increase social value within their own activities and how these can improve health outcomes. The Trust also procures a wide range of supplies, non-health care services and works. The introduction of the Procurement Act aims to streamline and improve procurement of these type of goods. When the Act comes into force in October 2024 the legal requirement for public sector buyers shifts from awarding contracts based on MEAT (Most Economically Advantageous Tender) to MAT (Most Advantageous Tender). This means considering the wider benefits for the community in which the contract will be delivered.
- The spend with local suppliers for 23/24 was £32.5million.
- A video was created that features students and staff promoting T Levels in Health, that we will be showcased across the Trust and at events. We introduced an "Induction into Health" week for students, which includes support, guidance, and careers advice for when attending work experience and help them to understand the variety of job roles within our Trust and how they can apply. There were 26 work experience placements for 2023/24 compared to 16 for 2022/23.
- At the end of Q1 24/25, there were 11 Peer Support Workers within the Trust compared to 10 in Q4 23/24. There were also 12 Expert by Experience staff and two Programme Facilitators. There was a total of 70 recorded shifts: 49 by B3 and 21 by programme facilitators.
- There were 23 Band 2 to 4 roles recruited to from May 23 to May 24. 65 Band 2 to 4 roles were exempted, significantly lower than previous years. Our 'apprenticeship first' approach is not yet embedded in all areas. The career development team are working with H&NY careers hub to attract people to careers in our services.

Negative Assurance / Gaps in Assurance

- As a snapshot at the end of Q4 there were 94 volunteers which is a decrease of 7 compared to the end of Q3. This is a significant decrease compared to Q4 2023/24 (119). Three volunteers moved into a career since 1st January outside of the Trust. The Trust continually works to build strong connections with Voluntary Services and the VCSE.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Quarterly Update on Actions
Internal and external stakeholder surveys to look at the Trust's involvement in joint strategies and actions to address health inequalities at Place and ICS level.	June 2025	Michele Moran	Stakeholder surveys were run during October – November 2023. This exercise will be carried out again in October/November 2024, and work will be done to promote the surveys. Good qualitative responses were received.
Repeat mapping exercise looking at representation at Humber and North Yorkshire (HNY) Health and Care Partnership Boards and decisions making groups	June 2025	Michele Moran	The Trust is to review representation at HNY ICB meetings. A paper was taken to EMT in December 2023.Divisions are being asked to contribute to this piece of work.

Social Values Report to be launched at Annual Members Meeting	June 2025	Michele Moran	
At the end of Q4, 17 volunteers are going through the recruitment process.	June 2025	Michele Moran	Options paper in progress to increase the number of volunteers

Fostering integration, partnerships, and alliances

Lead Director: Chief Executive

Lead Committee: Audit Committee

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

Risk Score: 8

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

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	8 HIGH	8 HIGH	8 HIGH	8 HIGH
Risk Appetite Threshold	15+	15+	15+	15+

Positive Assurance

- As of yearend 2024/25 the current value of working on 35 contracts across 16 partners was £11,995,629
- As at the end of Q4, there were an average of 16 patient in out of area beds for Adult/OP and PICU. Which is an improvement on the previous quarter. The average number of delayed patients for children's services has fallen to zero %.
- Focus this quarter on CHLD. LD and ASD community wellbeing hub was piloted in February in Goole following a successful pilot last year in Hull. This was delivered in partnership with the ICB and numerous system partners. Plans are in place to deliver a further hub event in Hull and one in Bridlington in the ER as part of a wider ambition to eventually deliver these regularly across all 6 places. LD cancer screening nurse project continues in Bridlington in collaboration with Bridlington PCN and the ICB, with some additional funding having been secured from the Cancer Alliance and the Trust's Health Stars to co-produce an additional video with experts by experience with a learning disability looking at the new Lung Cancer Screening process. Children's sensory processing service exploring options for collaborative working with Hull LA and Northeast Lincolnshire LA. - Working with patient groups, North Yorkshire Council, HNY ICB and PCN to gather ideas for optimising utilisation of Whitby Community Hospital.
- The Trust continues to be involved in system wide discussions around Learning Disability inpatient provision with the ICB and place partners. Discussions are continuing with Humber and HUTH focussing on collaborative working to improve the under 2's pathway for Children's Physiotherapy- Joint working with TEWV and Rethink Mental Health to deliver mental health services in HMP Hull, Humber, Full Sutton and Milsike and improve integration with forensics pathways.
- The Trust actively engages as a collaborative partner within the local system and beyond and in the ICBs workforce transformation programme 'Breakthrough'. This has seen the delivery of a Portability MOU which better enables workforce mobility across partners and work to deliver a Collaborative Bank solution, alongside wider collective efforts to jointly deliver system wide workforce and operational plans. In addition, with the Trust overseeing the Chair of the MHLDA Collaborative Workforce Steering Group, priorities for 2025/26 have been established to deliver against joint ambitions to collectively evaluate job profiles and deliver Reciprocal Mentoring.
- There were 574 QI charters as at Q4. 154 out of 503 Live/Completed activities resulted in 31% in partnership with 292 benefitting (58%). This does not include the projects that were not viable. There were 338 in training which is an increase of 51 (18%) compared to the last quarter.
- The Trust's children's services have contributed to the East Riding Joint Strategic Needs Assessment (JSNA) as well as the ER School Readiness Needs Assessment. The Trust was also present at a multi-agency discharge event.
- Organisations have increased connections of data. The Trust provide the technical leaders for the Yorkshire & Humber Secure Data Environment - https://yorkshirehumbersde.nhs.uk/) which connects data together for research purposes. This action has been completed as far as Humber Teaching NHS Foundation Trust can provide. The YH SDE and HNY ICS IRS will continue the work on behalf of partners.

Negative Assurance / Gaps in Assurance

- The average % of delayed transfer of care patients were 11.1% for Adults/OP (14.2% if you include PICU) which is an increase on Quarter 3.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Quarterly Update on Actions
The Trust is represented at all strategic PLACE meetings, is a member of the relevant collaborative and influential within both these areas	31/03/2026	Michele Moran	
The Trust is leading the Mental Health and Learning Disability Collaborative work and is a member influences in the Community Collaborative	31/03/2026	Michele Moran	
Regular meetings are taking place within the Collaborative and the CEO Leadership tea	31/03/2026	Michele Moran	

Developing an effective and empowered workforce

Lead Director: Associate Dir. of People and OD

Lead Committee: WFOD Committee

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

Risk Score: 8

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

Risk Analysis	Q3 (2023/24)	Q4 (2023/24)	Q1 (2024/25)	Q2 (2024/25)
Current Risk Rating	8 HIGH	8 HIGH	8 HIGH	8 HIGH
Risk Appetite Threshold	15	15	15	15+

Positive Assurance

- 6.72% vacancy rate (March 2025)
- A rolling 12 monthly turnover rate figure of 9.15% (March 2025), which is below the turnover rate this time last year (10.68% March 2024).
- Registered *Nursing* vacancy rate March 2025 – 6.72% (WF39 – High)
- Appraisal completion rate at the end of the window 92.6% (30th June 2024) The rate is currently at 98.65%
- In the 2024 NHS National Staff Survey;
  - The Trust positions better than the national average across all People Promise themes and subthemes areas.
  - The Trust positions better than the average for our benchmark group (50 MH and community Trusts) in all People Promise themes and subthemes areas.
  - The Trust improved across all people Promise themes compared to 2023
- Trust workforce plan for 2025 in development as part of annual planning cycle.
- Ongoing monitoring of hard to recruit roles in the recruitment and retention task and finish group.
- Overall statutory / mandatory training compliance 94.09% (March 2025).
- Extensive programme of health and wellbeing support and initiatives delivered, advanced in 2024/25 by the launch of Your Health and Wellbeing Plus. 731 (19.2%) Physical MOTs delivered since April 2024. Enhanced Menopause support and other initiatives launched in 2024/25.
- Trust People Strategy ratified which sets strategic direction for next four years, underpinned by an accompanying delivery plan.
- Workforce representation - ethnic diversity 9.06% (March 2025) which is better than the regional demographic in East riding, Humber and NY
- Workforce representation - LGBTQ+ 4.89% (March 2025) which is better than the regional demographic in East Riding, Humber and NY
- The breadth of the apprenticeship standards we offer has increased to 50 currently being undertaken across the Trust and this is continually expanding. 52 apprenticeships have been completed in the previous rolling 12 months.
- Subsequent to the national band 2 – 3 job matching reviewing a scoping exercise has been completed and relevant actions taken with limited risk to the Trust. (WF52 – Moderate)

Gaps in Assurance / Negative Assurance

EDI

- Representation of ethnically diverse staff in Band 7 or above roles has improved by 11% however remains an area of focus
- Representation of disabled staff in Band 8c-VSM roles has improved by 14% however remains an area of focus
- The 2024 staff survey saw a decrease in scores for 8 out of the 9 questions around discrimination on the grounds of a specific protected characteristic. (WF42, WF 45 – High)
- The 2024 staff survey saw 16.5% of ethnically diverse staff report higher rates of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public compared to 7.9% of white staff.
- 59.2% of staff with a disability or long-term condition compared to 68.1% without one report that the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age
- Workforce representation - Disability 10.22% (March 2025) which is lower than the regional demographic of between 16 and 20% in East Riding, Humber and North Yorkshire, but represents an improving position from 4.1% in 2019 to 10.22% in 2025.

Medical vacancies

- Consultant vacancy rate for March 2025 – 20.91% (WF38 – High)

Sickness

- The Workforce Scorecard (March 2025) reported a rolling sickness rate figure of 5.52% (Trust target 5%), and above national and regional benchmarks.
- The highest reason for sickness absence within the organisation remains stress, anxiety and mental ill health at 37.2%. The National Staff Survey identifies this as an area of focus.

- In the absence of guidance around the Band 5 – 6 national review of job matching profiles preparatory work is underway to understand the organisational position and engagement with system approach to create generic job descriptions and person specifications. (WF52 – Moderate)
- The 2024 staff survey saw the Trust's statistically most significant improvement in a score (6.89%) for the question 'the last time you experienced harassment, bullying or abuse at work, I or a colleague reported it'. This could be correlated to the Respect Campaign and contribution to improving rates of reporting.
- For People Promise 1 - We are compassionate and inclusive - Subscore 3: Diversity and equality – Asian/Asian British staff the score is 8.82, higher than the organisational Score 8.55. (WF41 and 42 – High)
  The 2024 staff survey saw a 5% improvement in scores on discrimination on grounds of age (WF44 – high)
- The 2024 staff survey reports higher rates for the organisation acts fairly regarding career progression / promotion, regardless of sexual orientation for LGBTQ+ staff (72.2% for LGBTQ+ compared to 66.4% for Heterosexual staff). (WF45 – High).
- Workforce planning underway for 2025/26.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Quarterly Update on Actions
EDI - Trust continues to monitor, review and re-address the EDI action plan which holds specific actions to improve experience and ensure career progression and development opportunities are accessible and harnessed by those from underrepresented groups and succession plans are robust and consider demographics.	July 2025	Karen Phillips	Actions currently being refreshed as part of the NSS, WRES, WDES and Gender pay gap action planning process. Respect campaign being refreshed with new resources and No excuse for Abuse being embedded organisationally. Humber Talent programmes and leadership development ring fence spaces for staff networks and those with protected characteristics. Focus on Succession planning in band 7 + roles. EDI assurance report presented to EMT in April 2025 showed completion across all actions for 2024/25 with the exception of one which is ongoing.
Medical Vacancies - Trust continues to monitor and review progress in line with the Medical Workforce Plan with assurances into EMT and the People & OD Committee. Medical vacancies remain in scope of the Recruitment and retention task and Finish Group, with associated actions developed.	Sept 2025	Kwame Fofie	Significant progress being made with consultant vacancies, all of which are advertised. 7 consultant vacancies as at March 2025. 5 covered by locum medics. Medical Workforce Plan in action presently with targets monitored in the Recruitment and Retention Task and Finish Group with good progress being made.
Sickness absence is monitored at Divisional Accountability reviews and six-monthly deep dives completed to assess absence trends and develop appropriate target actions to address areas of concern. Bespoke woke underway to focus on inpatient areas with the highest rates of absence to develop individualised and interactive solutions. In order to respond to one of the primary reasons for absence being stress, anxiety and mental ill health further evidenced as an area of focus in the National Staff Survey this has presence in the Health and Wellbeing group as a priority action and TRIM training currently being explored to strengthen our Psychological Support package with current work underway to source additional funding to create a role to support staff.	July 2025	Karen Phillips	Deep dive due in May 2025 with an overview of data for the 1st April 2024 – 31st March 2025. Divisional accountability reviews monitoring and exploring absence on a monthly basis. Reports continue to feed into EMT and People & OD Committee. Report into EMT in May regarding progress against the bespoke sickness intervention. Report being produced for ODG to explore TRIM training and other psychological support.

Optimising an efficient and sustainable organisation

Lead Director: Dir. Finance

Lead Committee: FI Committee

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

Risk Score: 8

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

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	8 HIGH	8 HIGH	8 HIGH	8 HIGH
Risk Appetite Threshold	15+	15	15	15

Positive Assurance

Negative Assurance / Gaps in Assurance

- The Trust has a breakeven financial plan that meets the ICS planning target set for it.
- Overall, the Trust has a high level of sustainability with a good cash position.
- The cash position at Month 12 stands at £18.8m.
- Lead Provider: Month 5 position breakeven, according to plan and annual forecast.
- The Trust has ensured a break-even position at the Year-end in line with the ICS Target
- Our current PLACE (2024) scores are as follows:
  Cleanliness – 99.77% (National average – 98.31%)
  Food and Hydration – 97.39% (National average – 91.32%)
  Privacy, Dignity and Wellbeing – 96.31% (National average – 88.22%)
  Condition, Appearance and Maintenance – 93.96% (National average – 96.36%)
  Dementia – 88.52% (National average – 83.66%)
  Disability – 95.06% (National average – 85.20%)
- Trust has moved the tenant for Power BI and now has 20 users up and running Trust Data Quality Maturity Index (DQMI) score at 99% above national average (95%).
- Annual Internal Stakeholder Survey - Q: Over the past 12 months, have you been involved in reading the "Humber Financial Times" e-newsletter to learn about finance matters? - 33% of respondents said that they had read the "Humber Financial Times" e-newsletter to learn about finance matters.
- Annual Internal Stakeholder Survey - Over the past 12 months, have you been involved in using finance or Patient Level Information and Costing Systems (PLICS) data to make decisions about changes to services? - 33% of respondents said that they had used finance or Patient Level Information and Costing Systems (PLICS) data to make decisions about changes to services. (*Examples given: Use PLICS data daily/weekly in relation to capacity/demand productivity and part of the new MH Payment model expert reference group to roll out this further, capacity and demand work that influences planning discussions, productivity of services and a "Value Maker" and used to be part of an expert reference group with NHSE at Portcullis house in a previous role around PBR etc*)

- The Learning Centre are working with professional leads to scope and assess the training needs of the Trust in relation to finance training for non-finance managers.
- Details of staff understanding of Trust finance measures and controls.
- The Trust's National Cost Collection Index (NCCI) is 121 for 2022/23 for 2023/24 the NCCI is 103 The national average is 100.
- The Trust's organisational use of resources score is not currently available.
- The cost to eradicate high risk backlog maintenance is £716,850; and the cost to eradicate significant risk backlog maintenance is £6,349,655.
- Wider ICS Financial Position under pressure

Mitigating Actions to Address Gaps	Target Date	Action Lead	Quarterly Update on Actions
Trust is commissioning an updated Conditional Survey of the estate which will establish an updated position. Backlog is addressed with the capital programme	July 2025	Pete Beckwith	Survey results will be presented to the Capital and Estates Group, who report into EMT.
Deliver a balanced net system financial position for 2025/26.	March 2026	Pete Beckwith	Trust has submitted a balanced plan to the ICS.
Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2025/26.	March 2026	Pete Beckwith	Current plan delivers the expected reduction, Agency is monitored at Finance Committee, EMT, ODG and forms part of the Accountability Review process.
Medium Term Financial Planning has been initiated across the ICB	August 2025	Pete Beckwith	Awaiting National Guidance, but a high level 3-year plan will be taken to the Finance Committee in July

RISK SCORING MATRIX

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

RISK TERMINOLOGY DEFINITIONS

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

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Agenda Item 24

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Finance Committee Assurance Report - Chair's Log
Author/s:	Keith Nurcombe, Chair
Recommendation:	To approve: ; To discuss: ; To note: ; To ratify: ; For assurance: ✓
Purpose of Paper:	The aim of this paper is to provide assurance to the Trust board on the financial performance of the Trust and any business development opportunities identified.

Key Issues within the report:

Positive Assurance to Provide:

- Achievement of agreed year end position for 2023/2024 with very small £25k surplus in accounts.
- Planning submission completed and submitted for 2025/2026 as per NHS England requirements.

Decisions Made:

- Agreed that productivity / efficiency would be presented at Finance Committee for escalation to board.

Matters of Concern or Key Risks to Escalate:

- Underlying deficits in the ICS system locally, the system is carrying significant financial risk.

  Requirement to reduce trusts corporate costs by 50% over 25/26 financial year.

Key Actions Commissioned/Work Underway:

- Finance and operations team to work up an agreed set of metrics to monitor productivity and increased efficiencies within the trust. Focusses on delivery of 25/26 planning requirement for increased productivity. Agreed offline and then coming to next Finance Committee.
- Scenario planning for next three years – both risks and potential opportunities to allow committee and then board to consider as part of strategic planning.
-

Governance: *Please indicate which committee or group*				
		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail) Report produced for the Trust Board	

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership and alliances
	Developing an effective and empowered workforce
x	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Committee Assurance Report – Key Issues

The key areas of note arising from the Committee meeting held on 15th April 2025 were:

- ICB system year end agreed position was met with significant additional cash being provided by the ICB to meet the agreed system deficit total.

- Coverage of the NHS England Sir Jim Mackey letter to the system and the changes around performance monitoring and productivity focus as well as key areas of focus such as:

  Corporate cost reduction of 50% required over the financial year – trust has increased costs based on numbers provided by NHS England. Current work ongoing to assess those numbers and work out baseline position for review at next Finance Committee meeting in July.

- Committee Annual Effectiveness Review was considered by the committee and discussed, overall the committee is tracking well against is Terms of Reference but with some areas for

focus this year including productivity and three year scenario planning and this needs to be built into the committee workplan.

- Year end result for 2024/2025 has been to deliver the agreed target for the trust and the committee noted their thanks for all trust staff for the efforts over the last year as this achievement has been very significant given the financial constraints in the last year.

- Budget Reduction Strategy was reviewed for the year and significant progress has been made achieving the annual target for 24/25.

- Agency spend analysis was discussed and agency costs have been reduced by over 30% this year and with another reduction in 25/26 through recruiting permanent staff especially in consultant roles this will achieve the required NHS England targets for 25/26. This result again has been with a huge amount of work and special note to the Medical Director regarding recruitment of vacant consultant posts was made by the committee.

- The budget plan for 25/26 was presented to the committee and discussed in detail including a new BRS for the new year with the requirement for another submission to be made by the end of April to NHS England.

- The committee discussed and agreed the re-worded and updated BAF and Risk Register with one challenge around the risk rating for agency staff levels which was to be taken back to EMT for review.

- Committee received papers from Partnerships and Strategy and Be Digital with an additional paper around the economic case for the recently rolled out EPR programme.

- Mapping work against the Insightful Strategy Board Domains will be taken off line for the committee and discussed before the next meeting.

- The committee reviewed the finance committee workplan in detail and added productivity to a quarterly cycle with 3 year scenario planning also coming regularly to the committee for review and then board escalation. We also tidied some of the other elements to make sure that the interval and timings for committee works well.

Humber Teaching NHS Foundation Trust

Agenda Item 25

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	People & Organisational Development Committee Assurance Report from meeting held on 07 May 2025.
Author/s:	Dean Royles – Non-Executive Director
Recommendation:	

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

Purpose of Paper:	The People and Organisational Development Committee is one of the sub committees of the Trust Board. This paper provides an executive summary of discussions held at the meeting on 07 May 2025 and a summary of key points for the board to note.

Key Issues within the report:

Positive Assurances to Provide: • Positive assurance around the Trust vacancy rate within both nursing & consultants. • Turnover rate is currently 9.15% which is the lowest for a considerable time. • For Core Psychiatric training the Trust is ranking 7th out of 22 Regional Trusts, and in terms of Higher Psychiatric training the Trust is ranking 3rd.	**Key Actions Commissioned/Work Underway:** • Contained within the report and supporting committee documents.
Key Risks/Areas of Focus: • Consultant vacancy rates continue to be a key focus with ongoing work to reduce vacancies further. • EDI protected characteristics.	**Decisions Made:** • Approved the proposed changes to the agenda and workplan for the People & Organisational Development Committee from the 31 July 2025. • Approved the Staff Survey Action plan.

	• Agreed & Approved the People & Organisational Committee Effectiveness Review for 2024/25. • Agreed & Approved the People & Organisational Committee Revised Terms of Reference for 2025. • Approved the Staff Health & Wellbeing Group revised Terms of Reference for 2025. • Approved the Equality, Diversity and Inclusion Steering Group • Revised Terms of Reference for 2025.

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		People & Organisational Development Committee	
Finance Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Collaborative Committee		Other (please detail) Trust Board	28/05/2025

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership and alliances
✓	Developing an effective and empowered workforce
	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			
Legal	√			To be advised of any

Compliance	√			future implications as and when required by the author
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Committee Assurance Report – Key Issues

Assurance Report 07 May 2025

Chairs Logs:
Staff Health & Wellbeing Group: The group remains well engaged, there has been a review of the risk register around Health and Wellbeing, and a detailed look at the staff survey results in respect of Health and Wellbeing

Equality, Diversity and Inclusion Steering Group: Active networks although attendance has been in a state of flux, however it feels like there's increased engagement and there's certainly increased encouragement for staff to attend the network meetings if they wish to.

Positive update in terms of the LGBT network and also the disability network with some practical examples that have been highlighted i.e. laptops available for staff to use in Trust HQ and also other reasonable adjustments, as well as access to work and work with Occupational Health to provide enhanced support.

Protected characteristics updates from the Staff Survey, with some positive things as well as wider areas of focus.

Medical Education Committee: Noted positive results in terms of the National Training Survey and the GMC survey and that 80% of trainees would recommend the Trust to receive care and slightly over that percentage as a place to receive their training.

People Insight Report: Maintaining low vacancy rates, turnover is below 10% and in a strong position around statutory and mandatory training and appraisal rates. Have seen 646 staff have a Health MOT since April 2024.

Continue the focus on sickness absence reduction, along with looking at how we capture the EDI data, so it is interrogated more in terms of the questions we want to ask about specific areas when the insight report has been reset.

Finance and Workforce Controls Assurance Report: Work in progress to familiarise ourselves with the productivity issues around workforce and some positive assurances to report in terms of agency reduction. Delivering our financial plan and understanding the overspend reasons /mitigating actions was well received.

Risk Register and BAF: Noted the Risk Register and Board Assurance Framework and welcomed the reduction in scores in both nurse and consultant vacancies following the work that had been done to reduce vacancies in both these areas acknowledging the incredible amount of work to improve these positions. Aware of the horizon scanning taking place in relation to a number of issues to keep the risk register and board assurance framework under review.

It was noted that there would be a new format in relation to the board assurance framework at the meeting on the 31 July 2025.

Future of the People & Organisational Development Committee Agenda/Work Plan: The committee approved the new approach/reset regarding the different areas of focus as part of the committee's continuous improvement journey with the revised template agenda and workplan set to be tested and adapted accordingly.

Insight Board – Workforce Elements: Noted the gap analysis that been taken and how that will feature into the forward plan as part of the reset around the People & OD Committee update. At a future Board look at how we triangulate with the various regulators and requirements that we've got to provide assurance.

Staff Survey Results Developing Action Plan: The Committee approved the Staff Survey Action plan and noted the areas of positive assurance along with the highlighted risk areas within the report.

Medical Workforce Plan Update: This agenda item was deferred until the People & Organisational Development Committee meeting on the 31 July 2025.

People & Organisational Development Committee Effectiveness Review: The committee agreed and approved to committees' effectiveness review for 2024/25.

People & Organisational Development Committee Terms of Reference: The committee agreed and approved to committees revised Terms of Reference for 2025.

Terms of Reference from subgroups:
Staff Health & Wellbeing Group: The committee approved the Staff Health & Wellbeing Groups revised Terms of Reference for 2025.

Equality, Diversity and Inclusion Steering Group: The committee approved the Equality, Diversity and Inclusion Steering Groups revised Terms of Reference for 2025

Medical Education Committee: Due to the April meeting of the Medical Education Committee being postponed until June 2025, the revised Terms of Reference for the group to be brought to the People & Organisational Development Committee on the 31 July for approval.

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Agenda Item 26

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Quality Committee Board Assurance Report – February 2025
Author/s:	Dr Phillip Earnshaw, Non-Executive Director and Chair of Quality Committee
Recommendation:	To approve: ; To discuss: ; To note: ; To ratify: ; For assurance: ✓
Purpose of Paper:	The Quality Committee is one of the sub committees of the Trust Board. The paper provides a summary of discussions held at the Quality Committee on 8th May 2025 with a summary of key issues for the Board to note.

Key Issues within the report:

Positive Assurances to Provide:

The Committee received positive assurances through the following reports.

- Insightful Board Discussion
- Quality Insight Report
- Progress update on the Nottingham Inquiry
- Quality Committee Risk Register Summary and BAF
- Draft Quality Accounts 2024/25
- Quality Committee Effectiveness Review and discussion
- Q3 Waiting List Performance update
- Complaints and Feedback Policy
- Sexual Misconduct Policy Update
- Summary of the Quality and Patient Safety Group

Key Actions Commissioned/Work Underway:

- For EMT to discuss a Learning from Deaths Report
- Request a Medical Examiner progress update report to be added to the work plan for a future Quality Committee
- To include internal audit recommendations updates relevant to the Quality Committee in future Quality Insight Reports
- To further discuss the training requirements for the Sexual Misconduct Policy at EMT

Key Risks/Areas of Focus:

- It was noted around the scoping work being undertaken following the Supreme Court judgement on clarifying the definition of sex and confirmation this had already been agreed as a new risk to be added to the risk register

Decisions Made:

- The Quality Accounts were discussed and approved for presentation at Trust Board
- The Annual Effectiveness review was agreed.

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

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

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
	Innovating Quality and Patient Safety
	Enhancing prevention, wellbeing and recovery
	Fostering integration, partnership and alliances
	Developing an effective and empowered workforce
	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Committee Assurance Report – Key Issues

The key areas of note arising from the Quality Committee held on 8th May 2025 are as follows:

The minutes of the meeting held on the 19th February 2025 were agreed as a true record and the action log approved noting all items closed. The March Quality Committee Assurance report was noted. The Committee work plan was reviewed and updated.

The following papers were discussed.

The Insightful Board Report (Discussion Item)
The Committee received the paper on the self-assessment of the standards within the guidance leading to a discussion held on the standards allocated to the quality committee, agreeing to request EMT to discuss further the Learning From Deaths Report and to add a Medical Examiner progress report to the work plan for the Quality Committee.

Quality Insight Report
The headlines from the report included an update on the National Safeguarding Reform, the patient safety information including an update on policy compliance and compliance with the national patient safety alerts, an update on continuous quality improvement and the Quality Dashboard summary with incident reporting and the audits and analysis completed around safeguarding training compliance.

The meeting were updated on the internal CQC Mock inspections for East and West Hull CMHT teams, and the external CQC Inspection report for Inspire. It was confirmed at the meeting that CQC had confirmed they accepted all the comments in the factual accuracy report and would be publishing the final report very soon.

Nottingham Inquiry Update
The report was presented the Committee highlighting the work undertaken since the last report. It was noted the standards are still awaiting publication but work is continuing during this time. Assurance was given around the Trust's action plan which has a number of action combined from both this Inquiry and the original CQC review, with an update given around the draft Personal Care Framework. The update was noted.

Quality Committee Risk Register Summary and BAF
The Committee reviewed the Quality Risk Register and BAF, noting 12 risks on the register rated nine or above which have been reviewed through QPaS. It was suggested to look at a different section of the BAF in more depth at meetings following updated format at the strategic board session and will be looked into further. Queries were raised about the risk register updates and assurances received on the scrutiny of the risk register and work being undertaken by divisions.

DRAFT Quality Accounts 2024/25
The Committee received the draft Quality Accounts 2024/25 which were being presented to Quality Committee prior to approval by the Trust Board for submission to NHS England by 20th June 2025. It was noted an executive summary had been requested by EMT due to the size of the document and that there was a planned refresh for next year's Quality Accounts to become a more concise, and outward facing document making it more patient and service user friendly. A discussion was held around stakeholder feedback and assurance received on the challenges of the deadlines with data availability. Following noting the audit recommendations within the report, it was agreed updates on audit recommendations relevant to Quality Committee would be included in the Quality Insight Report.

Quality Committee Effectiveness Review 2025
The Committee discussed the effectiveness review agreeing membership felt correct and identified three areas of development: -

- To develop time to focus on specific sections of the BAF at each meeting, allowing deeper strategic oversight.
- Horizon scanning and assurance withing the Quality Insight Report due to changes within the ICB and NHS landscape
- Development areas noted arising from the Insightful Board self-assessment discussion

The Terms of Reference were approved with updates to job titles and reflecting the change in reporting structures. It was agreed holding the discussion felt helpful and the completed review was agreed to be forwarded as included in the main Board paper

Waiting List trajectory and performance quarterly update
The Committee received the Q3 Waiting List update report noting the delay in reporting due to data availability. It was highlighted the changeover of the electronic patient record had significantly impacted data due to a number of data quality issues and this was requested to be considered when reading the report. Good assurance was received and the Committee look forward to seeing the Q4 report.

Complaints and Feedback Policy
The committee welcomed the oversight of the updates to the policy which has been through EMT and Trust Board for approval and ratification.

Launch of the NHS Sexual Misconduct Policy and Sexual Safety Guidance and Support
The Committee received the update paper on the launch of the policy which included the background to the Sexual Safety Charter and progress on actions undertaken since the original information presented to Quality Committee last year. A query was raised on the decision taken around who would be included in the mandated training and it was agreed to take this back to EMT for further discussion.

The meeting was reviewed with agreement on good discussion, time given to air particular issues and healthy professional challenge.

Agenda Item 27

Title & Date of Meeting:	Trust Public Board Meeting – 28 May 2025
Title of Report:	Mental Health Legislation Committee Assurance Report following a meeting on 1 May 2025
Author/s:	Stephanie Poole Non-Executive Director and Chair of Mental Health Legislation Committee
Recommendation:	

To approve		To discuss	
To note		To ratify	
For assurance	√		

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The Mental Health Legislation Committee (MHLC) is one of the sub-Committees of the Trust Board. This paper provides assurance to the Board with regard to the agenda issues covered in the committee held on 1 May 2025.

Key Issues within the report:

Positive Assurances to Provide:

- Compliance with Mental Capacity Act (MCA) 2005 – The Committee received a 6 month audit report regarding MCA capacity assessment and best interest decision paperwork for 6 months to 1/12/24. On this occasion focus was on inpatient units. The report highlights some good practice, particularly in person centred approaches in line with Trust's value of caring. However there were strong themes around the quality of recording decisions. Key recommendations: need for new improved forms with prompts; improved training re MCA assessment.

- The Mental Health Bill 2024 was introduced into parliament in November 2024 and is expected to receive royal assent in summer 2025. Once enacted it is likely to be phased in over 8 – 10 years to enable services to prepare for the changes. At this stage a series of amendments are being considered. In the meantime, the Care Quality Commission (CQC) is monitoring a number of key areas raised nationally to ensure there is no delay in the positive changes. The committee received an update on the key points of concern: Over-re representation of Black

Key Actions Commissioned/Work Underway:

- MCA - Specific actions are in hand to address issues raised in recent paperwork audit and a further audit will be completed once implemented. The actions are focused around improving the templates and training.

- The Care Programme Approach (CPA)/ Person Centred Planning (PCP). NHS England has informed the Trust that it will publish more detailed guidance regarding the full roll-out of the initiative in due course. Therefore, our Trust is initiating a staged approach.

- Performance Reports – Business Insight team are currently rebuilding all MH reporting due to the change in patient record system from Lorenzo to SystmOne. This has been specified and it is expected to ready for Q1.

- RRI/Use of Force Act – Due to the change from Lorenzo to SystmOne, it has been identified that some of the SystmOne templates need optimising to ensure the right data is easily reported in SystmOne by staff and is reported properly through the data warehouse reporting. As Datix is

people detained under the Mental Health Act and placed on community treatment orders (CTOs); Ongoing problems with care pathways and a lack of community provision for autistic people and people with a learning disability; Persisting abusive and closed cultures in too many mental health service; Impact on our second opinion appointed doctor (SOAD) service; Protecting patients' rights. • CQC as also published a report Monitoring the Mental Health Act in 2023 – 2024 which identifies some key themes: Systems; Workforce; Inequalities; Children and Young people; Patient Environment. The Committee received a detailed update regarding the Trust's work in these areas. • CQC Mental Health Act (MHA) visits - There have been 10 visits to units over the last year. Themes from CQC MHA visits appear to be around care planning, blanket restrictions, patients' rights and activities. Actions are being regularly addressed and are followed up by the trust Mental Health Legislation Lead and relevant operational committees and groups. Open and overdue actions are being closed off as soon as updates and evidence received from wards. • Associate Hospital Managers – the annual progress report was received. The trust currently has 11 AHMs. Regular training, support and development opportunities are in place. A recent recruitment drive was successful with 4 new appointments. • The Committee received Q4 performance report to end March 2025. Due to the migration to the new patient record system, the report was limited and it has not been possible to compare with previous quarters. As planned, this is expected to be rectified in Q1. The Medical Director and MHL team have not noted any significant variations. The number of new sections was 126. There was one use of s4, which was clinically appropriate. At the end of Q4 there were 3 patients clinically ready for discharge in secure beds (up from 1 last quarter). All were awaiting transfer to identified specialist providers. AWOL figures were reviewed with no significant issues. • The Committee reviewed the NHS Insightful Board domains as they relate to Mental Health. The key areas of positive assurance: Staff experiences at both ward and site levels are systematically triangulated with patient experience to ensure a comprehensive understanding; Active participation in local and	also used to monitor restrictive interventions appropriate monitoring and analysis of restrictive interventions continues while optimisation of reporting is undertaken.

national patient and carer surveys, alongside the development of action plans, drives continuous improvement in care delivery; Collaborative work with advocacy services fosters a more positive and inclusive patient experience; Full compliance with the Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR) framework is maintained to uphold quality and accountability.

- RRI/Use of Force Act – DMI training compliance has consistently remained above the 85% compliance rate throughout Q4. Despite an increase in number of people requiring CRT/Disengagement training there continues to be an increased compliance rate month on month. The use of restraint has continued to reduce again during Q4. The use of seclusion has slightly reduced during Q4. The use of rapid tranquilisation has reduced during Q4. Co-production and service user by experience involvement within the culture of care programme has continued to strengthen. All incidences of use of restrictive interventions continue to be subject to clinical review via the daily safety huddle and weekly by the Clinical Risk Management Group (CRMG). The committee received good practice stories from Humber Centre, Avondale, Newbridges and Townend Court.

- The Committee Received a report on health inequalities and mental health. The Trust is delivering a range of initiatives which aim to embed anti-racist, anti-discriminatory practice and ensure that staff are aware of the interactions between stigma, race and detentions under the Mental Health Act. The Trust has been preparing for implementation of the Patient and Carer Race Equality Framework (PCREF), which all providers of NHS mental health service providers must use to address discrepancies in serviced experienced by people from racialised communities. Co-production is a key principle underpinning this work, and local community groups and Experts by Experience will be invited to participate. The Trust has also become one of the 60 organisations taking part in the national roll-out of the Culture of Care Standards for Mental Health, Learning Disability and Autism inpatient services. The NHSE supported programme has Anti-Racist Practice embedded as one of three core underpinning principles.

- The Committee received the annual report on its effectiveness and completed a review of it terms of reference and workplan.

• All mental health legislation related policies/procedures/guidance are up to date.	
Key Risks/Areas of Focus: N/A	**Decisions Made:** N/A

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

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

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
√	Innovating Quality and Patient Safety
√	Enhancing prevention, wellbeing and recovery
√	Fostering integration, partnership and alliances
√	Developing an effective and empowered workforce
√	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Committee Assurance Report – Key Issues

Compliance with Mental Capacity Act 2025

The Committee received a 6 month audit report regarding MCA assessment and best interest decision paperwork for 6 months to 1/12/24. The work was carried out by the Business Intelligence Team and on this occasion focus was on inpatient units and limited to detail analysis of 10 records. This was challenging due to the technical difficulties in extracting data in an accessible from Lorenzo. The analysis looked at paperwork compliance with each of the 5 statutory principles:

- A person must be assumed to have capacity unless it is established that they lack capacity
- A person should not be treated as unable to make a decision unless all practicable steps have been taken to help the person understand
- A person should not be treated as unable to make a decision because they make an unwise decision
- An act done or decision made should always be made in a person's best interest
- Before the act is done or decision made, consideration should be given that this is the least restrictive of the person's basic rights and freedoms

A series of recommendations were made as a result of the audit:

- Implement new templates for mental capacity assessments to improve input and also allow data to be readily pulled off by business intelligence
- Review of MCA audit on InPhase
- Creation of a Gillick Competency Template
- Training - additional training, drop ins, advice, supervision around the completion of the new MCA 2005 templates.
- Creation of an MCA 2005 briefing to feed into the Mental Health Steering Group

The implementation of the recommendations will be led by Mental Health Legislation Steering Group and reported to MHLC in a further report in 6 months.

Associate Hospital Managers (AHM)

A recent recruitment drive has proved successful – 4 new AHMs appointed; 2 of diverse backgrounds. The Trust has 11 AHMs in total, but more are needed to ensure that there are enough who can chair meetings and complete in-person panels. Support and Trust updates are provided via quarterly forum meetings and regular Training / case law updates are provided at the beginning of each of the Forums. Reviews and appraisals completed and arranged in in line with Board dates. Feedback mechanisms in place for any problem areas. There has been a slight increase in numbers of requests for AHM Reviews and further consideration is being given to innovative ways to increase numbers of requests for AHM Reviews. Three NEDs have completed AHM training and are planning to observe a panel each shortly. The chair of MHLC will attend AHM Forum meetings and participate in reviews of AHM appointments.

NHS Insightful Board

The Committee reviewed the questions and measures detailed in the Mental Health domain areas and considered whether there is any more the Trust should be doing to monitor and gain assurance. There was a good level of assurance in all areas and for those gaps identified, either further actions were already in hand or have been identified, mainly in the area of triangulating and analysing data on patient experience and quality of care. The key area for MHLC is around safety and RRI, where there is a high level of assurance. The RRI group is working to ensure all incidents of physical restraint, rapid tranquilisation, seclusion and segregation are correctly inputted into the new EPR (SystmOne) to ensure that the data is accurately reported.

Health inequalities

In relation to race and deprivation, the data on Mental Health Act detentions and on Restrictive Intervention are informative and worth reflecting on:

In summary, the Trust had 1286 new admissions in 2024; 528 of those people admitted were detained under the MHA. People in the most deprived areas had a higher rate of detentions than the population split. Rates of MHA admissions are significantly higher than would be expected based on population split within the 'Black or Black British' ethnic group. This group represents 1%

of the overall local population, but 4.2% of MHA admissions. The use of RI is higher for those in the most deprived population. This trend may be linked to higher acuity and higher levels of trauma among patients within the most deprived deciles. The data shows that the rate of service users subject to RI is higher in the 'Black/Black British' groups and 'Other Mixed' than the population distribution. Overall, the percentage of patients who were subject to RI who came from minoritised communities was 6.5%. The percentage of the local population who are from minoritised backgrounds is 5.1%.

The use of restrictive interventions across the Trust is relatively low, with 252 individual service users subject to restrictive intervention in 2024.The Trust's Reducing Restrictive Intervention (RRI) Group continues to strive to further reduce the use of RI and recognises a hierarchy of RIs, placing particular focus on reducing the highest risk forms of intervention, such as prone restraint. Culture of Care programme and the Trust's RRI Improvement Plan has increased awareness across the Trust of the disproportionate use of RI with minoritised groups. Discussion of the issue has been incorporated in the Trust's De-escalation Management & Intervention training. The Culture of Care programme is supporting further work around reducing restrictive interventions with an explicit focus on ensuring all inpatient care is trauma-informed, autism-informed and culturally competent. Wards involved in the Mental Health Act Quality Improvement programme have had a focus on culturally appropriate care.

Agenda Item 28

Title & Date of Meeting:	Trust Board Public Meeting – 28 May 2025
Title of Report:	Assurance Report to Board from Audit Committee 19 May 2025
Author/s:	Stuart McKinnon-Evans
Recommendation:	

To approve		To discuss	
To note		To ratify	
For assurance	X		

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	Report to the Board of the outcomes of the Audit Committee, for information and assurance.

Key Issues within the report:

Positive Assurances to Provide:

- The BAF was endorsed in respect of Partnerships and Alliances, with further development of the BAF in play
- Community and Primary Care Division risk management was discussed
- External Audit is progressing well for the 2024/25 accounts
- The 2024/25 Internal Audit plan is nearly complete. The draft Head of Internal Audit Opinion is for Significant assurance overall.
- From a sample, 100% of recommendations to be implemented from internal audits are being implemented.
- The counter-fraud programme remains active.
- The single tender waiver regime is operating well, and the recent reforms to procurement regulations are now reflected in Standing Financial Instructions (SFIs)
- The SFIs have been reviewed and updated
- Losses and special payments were reviewed

Key Actions Commissioned/Work Underway:

- Action to clarify, for assurance, how the fire alarm risk at Whitby hospital will be resolved, as reported on Community and Primary Care Division register
- Complete implementation of overdue audit recommendations
- Further follow-up at EMT level on handling service users' money and property
- Finalisation of 2024/25 internal audit programme
- Audit of the 2024/25 accounts underway
- Encouragement to all staff to complete on ESR their Declaration of Interests

Key Risks/Areas of Focus:

- The salient risks on the Trust-wide register score 15 or above relate to neurodiversity waiting lists; and revenue and capital funding
- Community and Primary Care Division risks relate to capacity, staffing and financial pressure, but are being adequately mitigated

Decisions Made:

- Approved the external audit strategy, which is in train
- Approved the Counter Fraud plan for 2025/6
- Reflecting the Procurement Act, approved changes to the tender waiver regime, including

• Limited Assurance conclusion for handling service users' money and property at Mill View Lodge and Maister Lodge is concerning, especially since a similar conclusion was reached last year at other sites.	a name change to Direct Award Justification • Endorsed revisions to the SFIs • Endorsed the Losses and Special Payments report

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

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

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
√	Innovating Quality and Patient Safety
√	Enhancing prevention, wellbeing and recovery
√	Fostering integration, partnership and alliances
√	Developing an effective and empowered workforce
√	Maximising an efficient and sustainable organisation
√	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Assurance Report to Board from Audit Committee 15 May 2025

Committee Assurance Report – Key Issues
The Committee was quorate, and considered the following: **Minutes:** approved. **Terms of Reference and Work Plan** were endorsed with minor revisions. **Board Assurance Framework**: The Committee endorsed the current BAF, noting that further development of it is underway following the recent discussion at Strategic Board. We discussed whether ICS-level turbulence has now increased the strategic risk, because the recently published blueprint may distract personnel from collaborative working – EMT to consider at next iteration of the BAF's contents. **Trust-Wide Risk Register**: the 5 highest residual risks (scores)15/16 relate to neurodiversity service waiting times; and money (capital; and short-term financial performance and medium term financial sustainability). EMT will consider adding a further risk relating to wider NHS reform and the ICS blueprint recently published. **Risk Register of the Community and Primary Care Division**: a deep-dive into this register discussed the residuals risks. The residual risks discussed (9-12) relate to: fire alarms at Whitby Hospital; GP practice financial pressures; insufficient specialist nurses and consultant-led oversight in Pocklington; Virtual Frailty Ward processes; Speech and Language Therapy Team capacity; vacancies in Whitby community teams. The Committee were concerned to gain more definitive assurance about how the fire alarms issues at Whitby will be resolved. We also noted that the other risks are long-standing, and that interim solutions to mitigate them have been put in place. Kerry Brown from the Division explained the arrangements by which risks are identified, assessed and managed. **External Audit**: Forvis Mazars explained their Audit Strategy for the 2024/25 accounts (the audit work itself being underway). Progress is on track to complete as expected. Good working relationships between the Trust team and the auditors were noted. Fees have increased to 30% from £75K to £98K (already accepted in letter of appointment). The Committee endorsed the risks being addressed by the audit approach. **Internal Audit**: The internal audit programme for 2024/25 is nearly complete. Safe Handling of Medicines received Significant Assurance, though there were some signs of incomplete record-keeping. The Committee discussed the Limited Assurance rating for handling service users' money and property at Mill View Lodge and Maister Lodge. It was disappointing to note that despite all the action taken to address similar low levels of assurance from the same audit at different establishment last year, poor compliance with procedures were identified. The CEX and EMT will address as a matter of priority, and the audit will be repeated in 2025/26. There continues to be solid evidence of recommendations being implemented/monitored. The Head of Internal Audit opinion is shaping up to be a positive endorsement of the Trust's internal control regime. We thanked outgoing Audit lead Kim Betts for her sterling work, as she rotates to a new client, and formally welcomed Dannielle Hodson as the new lead manager. **Counterfraud:** Arrangements to counter fraud remain effective, with information, alerts, training, case studies, and background systems operating. The Trust's processes measured up well in recent Local Proactive Exercises.

We reviewed and approved the Counter Fraud Plan for 2025/26. The Plan reflects the adoption of Government Functional Standard GovS 013: Counter Fraud (Functional Standard) – in practice there is a high degree of continuity of approach from last year.

Procurement and Tender Waivers: Procurement procedures have been updated to reflect the Procurement Act. The Act regulates on what thresholds require tender (c £140k for goods or non-health services; £5.37m for works); situations when direct contracts can be awarded; and more transparency via public notification, with 8 day standstill when a contract is awarded without competition. For lower value contracts, we are permitted to make direct contracts, with public notification. This means revisions to the Single Tender Waiver process/documentation and increase in our thresholds to that £140k from £75k; and change of name to "Direct Award Justification" template. The Committee approved.

Since the last Committee, 7 new waivers have been authorised with a total value of £2.11m. The Committee were content with the justifications.

Losses and Special Payments: a small number of payments from 2024/25 were reviewed and noted.

Declarations of Interest: The Committee heard about the controls in play to ensure all staff complete via ESR a declaration of interest (which now incorporates Gifts and Hospitality). Staff who have not yet made a declaration are being contacted. The Committee asked for a progress update in 6 months.

Standing Financial Instructions: updates have been proposed made relating to Procurement Act, and use of the seal, all of which the Committee supported, for onward approval at Board.

Annual Committee effectiveness review: 7 respondents completed the effectiveness review questionnaire, which concluded that the Committee continues to work well, with only one action in hand. So the principle for the Committee will be "continuation without complacency". We agreed that a reference to CQC standards in the terms of reference should be deleted, since the relevant standards are set by HFMA. We noted the risk that self-assessment mean marking one's own homework, but this risk is offset by the presence of external voices. We agreed that the high quality of papers makes the work of the Committee easy, despite their sometimes inevitable length.

Finally we reviewed the meeting. We concluded it had been effective, supported by good quality papers, and in the spirit of Humber values.

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 29

Board Strategic Development Meeting

Agenda

25 June 2025, 9.30 am – 3.30 pm
Multi-use Room, Trust Headquarters

		Lead	Action	Report format	Timings
1.	Apologies for Absence	CF	Note	verbal	9.30
2.	Notes from 30 April 2025 Meeting and Action Log	CF	Note	✓	9.35
3.	Business Items: • Quality Accounts • Annual Report and Accounts •	SS SJ/PB	Approve	✓	9.40
4.	NHS Long-Term Plan/ICB Blue Print Guest speaker –		Discuss		10.00
5.	Humber Impacts (ICB Blue-Print) including Mental Health Host Provider Update	CF/MM	Discuss		10.30
6.	Annual Review of Risk Appetite	SS	Discuss		12.00
7.	**Lunch with Finance and People and OD Colleagues**				13.00
8.	CQC: Quality Statements 3 & 4	SS	Discuss		14.00
9.	Any Other Topical Issues	CF	Discuss		15.00
10.	**Date, Time and Venue of Next Meeting** • 27 August 2025, Multi-Use Room, Trust Headquarters				

Caring, Learning
& Growing Together